

HB

374

<TARGET><BILL>HB 374</BILL><SUBJECT>HB
374</SUBJECT><COMM>SFIN29</COMM></TARGET>

SENATE FINANCE COMMITTEE REPORT

DATE: 5/30/16

FURTHER:

DATE TURNED
IN TO OFFICE: _____

Finance Committee considered CS FOR HOUSE BILL NO. 374(FIN)

HB 374 REINSURANCE PROGRAM; HEALTH INS. WAIVERS

"An Act relating to coverage under a state plan provided by the Comprehensive Health Insurance Association; establishing the Alaska comprehensive health insurance fund; relating to a reinsurance program; relating to the definition of 'residents who are high risks'; relating to an application for a waiver for state innovation for health care insurance; and providing for an effective date."

and recommends:

- be replaced with SCS CS HB 374 (FIN) Same Title Technical Title Change
 New Title/SCR No. _____
- adopt previous SCS _____ (_____) Same Title Technical Title Change
 New Title/SCR No. _____
- attached amendment(s)
- adopt _____ Letter of Intent
- further referral to _____ Committee

Dept Abbr.	
ADM	LWF
CED	LAW
COR	LEG
EED	MVA
DEC	DNR
DFG	DPS
GOV	REV
DHS	DOT
AJS	UA

NEW FISCAL NOTE(S)				
Dept.	Fiscal	Indet.	Zero	FN #

PREVIOUS FISCAL NOTE(S)				
Dept.	Fiscal	Indet.	Zero	FN #
CED	✓			3

APPROPRIATION - no fiscal note

SIGNATURES AND RECOMMENDATIONS:	PRINTED LAST NAME	DO PASS	DO NOT PASS	NO REC	AMEND
<i>Cliff Bishop</i>	Bishop	✓			
<i>Donna Orson</i>	Orson			✓	
<i>John Hoffman</i>	Hoffman	✓			
<i>Patricia Micciche</i>	Micciche			✓	
CO-CHAIR:					
CO-CHAIR: <i>Anna Mackinnon</i>	Mackinnon			✓	

Fiscal Note

State of Alaska
2016 Legislative Session

Bill Version:	CSHB 374(FIN)
Fiscal Note Number:	3
(H) Publish Date:	5/28/2016

Identifier: HB374CS(FIN)-DCCED-DOI-05-27-16
 Title: REINSURANCE PROGRAM; HEALTH INS. WAIVERS
 Sponsor: RLS BY REQUEST OF THE GOVERNOR
 Requester: (H) Finance

Department: Department of Commerce, Community and Economic Development
 Appropriation: Insurance Operations
 Allocation: Insurance Operations
 OMB Component Number: 354

Expenditures/Revenues

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2017 Appropriation Requested	Included in Governor's FY2017 Request	Out-Year Cost Estimates					
			FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	
OPERATING EXPENDITURES								
Personal Services			***	***	***	***	***	***
Travel								
Services								
Commodities								
Capital Outlay								
Grants & Benefits	55,000.0							
Miscellaneous								
Total Operating	55,000.0	0.0	***	***	***	***	***	***

Fund Source (Operating Only)

1248 ACHI Fund	55,000.0							
Total	55,000.0	0.0	***	***	***	***	***	***

Positions

Full-time								
Part-time								
Temporary								

Change in Revenues			***	***	***	***	***	***
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Estimated SUPPLEMENTAL (FY2016) cost: 0.0 (separate supplemental appropriation required)
 (discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY2017) cost: 0.0 (separate capital appropriation required)
 (discuss reasons and fund source(s) in analysis section)

ASSOCIATED REGULATIONS

Does the bill direct, or will the bill result in, regulation changes adopted by your agency? Yes
 If yes, by what date are the regulations to be adopted, amended or repealed? 01/01/17

Why this fiscal note differs from previous version:

Updated analysis to reflect the fund source as a new designated fund code, and updated analysis to reflect creation of a new fund.
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Prepared By: Lori Wing-Heier, Director
 Division: Division of Insurance
 Approved By: Catherine Reardon, Director
 Agency: Division of Administrative Services, DCCED

Phone: (907)465-2560
 Date: 05/27/2016 02:50 PM
 Date: 05/27/16

**REPORTED OUT OF
HFC 05/28/2016**

Control Code: xnVOy

FISCAL NOTE ANALYSIS

STATE OF ALASKA
2016 LEGISLATIVE SESSION

Analysis

HB 374 amends AS 21.55.430, the Alaska Comprehensive Health Insurance Association (ACHIA), to allow legislative appropriation of insurance premium tax receipts collected by the Division of Insurance to fund the reinsurance program created in HB374.

In 2014 the division collected approximately \$74M in total receipts of which \$64M was premium taxes. Of that \$64M approximately \$5M transfers to the Department of Labor as a Workers' Compensation Service Fee as required under AS 23.05.067. The legislature could appropriate up to an estimated \$59M based on the division's 2015 annual report. Annual collections of premium taxes for the prior three fiscal years are: \$52 million in FY2013; \$55 million in FY2014; and \$64 million in FY2015.

The Alaska Comprehensive Health Insurance Fund will be created, as well as a new designated fund code. The Division of Insurance will enter into a grant agreement under AS37.05.316 with ACHIA to reimburse for claims paid in excess of policy premiums collected.

While there is no net change to revenue generated from premium taxes, premium taxes previously received and deposited into the general fund will instead be deposited in to the new fund, and used to fund the reinsurance program.

The operating expenses of the division are restricted funds and collected as licensing, surplus lines, risk-retention groups, purchasing groups certificate of authority, continuing education, examination expenses, fingerprinting and other fees in addition to retaliatory taxes, and do not come out of premium taxes.

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Governor Bill Walker
STATE OF ALASKA

March 24, 2016

The Honorable Mike Chenault
Speaker of the House
Alaska State Legislature
State Capitol, Room 208
Juneau, AK 99801-1182

Dear Speaker Chenault:

Under the authority of Article III, Section 18 of the Alaska Constitution, I am transmitting a bill relating to residents who are high risk and to the state health insurance plan.

The bill would make changes to the Alaska Insurance Code (code) for assessments made under a reinsurance program established to reinsure "residents who are high risks." As the code is currently written, a member of the reinsurance program may offset 50 percent of the amount of the assessment made under the reinsurance program (and other state health insurance programs) as a premium tax credit. The bill would remove the assessments made in relation to the high risk reinsurance program from the offset provision. The bill also would amend the definition of "residents who are high risks." These changes are intended to provide a mechanism to help insurers spread the risk of high-cost claims in the individual health insurance market.

The bill also would authorize legislation to allow the State to seek a waiver of certain requirements under the Affordable Care Act in order to implement innovations with respect to the provision of health insurance coverage in the state. This would give the State the ability to restructure the approach to health insurance reform by waiving and proposing alternatives to applicable provisions of the Affordable Care Act.

I urge your prompt and favorable action on this measure.

Sincerely,

A handwritten signature in black ink that reads "Bill Walker".

Bill Walker
Governor

Enclosure



History of ACHIA High-Risk Health Insurance Pool
Prepared for Senate Finance
June 2, 2016

Enacted in 1992, the Alaska Comprehensive Health Insurance Association (ACHIA) was created by the Alaska State Legislature to provide coverage for uninsurable residents through a state high-risk health insurance pool.

ACHIA allowed individuals who didn't have access to the group market (insurance through an employer or family member's employer), and who were denied coverage in the individual market because of a pre-existing medical condition, to obtain health insurance.

Premiums were set at 150 percent above the standard individual market rate.

If claims and pool expenses exceeded the premiums paid, assessments were made on health insurers transacting business in the state to cover those costs.

In 2006, the legislature amended AS 21.55 to allow insurers to offset 50 percent of the amount of any assessment as a premium tax credit, reducing the premium tax paid under AS 21.09.210.

Premium Tax

Insurers pay premium tax in lieu of all other state taxes based on income; insurers do not pay corporate income tax in Alaska. This tax revenue is general fund money that the legislature may appropriate for any purpose.

Division of Insurance Funding

The receipts that fund the Division of Insurance include certificate of authority fees paid by insurers and license or registration fees paid by producers, brokers, adjusters, and others.

*adopted
6/2/16*

29-GH2126V
Glover/Wallace
6/2/16

SENATE CS FOR CS FOR HOUSE BILL NO. 374(FIN)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-NINTH LEGISLATURE - FOURTH SPECIAL SESSION

BY THE SENATE FINANCE COMMITTEE

Offered:

Referred:

Sponsor(s): HOUSE RULES COMMITTEE BY REQUEST OF THE GOVERNOR

A BILL

FOR AN ACT ENTITLED

1 **"An Act relating to coverage under a state plan provided by the Comprehensive Health**
2 **Insurance Association; establishing the Alaska comprehensive health insurance fund;**
3 **relating to a reinsurance program; relating to the definition of 'residents who are high**
4 **risks'; relating to an application for a waiver for state innovation for health care**
5 **insurance; and providing for an effective date."**

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

7 *** Section 1.** AS 21.55.320 is amended by adding a new subsection to read:

8 (b) When a person with a disability that is covered under 42 U.S.C. 1395 -
9 1395b-10 (Title XVIII of the Social Security Act) is referred by an insurer to a state
10 plan under AS 21.55.310, the plan administrator shall request that the Department of
11 Health and Social Services provide information to the person about applying for the
12 federal benefits.

13 *** Sec. 2.** AS 21.55.400 is amended to read:

Sec. 21.55.400. Duties of director. The director may

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

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

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

(4) formulate general policy and adopt regulations that are reasonably necessary to administer this chapter, including regulations establishing a reinsurance program reinsuring residents who are high risks and specifying covered conditions eligible for payment through the reinsurance program [, THAT ARE REASONABLY NECESSARY TO ADMINISTER THIS CHAPTER].

* **Sec. 3.** AS 21.55 is amended by adding a new section to read:

Sec. 21.55.430. Alaska comprehensive health insurance fund. (a) The Alaska comprehensive health insurance fund is established in the general fund. The Department of Administration shall separately account for revenue collected under AS 21.09.210, AS 21.33.055, 21.33.061, AS 21.34.180, and AS 21.66.110 and deposit net proceeds into the Alaska comprehensive health insurance fund. The Department of Administration shall deposit interest earned on the Alaska comprehensive health insurance fund in the general fund.

(b) The legislature may use the annual estimated balance in the Alaska comprehensive health insurance fund to make appropriations to the Department of Commerce, Community, and Economic Development to fund the reinsurance program under this chapter.

(c) Payment for claims under the reinsurance program under this chapter is subject to appropriation.

(d) Money in the fund does not lapse.

(e) Nothing in this section creates a dedicated fund.

(f) In this section, "net proceeds" includes

(1) revenue accounted for under (a) of this section, less all return

1 premiums, fees under AS 23.05.067, errors, and other adjustments;

2 (2) penalties and interest on late payments accounted for under (a) of
3 this section.

4 * **Sec. 4.** AS 21.55.500(20) is amended to read:

5 (20) "residents who are high risks" means residents who

6 (A) have been rejected for medical reasons after applying for a
7 subscriber contract, a policy of health insurance, or a Medicare supplement
8 policy by at least one association member within the six months immediately
9 preceding the date of application for a state plan; medical reasons may include
10 preexisting medical conditions, a family history that predicts future medical
11 conditions, or an occupation that generates a frequency or severity of injury or
12 disease that results in coverage not being generally available;

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

16 (C) meet other requirements adopted by regulation by the
17 director that are consistent with this chapter [AND THAT INDICATE THAT
18 A PERSON IS UNABLE TO OBTAIN COVERAGE SUBSTANTIALLY
19 SIMILAR TO THAT WHICH MAY BE OBTAINED BY A PERSON WHO
20 IS CONSIDERED A STANDARD RISK];

21 * **Sec. 5.** AS 21.96 is amended by adding a new section to read:

22 **Sec. 21.96.120. Waiver for state innovation.** The director may apply to the
23 United States Secretary of Health and Human Services under 42 U.S.C. 18052 for a
24 waiver of applicable provisions of P.L. 111-148 (Patient Protection and Affordable
25 Care Act) with respect to health insurance coverage in the state for a plan year
26 beginning on or after January 1, 2017. The director may implement a state plan
27 meeting the waiver requirements in a manner consistent with state and federal law and
28 as approved by the United States Secretary of Health and Human Services.

29 * **Sec. 6.** AS 21.55.430 is repealed June 30, 2018.

30 * **Sec. 7.** The uncodified law of the State of Alaska is amended by adding a new section to
31 read:

1 RETROACTIVITY. If sec. 3 of this Act takes effect after June 30, 2016, sec. 3 of this
2 Act is retroactive to June 30, 2016.

3 * **Sec. 8.** Sections 1, 2, 4, 5, and 7 of this Act take effect immediately under
4 AS 01.10.070(c).

5 * **Sec. 9.** Section 3 of this Act takes effect June 30, 2016.



HB 374 – Version P
Reinsurance Program; Health Insurance Waivers
Sectional Analysis

Sec. 1. AS 22.55.320 is amended by adding a new subsection to require that the when a person with a disability, (as defined by Title XVIII of the Social Security Act) is to be referred by the insurer to ACHIA. ACHIA's administrator shall then request that the State of Alaska's Department of Health and Social Services provide the person with information about applying for any federal benefits that they may qualify for, such as Medicare or Medicaid.

Sec 2. AS 21.55.400 amends the duties of the director to allow the director to formulate and adopt regulations that are reasonably necessary to administer the chapter (ACHIA) and specify the covered conditions eligible for payment through appropriations from the Alaska comprehensive health insurance fund established under AS 21.55.430.

Sec. 3. AS 21.55.430 (a) amends the Alaska Comprehensive Health Insurance Association (ACHIA), Chapter 55, by creating the Alaska comprehensive health insurance fund and by providing that the Department of Administration, shall separately account for revenue collected as insurance premium tax under:

- AS 21.09.210 – Tax on insurers
- AS 21.33.055 – Unauthorized insurance premium
- AS.22.33.061 – Independently procured insurance
- AS 21.34.180 – Surplus lines
- AS 21.66.110 – Title insurance

The net proceeds shall then be deposited into the Alaska comprehensive health insurance fund. The Department of Administration shall deposit interest earned on the Alaska comprehensive health insurance fund into the general fund.

(b) provides that the legislature may use the annual balance in the Alaska comprehensive health insurance fund, as established in (a), to make appropriations to the Department of Commerce, Community, and Economic and Economic Development to fund the reinsurance program under Chapter 55.

(c) states that payment for claims under the reinsurance program is subject to appropriation.

(d) provides that money in the Alaska comprehensive health insurance fund does not lapse.

(e) states that the Alaska comprehensive health insurance fund is not a dedicated fund.

(f) defines net proceeds, as used in (a) to include the revenue under the taxes listed in (a) less all return premiums, fees under AS 23.05.067, errors and other adjustments, penalties and interest on late payments.

In 2014 the division collected approximately \$74M in total receipts of which \$64M was premium taxes. Of that \$64M approximately \$5M transfers to the Department of Labor as a Workers' Compensation Service Fee as required under AS 23.05.067. The potential would be that the legislature could appropriate up to an estimated \$59M based on the division's 2015 annual report.

The operating expenses of the division are restricted funds and collected as licensing, surplus lines, risk-retention groups, purchasing groups certificate of authority, continuing education, examination expenses, fingerprinting and other fees in addition to retaliatory taxes and are not be subject to this bill.

Sec. 4. AS 21.55.500 (20) amends the definition of "residents who are high risks" by deleting the requirement that the person be unable to obtain insurance coverage substantially similar to that which may be obtained by a person who is considered a standard risk. Under the ACA, an insurer is no longer allowed to deny coverage to a person based on a pre-existing condition making this part of statute a moot point. Deleting this language enables the creation of the reinsurance program and provides the director of insurance with the flexibility needed in designing the program by authorizing the director to supplement the definition of "residents who are high risk"

Sec. 5. AS 21.96 is amended by adding a new section to allow for a waiver for state innovation. Under the ACA, states may submit an application to the Secretary of the United States Department of Health and Human Services requesting a waiver from certain provisions of the Act. In order to receive this waiver, the state must have enabling legislation and Sec. AS 21.96.120 provides that the director of the Division of Insurance may apply for a waiver and, if granted, implement a state plan meeting the waiver requirements in a manner consistent with state and federal law.

Sec. 6. Provides for retroactivity for section 3.

Sec. 7. Provides for an immediate effective date.



THE STATE
of **ALASKA**
GOVERNOR BILL WALKER

**Department of Commerce, Community,
and Economic Development**

DIVISION OF INSURANCE

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**HB 374 – Version A to Version P
Reinsurance Program; Health Insurance Waivers
Summary of Substantive Changes**

Section 1: Section one is a new section requiring the plan administrator and the Department of Health and Social Services provide information about federal benefits to persons referred to the Alaska Comprehensive Health Insurance Association (ACHIA) reinsurance program.

Section 2: Section two is a new section amending the duties of the director to adopt regulations specifying covered conditions for the ACHIA reinsurance program.

Section 3: The initial version of HB 374 funded the reinsurance program by amending statute to allow for an assessment to insurers based on total covered lives. In version P, the program is funded by creating the Alaska comprehensive health insurance fund and separately accounting for insurance premium tax revenues. This section is renumbered.

Sections 4-7: The remaining sections of this legislation have been renumbered without any substantive changes in content.

Historical Eligibility for ACHIA

Any Alaska resident is eligible for the ACHIA plan if he or she:

- has received from at least one health insurer a notice of rejection for health insurance dated within the last six months;
- has received restrictive riders that substantially reduce coverage;
- has any of the conditions listed below:

Acquired Immune Deficiency Syndrome (AIDS)

Alzheimer's

Angina Pectoris

Anorexia Nervosa

Arteriosclerosis Obliterans

Artificial Heart Valve

Ascites

Brain Tumors

Cardiomyopathy

Cerebral Palsy

Chronic Pancreatitis

Cirrhosis of the Liver

Coronary Insufficiency

Coronary Occlusion

Crohn's Disease

Cystic Fibrosis

Dermatomyositis

Diabetes

Epilepsy

Friedreich's Disease

Heart Disorders

Hemophilia

Hepatitis C (Active)

HIV+

Hodgkin's Disease

Huntington's Chorea

Hydrocephalus

Intermittent Claudication

Kidney Failure

Lead Poisoning with Cerebral Involvement

Leukemia

Lupus Erythematosus Disseminate

Malignant Tumor (if treated or has occurred in last four years)

Mental Retardation

Metastatic Cancer

Motor or Sensory Aphasia

Multiple or Disseminated Sclerosis

Muscular Atrophy or Dystrophy

Myasthenia Gravis

Myotonia

Obesity - Morbid

Open Heart Surgery

Paraplegia or Quadriplegia

Parkinson's Disease

Peripheral Arteriosclerosis (if treated within last three years)

Poliomyelitis

Polycystic Kidney

Polyarteritis (periarteritis nodosa)

Postero-lateral Sclerosis

Psychotic Disorders

Rheumatoid Arthritis

Sickle Cell Anemia

Silicosis

Splenic Anemia (True Banti's Syndrome)

Still's Disease

Stroke (CVA)

Syringomyelia

Tabes Dorsalis (locomotor ataxia)

Thalassemia (Cooley's or Mediterranean Anemia)

Topectomy and Lobotomy

Ulcerative Colitis

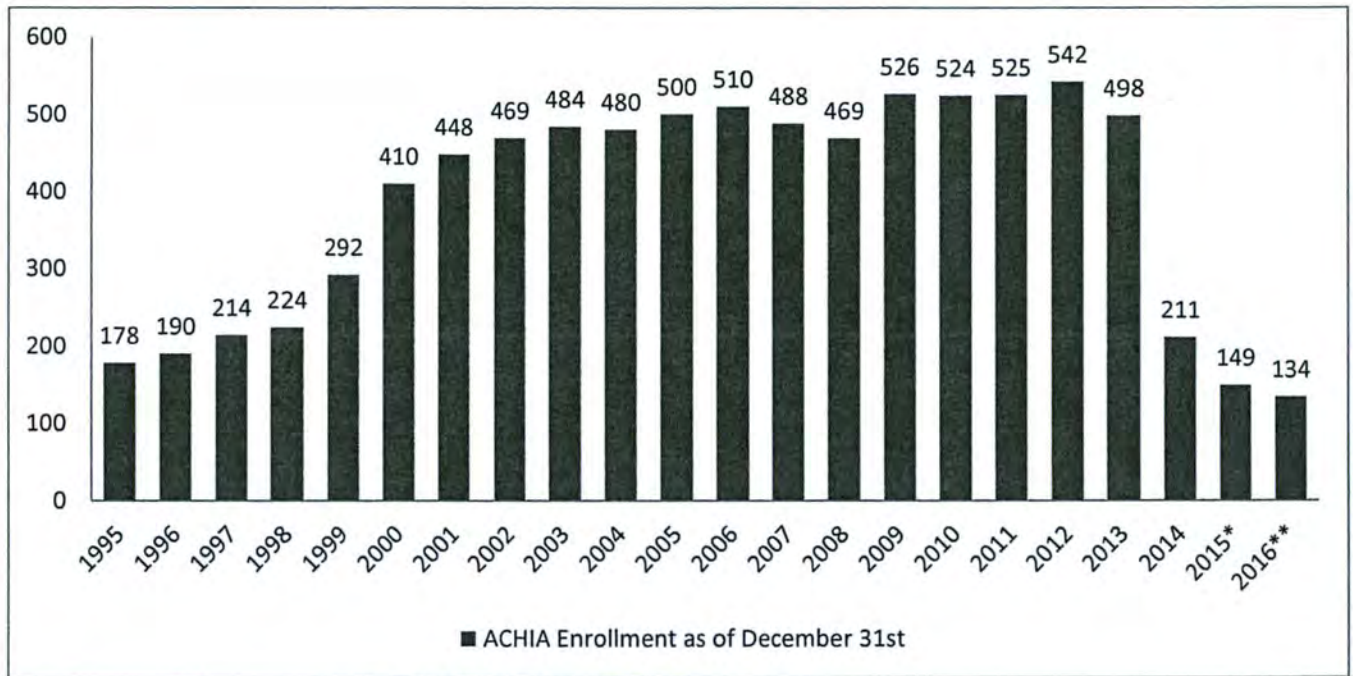
Wilson's Disease

Individuals covered by Medicare may still be eligible for coverage.

Effective July 1, 1997, a 'federally eligible individual' can purchase ACHIA coverage provided they are a resident of Alaska at the time of application. ACHIA is also available to those individuals who qualify under the federal Health Coverage Tax Credit program.

All data from ACHIA <http://www.achia.com> and ACHIA Annual Reports http://www.achia.com/annual_reports.asp.

ACHIA Total Enrollment



*As of June 2015. 53.7% of enrollment is in Medicare Supplement plans.

**As of May 2016.

At the beginning of 2014, there were 498 insureds on the plan. During the year, there were 330 terminations.

ACHIA Enrollment by Zip Code

	2013	2014	Change
Anchorage Zip 995	246	102	58.5%
Zip 996	145	56	61%
Fairbanks Zip 997	56	22	61%
Juneau Zip 998	34	18	47%
Ketchikan Zip 999	17	13	23.5%

If HB374 is passed by the Alaska State Legislature ACHIA will now service two purposes. It will continue to act as it has since 1992, and beginning in January of 2017, enrollees in the individual market who have been diagnosed with certain claim conditions will be ceded to ACHIA. In this function, ACHIA will be the reinsurer of the primary insurer (i.e. Premera).

Currently there are 495 enrollees that have been diagnosed with the following conditions:

HCC #	HCC
26	Mucopolysaccharidosis
70	Sickle Cell Anemia (Hb-SS)
112	Quadriplegic Cerebral Palsy
66	Hemophilia
75	Coagulation Defects and Other Specified Hematological Disorders
184	End Stage Renal Disease
118	Multiple Sclerosis
251	Stem Cell, Including Bone Marrow, Transplant Status/Complications
115	Myasthenia Gravis/Myoneural Disorders and Guillain-Barre Syndrome/Inflammatory and Toxic Neuropathy
10	Non-Hodgkin's Lymphomas and Other Cancers and Tumors
9	Lung, Brain, and Other Severe Cancers, Including Pediatric Acute Lymphoid Leukemia
8	Metastatic Cancer
247	Premature Newborns, Including Birthweight 2000-2499 Grams

These enrollees have claims that have cost the individual market approximately \$58,872,151. Under the HB374; these enrollees would be ceded to ACHIA meaning that their claims and premiums would be sent to ACHIA for administration and resolution upon diagnosis. Adjusting for medical trends and the premiums that would also be ceded; the net cost to ACHIA would \$51,005,403.

If the claims exceed the \$55M appropriated by the legislature, the claim would become the responsibility of the insurer again. To the enrollee, the process would be transparent and they would most likely not know that their claim was ceded to ACHIA as all claims management, etc. would be performed by the primary insurer.

Please note, that the exact operation of the program is to be defined by regulation which will begin once the bill has been enacted.

CC Set 1

Paid Claims	237,774,342
Claims Removed	26,332,990
Remaining Claims	211,451,352
Percentage Remaining	88.9%
# Claimants	29,869
Claimants Removed	196
Remaining Claimants	29,673
Percentage Remaining	99.3%

HCC # HCC

- 26 Mucopolysaccharidosis
- 70 Sickle Cell Anemia (Hb-SS)
- 112 Quadriplegic Cerebral Palsy
- 66 Hemophilia
- 75 Coagulation Defects and Other Specified Hematological Disorders
- 184 End Stage Renal Disease
- 118 Multiple Sclerosis
- 251 Stem Cell, Including Bone Marrow, Transplant Status/Complications

CC Set 2

Paid Claims	237,774,342
Claims Removed	53,872,151
Remaining Claims	185,845,858
Percentage Remaining	78.2%
# Claimants	29,869
Claimants Removed	495
Remaining Claimants	29,374
Percentage Remaining	98.3%

HCC #	HCC
26	Mucopolysaccharidosis
70	Sickle Cell Anemia (Hb-SS)
112	Quadriplegic Cerebral Palsy
66	Hemophilia
75	Coagulation Defects and Other Specified Hematological Disorders
184	End Stage Renal Disease
118	Multiple Sclerosis
251	Stem Cell, Including Bone Marrow, Transplant Status/Complications
115	Myasthenia Gravis/Myoneural Disorders and Guillain-Barre Syndrome/Inflammatory and Toxic Neuropathy
10	Non-Hodgkin's Lymphomas and Other Cancers and Tumors
9	Lung, Brain, and Other Severe Cancers, Including Pediatric Acute Lymphoid Leukemia
8	Metastatic Cancer
247	Premature Newborns, Including Birthweight 2000-2499 Grams

CC Set 3

Paid Claims	237,774,342
Claims Removed	70,911,323
Remaining Claims	169,030,235
Percentage Remaining	71.1%
# Claimants	29,869
Claimants Removed	874
Remaining Claimants	28,995
Percentage Remaining	97.1%

HCC # HCC

- 26 Mucopolysaccharidosis
- 70 Sickle Cell Anemia (Hb-SS)
- 112 Quadriplegic Cerebral Palsy
- 66 Hemophilia
- 75 Coagulation Defects and Other Specified Hematological Disorders
- 184 End Stage Renal Disease
- 118 Multiple Sclerosis
- 251 Stem Cell, Including Bone Marrow, Transplant Status/Complications
- 115 Myasthenia Gravis/Myoneural Disorders and Guillain-Barre Syndrome/Inflammatory and Toxic Neuropathy
- 10 Non-Hodgkin's Lymphomas and Other Cancers and Tumors
- 9 Lung, Brain, and Other Severe Cancers, Including Pediatric Acute Lymphoid Leukemia
- 8 Metastatic Cancer
- 247 Premature Newborns, Including Birthweight 2000-2499 Grams
- 109 Paraplegia
- 94 Anorexia/Bulimia Nervosa
- 254 Amputation Status, Lower Limb/Amputation Complications
- 48 Inflammatory Bowel Disease
- 2 Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock
- 159 Cystic Fibrosis
- 45 Intestinal Obstruction
- 29 Amyloidosis, Porphyria, and Other Metabolic Disorders
- 111 Amyotrophic Lateral Sclerosis and Other Anterior Horn Cell Disease
- 1 HIV/AIDS

CC Set 4

Paid Claims	237,774,342
Claims Removed	78,486,590
Remaining Claims	160,827,834
Percentage Remaining	67.6%
# Claimants	29,869
Claimants Removed	1,291
Remaining Claimants	28,578
Percentage Remaining	95.7%

HCC # HCC

- 26 Mucopolysaccharidosis
- 70 Sickle Cell Anemia (Hb-SS)
- 112 Quadriplegic Cerebral Palsy
- 66 Hemophilia
- 75 Coagulation Defects and Other Specified Hematological Disorders
- 184 End Stage Renal Disease
- 118 Multiple Sclerosis
- 251 Stem Cell, Including Bone Marrow, Transplant Status/Complications
- 115 Myasthenia Gravis/Myoneural Disorders and Guillain-Barre Syndrome/Inflammatory and Toxic Neuropathy
- 10 Non-Hodgkin's Lymphomas and Other Cancers and Tumors
- 9 Lung, Brain, and Other Severe Cancers, Including Pediatric Acute Lymphoid Leukemia
- 8 Metastatic Cancer
- 247 Premature Newborns, Including Birthweight 2000-2499 Grams
- 109 Paraplegia
- 94 Anorexia/Bulimia Nervosa
- 254 Amputation Status, Lower Limb/Amputation Complications
- 48 Inflammatory Bowel Disease
- 2 Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock
- 159 Cystic Fibrosis
- 45 Intestinal Obstruction
- 29 Amyloidosis, Porphyria, and Other Metabolic Disorders
- 111 Amyotrophic Lateral Sclerosis and Other Anterior Horn Cell Disease
- 1 HIV/AIDS
- 56 Rheumatoid Arthritis and Specified Autoimmune Disorders
- 38 Acute Liver Failure/Disease, Including Neonatal Hepatitis
- 37 Chronic Hepatitis
- 119 Parkinson's, Huntington's, and Spinocerebellar Disease, and Other Neurodegenerative Disorders
- 35 End-Stage Liver Disease
- 69 Acquired Hemolytic Anemia, Including Hemolytic Disease of Newborn
- 113 Cerebral Palsy, Except Quadriplegic
- 71 Thalassemia Major
- 27 Lipidoses and Glycogenosis
- 46 Chronic Pancreatitis

Annualized Adjustment Estimate

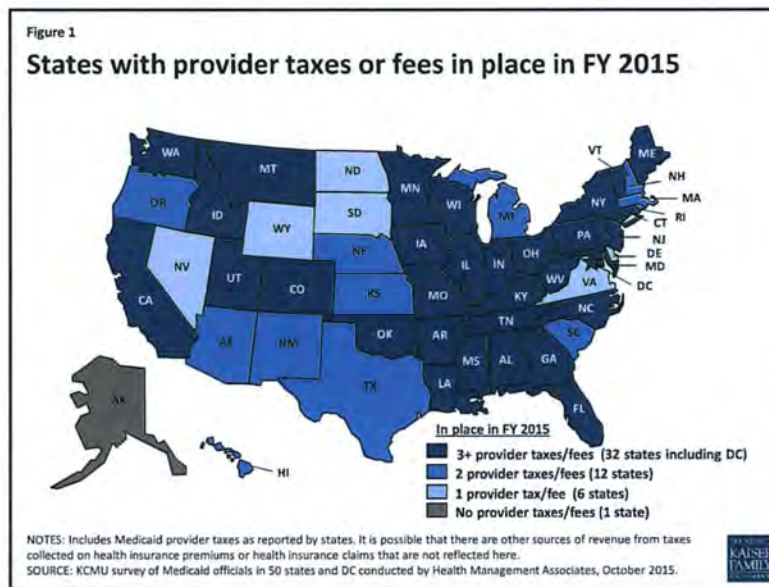
2015 Adjusted Claims	197,993,163
Medical Trend Factor (2 years at 12%)	1.254
2017 Claim Estimate	248,362,624
2017 Premium Estimate	285,514,814

	Condition Set 1	Condition Set 2	Condition Set 3	Condition Set 4
2017 Claim Estimate	248,362,624	248,362,624	248,362,624	248,362,624
Estimated Percentage of Claims Remaining	88.9%	78.2%	71.1%	67.6%
Estimated Claims Remaining	220,867,450	194,121,722	176,557,286	167,989,626
Estimated Claims Ceded	27,495,174	54,240,902	71,805,338	80,372,998
Estimated Percentage of Claimants Remaining	99.3%	98.3%	97.1%	95.7%
<i>Estimated Percentage of Members Remaining</i>	<i>99.6%</i>	<i>98.9%</i>	<i>98.0%</i>	<i>97.0%</i>
Estimated Premium Ceded	1,281,127	3,235,499	5,712,780	8,438,443
Estimated Net Cost to Program	26,214,047	51,005,403	66,092,558	71,934,555

March 2016 | Fact Sheet

States and Medicaid Provider Taxes or Fees

Medicaid is jointly financed by states and the federal government. Provider taxes are an integral source of Medicaid financing governed by long-standing regulations. Currently, all but one state (Alaska) reported a provider tax in FY 2015. (Figure 1) Congress is currently considering proposals to limit the use of provider taxes. This would restrict states' ability on how to come up with the state share to finance Medicaid and could therefore shift additional costs to states. If states were not able to find additional funds to replace provider tax funding with other state sources, limits on provider taxes could result in program cuts with implications for Medicaid providers and beneficiaries. Since states use provider taxes differently, limits would have different effects across states. This factsheet briefly highlights the role of provider taxes in states and the possible impact of proposals to limit the use of these taxes. Data is based on findings from the most recent [survey of Medicaid programs](#) conducted by the Kaiser Commission on Medicaid and the Uninsured and Health Management Associates.



HOW IS THE MEDICAID PROGRAM FINANCED? States and the federal government share in the financing of the Medicaid program. Under federal Medicaid law, the federal government pays between 50 and 74 percent of all the costs of providing services to beneficiaries under the program. These matching rates (FMAPs) vary across states based on the state's per capita income in comparison to the national average (i.e. states with lower per capita income have higher matching rates.) The remaining share of program funding comes from state and local sources. One of the ways states raise funds for their share of Medicaid spending is through provider taxes/fees. Some states also indicated that they planned to use provider taxes/fees to fund the state share of the Medicaid expansion when the federal match drops to from 100% to 95% in January 2017.¹

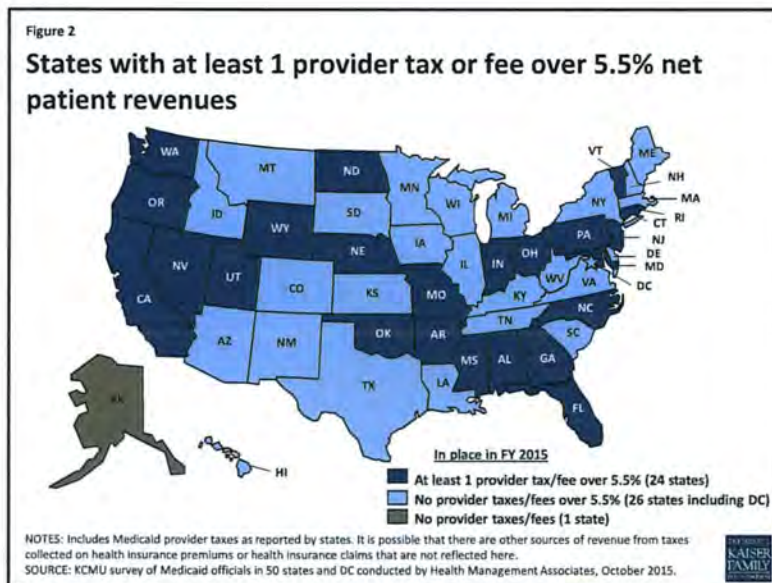
WHAT ROLE DO PROVIDER TAXES PLAY IN STATE FINANCING OF MEDICAID? Provider taxes are imposed by states on health care services where the burden of the tax falls mostly on providers, such as a tax on inpatient hospital services or nursing facility beds. Provider taxes have become an integral source of financing for Medicaid. For FY 2015, all but one state (Alaska) reported having at least one Medicaid provider tax and nearly two-thirds of states reported three or more provider taxes. (Table 1, Figure 1)

States use the additional revenue collected by provider taxes in a number of ways to support Medicaid programs. For example, provider taxes help to support provider rate increases or to help mitigate provider rate cuts. States also have used funds collected from provider taxes to support the Medicaid program more broadly. For example, Colorado used some of the funds raised through their Hospital provider fee to expand eligibility to parents and children. During economic downturns, when state tax revenues fall at the same time that demand for public services like Medicaid increases, states are more likely to impose or increase provider taxes to help fund the state share of Medicaid.

In the past, states were able to use provider taxes and other state financing arrangements to enable states to receive higher effective federal matching rates than the statutory formula provides. However, legislation enacted in 1991 restricted the use of provider taxes to curb abusive practices. Under current regulations, states may not use provider tax revenues for the state share of Medicaid spending unless the tax meets three requirements: must be broad-based, uniformly imposed, and cannot hold providers harmless from the burden of the tax. Federal regulations create a safe harbor from the hold-harmless test for taxes where collections are 6.0 percent or less of net patient revenues.²

WHAT WOULD THE IMPACT OF LIMITING THE USE OF PROVIDER TAXES BE ON STATES?

Recent legislative proposals have suggested lowering the safe harbor threshold from 6.0 percent to 5.5 percent of net patient revenues. States have indicated that nearly 3 in 10 provider taxes currently in use by states are above that threshold. During our survey conducted in July 2015, 24 states estimated that at least one provider tax above this 5.5 percent threshold (Figure 2); half of these states (12) reported 2 or more provider taxes/fees above this threshold.³ (Table 1)



Limitations on provider taxes would have a more notable impact in those states that are heavily dependent on provider tax revenues to fund their state share of Medicaid spending. If provider taxes are limited, states would need to increase state funds to maintain current programs or make program cuts. Such changes in available financing could have negative implications for providers and beneficiaries under the current operation of the program as well as for the implementation of the ACA.

Table 1: Provider Taxes and Fees in Place in FY 2015

State	Have at least 1 provider tax	# of taxes	Have at least 1 provider tax over 5.5% of net patient revenue	# of taxes over 5.5%
AK	-	0	-	0
AL	X	3	X	1
AR	X	3	X	2
AZ	X	3	-	0
CA	X	4	X	2
CO	X	3	-	0
CT	X	3	X	1
DC	X	4	-	0
DE	X	1	-	0
FL	X	3	X	2
GA	X	3	X	2
HI	X	2	-	0
IA	X	3	-	0
ID	X	3	-	0
IL	X	3	-	0
IN	X	3	X	1
KS	X	2	-	0
KY	X	5	-	0
LA	X	3	-	0
MA	X	3	-	0
MD	X	4	X	2
ME	X	4	-	0
MI	X	2	-	0
MN	X	4	-	0
MO	X	5	X	3
MS	X	4	X	4
MT	X	3	-	0
NC	X	3	X	1
ND	X	1	X	1
NE	X	2	X	1
NH	X	2	-	0
NJ	X	5	X	1
NM	X	2	-	0
NV	X	1	X	1
NY	X	5	-	0
OH	X	3	X	2
OK	X	3	X	2
OR	X	2	X	1
PA	X	5	X	3
RI	X	3	X	1
SC	X	2	-	0
SD	X	1	-	0
TN	X	4	-	0
TX	X	2	-	0
UT	X	3	X	1
VA	X	1	-	0
VT	X	5	X	4
WA	X	3	X	2
WI	X	4	-	0
WV	X	5	-	0
WY	X	1	X	1
Total	50	151	24	42

NOTES: This table includes Medicaid provider taxes as reported by states. Some states also have premium or claims taxes that apply to managed care organizations and other insurers. Since this type of tax is not considered a provider tax by CMS, these taxes are not counted as provider taxes in this report. CA, DC, MD, NM, RI, TN, TX reported MCO taxes that were counted as Medicaid provider taxes; none of these taxes exceeded 5.5% of net patient revenues.

SOURCE: Kaiser Commission on Medicaid and the Uninsured Survey of Medicaid Officials in 50 states and DC conducted by Health Management Associates, October 2015.

Endnotes

¹ As part of the July 2015 survey, at least seven states (Arizona, California, Colorado, Indiana, Kentucky, Nevada and Ohio) indicated plans to use provider taxes/fees to fund at least some of the state share of the Medicaid expansion when the federal match rate declines from 100% for those newly eligible.

² Prior to October 2011, this safe harbor threshold was temporarily reduced to 5.5 percent of net patient revenues.

³ State responses reflect estimates; some taxes are imposed in a way that is not directly tied to the % of net patient revenue (e.g. nursing home bed tax.)

- Thank you, Chair MacKinnon and Co-Chair Kelly and members of the Committee
- For the record, I am Sheela Tallman with Premera Blue Cross Blue Shield of Alaska
- I am here today testifying **in support of HB 374**
- The individual health insurance market is in crisis
- I'd like to start by briefly describing what got us here-- With health reform, in 2014, the **major change** to the insurance market was **guaranteed issue** to all individuals without preexisting condition exclusions. This provided access to insurance for several thousands of individuals
 - And, Premera and insurers priced products estimating the impact of the uninsured purchasing coverage for the first time
 - We experienced a significant influx of new enrollees with very high medical costs , **many leaving the high risk pool (which has shrunk by half)** and the **federal preexisting condition pool** and Premera lost approximately \$13 million in the individual market
- For 2015 and 2016, Premera had approximately 37% and 39% average rate increases **for the individual metallic** plans, but claims continue to exceed premiums.
 - To break even in 2015, Premera would have needed a 70% increase
- To say it differently, Premera is taking in on average \$713 in premium PMPM and paying claims at \$919 PMPM, demonstrating the very high claims costs in the individual pool
- In a very small sized market like Alaska, **there are not enough healthy individual purchasers to offset the costs of enrollees with very high medical needs**
- Today-- Alaska's average benchmark plan premium is the highest in the country (over \$700 per month; next highest state is \$468)
 - While states are experiencing similar increases, impacts in Alaska are more than double
 - While subsidies help many, Premera has **over 1,200** individuals who do not qualify for them

- We are very concerned that **premiums will continue to skyrocket** due to the small size of the individual pool
 - With fewer people to spread risk across, a small number of individuals with high cost conditions is destabilizing the pool and impacting costs dramatically
 - One solution – is an approach other insurers already took- to exit the individual market
 - Alternatively, Premera has been working collaboratively with the DOI to come up with a sustainable option for Alaskans—which is the reinsurance program administered by the state’s high risk pool, ACHIA
 - The reinsurance program would **cover/reinsure the claims** for the **highest cost medical conditions** (long term, chronic conditions- heart failure, kidney disease)
 - A reinsurance program would help mitigate the premium increases for individual policyholders, but also stabilize the market which can potentially attract new competitors
 - It also provides more financial certainty to customers about their health insurance
 - Premera also supports the state innovation waiver
 - Premera supports flexibility at the state level to help Alaskans maintain the coverage they’ve had and to tailor reforms to meet the unique needs of the AK market.
 - A waiver would allow the state to explore long term ideas to help address the high cost of healthcare in this state
 - What Alaskans need is immediate relief from these year over year premium increases
 - HB 374 will help mitigate these swings and on behalf of the 23k individual policyholders, we ask for your support
 - Thank you
-

**Alaska Mental Health Board
Advisory Board on Alcoholism and Drug Abuse
431 N. Franklin St. Suite 200
Juneau, Alaska, 99801**



June 1, 2016

To: Senate Finance Committee

Re: Support for HB 374 Reinsurance, Health Insurance Waiver

While many of the constituents of the Alaska Mental Health Board and Advisory Board on Alcoholism and Drug Abuse rely on Medicaid for their health insurance coverage, there are just as many who rely on private insurance – through employers or through the private insurance marketplace – for their coverage. There are many working Alaskans who are ineligible for Medicaid who cannot afford the private health insurance plans available in the limited market. This results in some families incurring debt for health care services due to high deductible, co-pay, or coinsurance costs. Other families go without insurance and without preventative and therapeutic health care services.

Many behavioral health practitioners operate as small businesses, either as solo practitioners or small practices. Private behavioral health practitioners cannot always purchase for themselves or provide for employees affordable insurance, because the plans are so limited and so expensive. Even large non-profit behavioral health centers struggle with the costs of providing health insurance for their employees. The difficulty in providing health insurance benefits compromises the recruitment and retention of qualified behavioral health providers in some communities.

The number of Alaskans experiencing behavioral health conditions is significant, and so is the need for affordable health insurance to support access to necessary services. HB 374 helps to address some of the significant barriers by hopefully stabilizing the insurance market, encouraging more companies to participate in the market (thereby increasing competition), and providing the Division of Insurance with the authority to explore a 1332 waiver to design solutions specific to Alaska's needs that are currently not addressed by the Affordable Care Act.

HB 374 is an imperative first step to addressing the crisis in Alaska's private insurance market. It provides the framework for the State of Alaska and its partners to design short and long-term solutions. The Boards appreciate your careful consideration of the bill and your commitment to the ongoing effort to insure affordable access to health care for all Alaskans.

Sincerely,

J. Kate Burkhart
Executive Director

cc: Charlene Tautfest, Chairperson, AMHB
Gunnar Ebbesson, Chairperson, ABADA
Lori Wing-Heier, Director, Division of Insurance

Doniece Gott

From: Andrew Hawk <aphawk@ak.net>
Sent: Wednesday, June 01, 2016 9:56 AM
To: Senate Finance Committee
Subject: HB 374

Dear Senators

My name is Andrew Hawk. I have owned and operated a successful and well- respected gunsmithing business in Anchorage for the past 19 years.

I am writing in support of House Bill 374, the Reinsurance Program.

As you know, the cost of purchasing health insurance on the individual marketplace has increased close to 40 percent for each of the past two years and, it is expected, that this percentage increase will be similar for 2017.

As a healthy individual I hope to never (or at least very rarely) need to utilize health insurance but having it affords me a significant amount of financial security. It's important for me to know that, should I injure myself or get diagnosed with a significant disease I will be able to pay my medical bills without declaring bankruptcy and still afford the care I might need to recover and continue to contribute to the Alaskan economy.

If health insurance rates increase at past levels, I could easily be looking at an annual premium of about \$16,000 with a deductible of \$5,250 for a plan that pays nothing until the deductible is met (so in essence at total of about \$21,000 yearly before coverage kicks in). Even with a hypothetical income of \$73,000 my insurance costs would still be about 30% of my annual "take home" pay. This would not be sustainable for me and I would reluctantly decide to go without insurance.

The repercussions of this decision, as you can imagine, are multiplied substantially when you consider that out of the 23,000 Alaskans buying insurance on the marketplace just about everyone of us who does not qualify for a tax subsidy will likely be faced with making a similar choice. The effects of this will extend into Alaska's economy well beyond those individuals and their family's ability to access health care. Should large numbers of middle class Alaskans be unable to afford health insurance than medical providers will lose business (the uninsured tend not to seek medical care unless the situation becomes dire) or, worse, providers will end up providing emergency care for those of us who become seriously ill or injured and pass the costs along to those who are covered. Lack of a sustainable health insurance marketplace also means that some small business owners or their employees will end up leaving the state as the risk of being uninsured outweighs the advantages of staying in Alaska. In turn, that results in fewer people providing services to our communities as well as fewer people contributing to the economy by buying gas and groceries, using local services and businesses, paying property taxes, supporting local charities... the list goes on.

In closing, I urge you to pass House Bill 374

Thank you for taking the time to read my testimony and consider this important bill.

Andrew Hawk

Anchorage, Alaska

907-562-0881

aphawk@ak.net

Doniece Gott

From: David Mitchell <dmitchy@hotmail.com>
Sent: Wednesday, June 01, 2016 7:44 AM
To: Senate Finance Committee
Subject: Letter of support for HB 374

Dear Senators,

My name is David Mitchell and I live in Anchorage.

I am writing in support of House Bill 374, the Reinsurance Program.

With only one insurer, Premera, providing marketplace plans in Alaska for 2017, premium rates, which are already high, can be expected to go beyond what is affordable for most middle income Alaskans. It is easy to imagine that, without your action, self employed Alaskans and those that work for small businesses (the plumbers, real estate agents, barbers, hairdressers, housekeepers, dentists, chiropractors, baristas, mechanics, attorneys, etc.) will be faced with the unenviable choice of either purchasing health insurance with premiums that might exceed 20 to 35 percent of their adjusted gross income or roll the dice and go without insurance.

Thank you for this opportunity to voice my opinion and support of HB 374.

David Mitchell

223 W Harvard Ave.

Anchorage, AK 99501

907-350-0078



THE STATE
of **ALASKA**
GOVERNOR BILL WALKER

**DEPARTMENT OF COMMERCE, COMMUNITY
AND ECONOMIC DEVELOPMENT
DIVISION OF INSURANCE**

HB 374 – Reinsurance Program; Health Insurance Waivers
presented to
Senate Finance

Director Lori Wing-Heier
May 31, 2016



Division of Insurance

The mission of the Division of Insurance is to regulate the insurance industry to protect Alaskan consumers.

- The division has a statutory responsibility to review and approve rules, forms and rates based on an analysis of whether they are excessive, inadequate, or unfairly discriminatory.
- The division does not have statutory authority to deny rates because of the financial impact to the consumer.



Timeline - *Update*

- September 2014 – Premera’s average increase 37.2%.
Moda’s average increase was 27.4%
- August 2015 – Premera’s average increase was 38.7%.
Moda’s average rate increase was 39.6%
- October 1, 2015 – Letter received that the 2014 risk corridor payments will be paid at 12.6% requests
- **May 2, 2016 – Moda announces exit from Alaska’s individual market beginning January 1st, 2017**
- **January 1, 2017 – State of Alaska has one insurer in the individual market on/off the federally facilitated exchange, impacting 23,000+ Alaskans**



HEALTH & HUMAN SERVICES

Another Health Insurer Abandons Alaska

BY TRIBUNE NEWS SERVICE | MAY 3, 2016



By *Laurel Andrews*



Moda Health will exit Alaska's individual insurance market next year, the company announced Monday, leaving only one health insurance provider in the state's market that, so far, has been defined by drastic annual rate increases for consumers and big losses for insurance companies.



Moda will focus on its other group and individual plans in the state, it said in a release. It may consider returning in the future but "the market requires significant reform in order to be sustainable," the company said.



The exit applies only to Moda's 14,000 customers who have health insurance plans on the individual marketplace. The company's other medical and dental plans are not affected by the decision, the company wrote.



RELATED

UnitedHealthcare's Exit Leaves Monopolies in Many Places

Why Health Insurers Are Closing in So Many States

"Obviously this is not good news," Alaska Division of Insurance Director Lori Wing-Heier said after the announcement.



Even the Wall Street Journal

By **ANNA WILDE MATHEWS** and **STEPHANIE ARMOUR**

217 COMMENTS

May 15, 2016 7:47 p.m. ET

Health-insurance customers in a growing number of mostly rural regions will have just one insurer's plans to choose from on the Affordable Care Act's exchanges next year, as some companies pull out of unprofitable markets.

The entire states of Alaska and Alabama are expected to have only one insurer on the health law's signature online marketplaces next year, according to state regulators. The same is expected to be true in parts of several other states, including Kentucky, Tennessee, Mississippi, Arizona and Oklahoma, state regulators said.



Washington

THE SPOKESMAN-REVIEW

Wed., May 25, 2016

63° ☀

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THURSDAY, MAY 12, 2016, 5:15 P.M.

Premera to stop offering individual health plans in some Eastern Washington counties



Three Rs

- **Risk Adjustment** transfers money among insurers to adjust for the possibility that some insurers may get more or less than their proportionate share of costly enrollees. Risk Adjustment is only:
 - ✓ Applied to the individual and small group market; and
 - ✓ Permanent program to help stabilize the costs of the ACA
- **Reinsurance** is one of the taxes associated with the ACA and is applied against health insurance policies and employer group health plans. Proceeds are used to provide the individual market plans with additional subsidies for higher-cost enrollees. The program sunsets in 2016
 - ✓ Attachment point in 2014 is \$45,000 but will increase to \$70,000 in 2015
 - ✓ Coinsurance decreases from 80% in 2014 to 50% in 2015
- **Risk Corridor** provides a range for profits or losses for insurance on the FFM. If an insurer has higher than expected profits, the federal government will “claw back” some of the premiums. Conversely, if an insurer has higher than expected losses, the federal government will pay the insurer additional subsidies to offset those losses. This program sunsets in 2016



We are working to keep the market solvent

Premera gets more time to file rates as fix awaits special session

By: [DJ Summers](#)

Alaska Journal of Commerce

Posted: Wed, 05/11/2016 - 4:42pm

Addressing Alaska's broken individual health insurance market will likely have to take place in special session of the Legislature, and in the meantime the state's last provider has been given extra time to calculate its rate increase for 2017.

Premera Blue Cross — Alaska's sole remaining individual insurance provider following the [May 1 announcement](#) by [Moda Health](#) that it will depart the market in 2017 — says it will stay in the Alaska market next year.

"Premera is committed to the Alaska market and will continue to offer individual coverage to Alaskans through the federal marketplace," said Premera spokesperson Melanie Coon in a statement.

Premera was due to release a rate schedule on May 11, but the circumstances will push that date back to this summer, Coon said. Because Moda dropped from Alaska's market, Premera, which covers 10,000 people in the state, has a new deadline to renew premium rate estimates to include the rates Moda charged its 14,000 customers.

"We've requested from the (Division of Insurance) Moda's numbers so we can kind of sharpen our pencils," said Coon. "We have until July."



Funding Mechanisms

- Version A of HB 374 funded the reinsurance program by amending statute to allow for an assessment to insurers based on total covered lives. This funding mechanism would have increased costs for organizations and businesses purchasing stop loss insurance by approximately 20 dollars per covered life, and met with strong opposition by those impacted, such as school districts.
- In version P, the program is funded by creating the Alaska comprehensive health insurance fund and separately accounting for insurance premium tax revenues which would then be appropriated by the Legislature to pay for ACHIA. Previously, the premium taxes lapsed to the general fund after being collected.



Actuarial Analysis

CC Set 2

Paid Claims	237,774,342
Claims Removed	53,872,151
Remaining Claims	185,845,858
Percentage Remaining	78.2%
# Claimants	29,869
Claimants Removed	495
Remaining Claimants	29,374
Percentage Remaining	98.3%

HCC #	HCC
26	Mucopolysaccharidosis
70	Sickle Cell Anemia (Hb-SS)
112	Quadriplegic Cerebral Palsy
66	Hemophilia
75	Coagulation Defects and Other Specified Hematological Disorders
184	End Stage Renal Disease
118	Multiple Sclerosis
251	Stem Cell, Including Bone Marrow, Transplant Status/Complications
115	Myasthenia Gravis/Myoneural Disorders and Guillain-Barre Syndrome/Inflammatory and Toxic Neuropathy
10	Non-Hodgkin's Lymphomas and Other Cancers and Tumors
9	Lung, Brain, and Other Severe Cancers, Including Pediatric Acute Lymphoid Leukemia
8	Metastatic Cancer
247	Premature Newborns, Including Birthweight 2000-2499 Grams



Premium Taxes

Annual collections of premium taxes for the prior three fiscal years are: \$52 million in FY2013; \$55 million in FY2014; and \$64 million in FY2015.

- *AS.21.09.210 – Tax on insurers*
- *AS 21.33.061 – Independently procured insurance; premium tax*
- *AS 21.34.180 – Surplus lines tax*
- *AS 21.66.110 – Annual tax on title insurance premiums*



2017 Rate Filings

- Premera must file rates with DOI by 7/15/16
- Rates must be approved 8/23/16
- Open enrollment begins 11/1/16
- Is then effective 1/1/17
- In order to include the reinsurance program in the 2017 rate filings, the insurer must have two weeks notice of the amount (if any) appropriated under HB374



Section 1332 Innovation Waiver

Alaska should explore a Section 1332 Innovation Waiver to allow the state to withdraw from the ACA if, *and subject to many provisions*, the state could provide the same benefits to consumers without any additional cost to the federal government.

States that are working on 1332:

- Colorado
- Minnesota
- Hawaii
- Massachusetts



Section 1332 Innovation Waiver

- Provide coverage at least as comprehensive as under the ACA
- Provide coverage and protection against excessive out-of-pocket expenditures at least as affordable as that provided under the ACA
- Cover a number of residents comparable to the number who would be covered under the ACA
- Not increase the federal deficit
- Must be authorized by the State Legislature
- Developed through a public process
- A state that is granted an innovation waiver that restricts access to premium tax credits, cost-sharing reduction premiums or the small employer tax credit can be paid the amounts that would have been paid to its residents under these programs to finance its waiver program



Conclusion

Questions?