

LEGISLATIVE FINANCE-HOUSE / SENATE FINANCE COMM. FILES 8879

SB 299 cont. SB 304 650

24

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HOUSE COMMITTEE REPORT

(11)

Date Referred: May 4, 1989

FURTHER REFERRALS:

Date of Committee Action: 5/6/89

The FINANCE Committee considered:

CSSB 299 (FINANCE) am

CS FOR SENATE BILL NO. 299 (Finance) am

[OIL & GAS PROPERTIES PRODUCTION TAX]

"An Act omitting from the calculation of the gross value of oil, for purposes of administration of the oil and gas properties production tax, certain costs, losses, damages, and expenses relating to catastrophic oil discharges from vessels; and providing for an effective date."

RECOMMENDATIONS:

- [] be replaced with HCS CSSB 299 (Red) [] the same title
- [] a new title
- [] have attached amendment(s)
- [] do pass
- [] do not pass
- [] no recommendation
- [] individual recommendations
- [] additional referral to the _____ Committee

ADOPTS: Senate Finance letter of intent

ATTACHES NEW FISCAL NOTE(S): _____
(Dept)

APPROVES PREVIOUS: _____
(Date/Dept)

- [] fiscal impact _____
- [] zero fiscal note _____
- [] zero with analysis _____

- [] fiscal note(s) Revenue 4/28/89
- [] zero fiscal note(s) _____
- [] zero fn/analysis _____

SIGNING DO PASS:

SIGNING:
(Check approp. column)

Do Not
Pass No Rec Amend

Leon Hill Hoffman

Ronald J. Larson Larson

Jay Brown Brown

Al Koponen Koponen

Mike Ulmer Ulmer

Dick Shultz Shultz

Roll E. Phillips Phillips

Steve Rieger Rieger

Kay Wallis Wallis

co- Leon Hill
Chairman's Signature

co- Ronald J. Larson

By the Senate Finance Committee

LETTER OF INTENT - SB 299

The Alaska State Legislature believes the expenses and costs referred to in SB 299 are not presently allowable as reasonable costs of transportation for determination of the gross value of oil or gas under AS 43.55.150(a). The purpose of passing SB 299 is to avoid lengthy and costly litigation by clarification of this point.

Senate Letter of Intent adopted 4/29

FISCAL NOTE

REQUEST:

Revision Date: _____ Agency Affected: Department of Revenue
Title: Amending manner of calculating BRU: Oil and Gas Audit Division
gross value of oil & gas production
Sponsor: Sturqulewski, Kerttula Components: _____
Requestor: _____

EXPENDITURES/REVENUES: (Thousands of Dollars)

	FY 89	FY 90	FY 91	FY 92	FY 93	FY 94
OPERATING						
PERSONAL SERVICES	0	0	0	0	0	0
TRAVEL	0	0	0	0	0	0
CONTRACTUAL	0	0	0	0	0	0
SUPPLIES	0	0	0	0	0	0
EQUIPMENT	0	0	0	0	0	0
LANDS & STRUCTURES	0	0	0	0	0	0
GRANTS, CLAIMS	0	0	0	0	0	0
MISCELLANEOUS	0	0	0	0	0	0
TOTAL OPERATING	0	0	0	0	0	0
CAPITAL	0	0	0	0	0	0
REVENUE	0	5,500	0	0	0	0

FUNDING: (Thousands of Dollars)

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

POSITIONS:

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

ANALYSIS: Attach a separate page for analysis.

SEE ATTACHED

Prepared By: Chuck Logsdon

Division: Oil and Gas Audit Division

Phone: 277-5627

Date: April 25, 1989

Approved by Commissioner: Hugh Malone

Agency: Department of Revenue

Date: 4/27/89

Distribution (by preparer):

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

RECEIVED

APR 27 1989

page 1 of 2

LEGISLATIVE FINANCE

SB 299
ANALYSIS

This bill would disallow, in the calculation of gross value at the point of production, any increase in transportation cost associated with a catastrophic oil discharge. At this time, it is unclear what impact the Valdez spill will have on these costs (vessel repair or incremented chartering costs). If these costs amount to \$50 million and are included in the calculation of reasonable transportation costs, the severance tax would be reduced by \$5.5 million. This analysis assumes that under current interpretation costs incurred in cleaning up a catastrophic oil discharge are clearly not associated with the reasonable costs of transportation.

Original sponsors: Sturgulewski and
Kerttula

1 IN THE SENATE BY THE RESOURCES COMMITTEE
2 HOUSE CS FOR CS FOR SENATE BILL NO. 299 (Resources)
3 IN THE LEGISLATURE OF THE STATE OF ALASKA
4 SIXTEENTH LEGISLATURE - FIRST SESSION

5 A BILL

6 For an Act entitled: "An Act omitting from the calculation of the gross
7 value of oil, for purposes of administration of the
8 oil and gas properties production tax, certain costs,
9 losses, damages, and expenses relating to catas-
10 trophic oil discharges from vessels; and providing
11 for an effective date."

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

13 * Section 1. AS 43.55.150 is amended by adding a new subsection to
14 read:

15 (c) In determining the gross value of oil under (a) of this
16 section, the department may not allow as reasonable costs of transpor-
17 tation

18 (1) the amount of loss of or damage to, or of expense
19 incurred due to the loss of or damage to, a vessel used to transport
20 oil if the loss, damage, or expense is incurred in connection with a
21 catastrophic oil discharge from the vessel into the marine or inland
22 waters of the state;

23 (2) the incremental costs of transportation of the oil that
24 are attributable to temporary use of or chartered or substituted
25 service provided by another vessel due to the loss of or damage to a
26 vessel regularly used to transport oil and that are incurred in con-
27 nection with a catastrophic oil discharge into the marine or inland
28 waters of the state; and

29 (3) the costs incurred to charter, contract, or hire

1 vessels and equipment used to contain or clean up a catastrophic oil
2 discharge.

3 * Sec. 2. AS 43.55.140 is amended by adding a new paragraph to read:

4 (15) "catastrophic oil discharge" has the meaning given in
5 AS 46.04.120.

6 * Sec. 3. This Act is retroactive to March 1, 1989, and applies to oil
7 produced after February 28, 1989.

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

Alaska State Legislature



2937 SHELDON JACKSON STREET
ANCHORAGE, ALASKA 99508

SENATOR
ARLISS STURGULEWSKI
Senate President Pro Tempore
Chairman, Senate Rules Committee

While in Juneau
P.O. BOX V
JUNEAU, ALASKA 99811
(907) 465-3818

Senate

M E M O R A N D U M

May 4, 1989

TO: Representative Ron Larson, Co-Chairman
Representative Lyman Hoffman, Co-Chairman
House Finance Committee

FROM: Senator Arliss Sturgulewski, Chairman
Senate Rules Committee

RE: HCS CSSB 299 (Res) "An Act omitting from the calculation of the gross value of oil, for purposes of administration of the oil and gas properties production tax, certain costs, losses, damages, and expenses relating to catastrophic oil discharges from vessels; and providing for an effective date."

Senate Bill 299 is a simple bill with a long title. At a minimum it will save the state from a lengthy and costly legal dispute and it may save the state approximately five and a half million dollars.

The state's severance tax on oil is based on the wellhead value of oil. The wellhead value is established by subtracting transportation costs from the price of oil. There is a possibility that companies may attempt to claim the costs of tanker repair, incremental tanker charter costs to replace the damaged tanker, and selected cleanup costs as transportation costs to be deducted when establishing wellhead value.

Senate Bill 299 prevents any of these costs incurred in connection with a catastrophic oil discharge into the marine or inland waters of the state from being allowed by the Department of Revenue as reasonable costs of transportation. The Department of Revenue was concerned about this potential loss of severance tax.

The department was also worried, however, that the existence of this bill, if it did not pass this session, would be used as evidence in a legal dispute that there is a presumption these costs are deductible. We have attached a letter of intent which addresses Revenue's concerns to their satisfaction on this issue. It is important that this letter of intent continue with this bill.

I support the House Resources committee substitute and urge your swift action. Thank you.

STATE OF ALASKA
THE LEGISLATURE

LEGISLATIVE AFFAIRS AGENCY


POUCH Y STATE CAPITOL
JUNEAU, ALASKA 99811
907 465 3800

MEMORANDUM

April 21, 1989

SUBJECT: Retrospective application of Senate
~~Bills 286 and 299~~

TO: Senator Arliss Sturgulewski

FROM: Jack Chenoweth
Legislative Counsel 

Each of the two above-captioned bills has a retroactivity feature. ~~The state's net income tax is computed and paid on an annual basis. Senate Bill 286, amending the net income tax, applies the changes made in that bill back to income earned since the start of this calendar year.~~ The oil and gas properties production (i.e. "severance") tax is due and payable monthly. 1/ Senate Bill 299, amending the chapter that imposes the severance tax, applies the changes made in that bill back to production from the first day of the month in which the Act takes effect.

Since retroactivity is common to both, let me discuss the common concept in the material that follows.

1/ Under AS 43.55.020(a):

The gross production tax on oil or gas shall be paid monthly. The tax is due on the 20th day of each calendar month on oil or gas produced from each lease or property during the preceding month. If the tax is not paid before the end of the month in which it becomes due, the tax becomes delinquent.

Thus, tax liability is incurred and remitted on a monthly, not an annual basis. For oil production during December, 1988, the tax became due and payable January 20, 1989, and tax liability for oil production during January, 1989, becomes due and payable February 20, 1989.

A retroactive tax adjustment will apply if there is a valid public purpose served by giving retrospective effect to that adjustment. Here, the committee's deliberations may be critical. As the bills are considered, it would, in my judgment, be important to develop a record on which a court, if called upon to consider an argument, would conclude that there was a public purpose served by giving the amendments a retrospective effect.

A reasonable retrospective application will be sustained. The farther back the retroactive provision is given effect, the less likely a court would be to sustain the provision without a clear showing of public purpose. (To foreclose a claim altogether, in other legislation I have discouraged retrospective application of severance tax adjustments, for example, beyond the narrow period recognized under AS 43.55.020(a), that is, a change amending the economic limit factor to be made retroactive only to the beginning of the month in which the bill is to take effect. That approach should not create any problems of retrospective applications since the tax liability would not have become due on that date.)

RETROSPECTIVE APPLICATION OF THE BILLS:

Tax statutes may be made retroactive. 2/ The threshold

2/ This office has also recently considered proposed retrospective application of severance tax adjustments, specifically relying on the federal and state constitutional prohibitions against passage of ex post facto laws. There are two ex post facto law prohibitions of the federal constitution. Article I, section 9, clause 3 is a limitation on the federal government, while article I, section 10, clause 1 imposes a similar limitation on the states. Alaska's constitution also contains a limitation in section 15 of article I.

Our previous conclusion that federal and state constitutional prohibitions against enactment of ex post facto laws would support a challenge to the amendment's retrospective application was surely in error. Federal court decisions have limited the application of the limitations to criminal or penal

consideration is that the retrospective application of the measure must not impair an obligation of contract. The impairment of contract consideration appears to be inapplicable in this instance. Retrospective application of a newly-enacted statute may, in some instances, impair obligations of contract, in violation of article I, section 10 of the United States Constitution and article I, section 15 of the State Constitution. However, the Alaska Supreme Court appears to have cut off an impairment of contract argument applicable to retrospective application of a tax amendment in Atlantic Richfield Co. v. State, 705 P.2d 418 (Alaska, 1985). To the argument that the oil and gas corporate income tax then in litigation impaired the obligation of the state's underlying lease contracts, the court concluded that "[the] argument [was] without merit":

. . . No lease provision has been impaired. In entering into the leases the state could not, and did not, contract away its power as a sovereign to tax income earned in the state. Merrion v. Jicarilla Apache Tribe, 455 U.S. 130, 102 S.Ct. 894, 71 L.Ed.2d 21 (1982) disposes of this issue:

Contractual arrangements remain subject to subsequent legislation by the presiding sovereign. Even where the contract at issue requires payment of a royalty for a license or franchise issued by the government entity, the government's power to tax remains unless it "has been specifically surrendered in terms which admit of no other reasonable interpretation." St. Louis v. United R. Co., 210 U.S. 266, 280, 28 S.Ct. 630, 634, 52 L.Ed. 1054 (1908).

455 U.S. at 148, 102 S.Ct. at 907, 71 L.Ed.2d at 36 (citations omitted); see also Exxon v. Eagerton, 462

statutes, concluding that retrospective tax legislation is not prohibited by the ex post facto clause. Personal Finance Co. v. United States, 86 F. Supp. 779 (D.Del., 1949). See 16A Am. Jur. 2d secs. 636, 677. Decisions in other state courts have similarly concluded. Parlato v. McCarthy, 69 A.2d 648 (Ct., 1949), Walker v. Commonwealth, 130 S.W.2d 27 (Ky., 1939). The Alaska Supreme Court has not extended application of the state constitutional ex post facto prohibition beyond penal or criminal matters. Danks v. State, 619 P.2d 720 (Alaska, 1980); Creekpaum v. State, 753 P.2d 1139 (Alaska, 1988).

Senator Arliss Sturgulewski
Page 4
April 21, 1989

U.S. at 187-94, 103 S.Ct. at 2304 - 2307, 76 L.Ed.2d at 508-12.

705 P.2d 418, at 438.

*

If legislation acts retrospectively, the nature and duration of its retrospective application should be reasonable. The arguments favoring a reasonable retrospective operation arise out of the equal protection and due process clauses of the state and federal constitutions.

Federal equal protection considerations:

State legislation retroactively imposing a tax is not necessarily and certainly invalid under the equal protection clause of the Fourteenth Amendment to the federal constitution. The inquiry to be made is one of whether the retroactivity impairs substantial, vested rights, and is reasonable in the circumstances. As to retroactively imposed new taxes, the courts have been reluctant to find a violation because of the impairment of a vested right. Welch v. Henry, 305 U.S. 134, 83 L.Ed. 87, 59 S.Ct. 121 (1938), rehearing denied 305 U.S. 675, 83 L.Ed. 437, 59 S.Ct. 250 (1938). ^{3/} Several state courts have agreed. See Garrett

^{3/} In Welch, the United States Supreme Court concluded that a Wisconsin state statute, enacted in 1935 and operating retrospectively to tax corporate dividends earned in 1933 which, when received, were deductible from gross income, did not violate the equal protection clause. The tax rates applied to the dividends differed from the rates applicable to other types of taxable income. As to the retrospective application of the new tax to dividends that were, when earned, exempt from tax, the court noted that:

The equal protection clause does not preclude the legislature from changing its mind in making an otherwise permissible choice of subjects of taxation. The very fact that the dividends were relieved of tax [in 1933], when the need was less, is basis for the legislative judgment that they should bear some of the added burden when the need is greater.

Freight Lines v. State Tax Commission, 135 P.2d 523, at 526, 527 (Utah, 1943); Colonial Pipeline Co. v. Commonwealth, 145 S.E.2d 227 (Va., 1965), reh. den. (1966), app. dismissed, 384 U.S. 268, 16 L.Ed.2d 523, 86 S.Ct. 1476 (1966). 4/

Numerous retroactive revisions of the federal and Wisconsin revenue laws . . . have imposed taxes on subjects previously untaxed and shifted the burden of old taxes by changes in rates, exemptions, and deductions. It has never been thought that such changes involve a denial of equal protection if the new taxes could have been included in the earlier act when adopted. If some retroactive alteration in the scheme of a tax act is permissible, as is conceded, it seems plain that validity, so far as equal protection is concerned, must be determined, as in the case of any other tax, by ascertaining whether the thing taxed falls within a distinct class which may rationally be treated differently from other classes. If such changes are forbidden in the name of equal protection, legislatures in laying new taxes would be left powerless to rectify to any extent a previous distribution of tax burdens which experience had shown to be inequitable, even though constitutional.

83 L.Ed. 87, at 92.

4/ In Garrett Freight Lines v. State Tax Commission, 135 P.2d 523 (Utah, 1943), the Utah Supreme Court, called upon to determine whether an excise tax levied on the use of diesel motor fuel that was used prior to the date the legislative act became law, found no equal protection violation:

It is well settled that a tax does not necessarily violate the Federal Constitution merely because it contains retroactive features. Milliken v. United States, 283 U.S. 15, 21, 51 S.Ct. 324, 75 L.Ed. 809 [(U.S., 1931)]; Billings v. United States, 232 U.S. 261, 34 S.Ct. 421, 58 L.Ed. 596 [(U.S., 1914)]; Welch v. Henry, 305 U.S. 134, 59 S.Ct. 121, 125, 83 L.Ed. 87 [(U.S., 1938)]

. . . .

Neither the Federal Constitution nor the Utah

Federal due process considerations:

Retroactive imposition of a tax is not necessarily a violation of the due process clause of the Fourteenth Amendment to the federal constitution. The leading case is Welch, cited earlier, in which the United States Supreme Court determined:

The objection chiefly urged to the taxing statute is that it is a denial of due process of law because in 1935 it imposed a tax on income received in 1933. But a tax is not necessarily unconstitutional because retroactive. Milliken v. United States, 283 U.S. 15, 21, 75 L.Ed. 809, 814, 51 S.Ct. 324 [(1931)], and cases cited. Taxation is neither a penalty imposed on the taxpayer nor a liability which he assumes by contract. It is but a way of apportioning the cost of government among those who in some measure are privileged to enjoy its benefits and must bear its burdens. Since no citizen enjoys immunity from that burden, its retroactive imposition does not necessarily infringe due process, and to challenge the present tax it is not enough to point out that the taxable event, the receipt of income, antedated the statute.

83 L.Ed. 87, at 93. But the assertion that due process is not violated is not absolute and, the court has said that

In each case it is necessary to consider the nature of the tax and the circumstances in which it is laid before it can be said that its retroactive application is so harsh and oppressive as to transgress the constitutional limitation.

Id.

Similarly, in Garrett Freight Lines, earlier cited, the Utah Supreme Court determined that the due process clause is not

Constitution has any provision in terms prohibiting retroactive legislation -- excepting that which forbids the enactment of ex post facto laws. [Citations omitted.] That clause relates to criminal and penal matters and does not affect legislation such as the statute here involved. Calder v. Bull, 3 Dall. 386, 390, 1 L.Ed. 648, 1 Kent Commentaries 409; 3 Story on Constitution 212; 18 C.J.S. Constitutional Law, sec. 435, p. 886.

a limitation on the state's ability to retrospectively impose a tax:

Although basing its case upon the due process clause, appellant does not show wherein the tax constitutes any arbitrary and oppressive discrimination except to assert that a tax based upon a transaction consummated prior to passage of the act amounts to a taking of property without due process. It has many times been questioned whether the due process clause constitutes any limitation upon the taxing power. In this connection we quote from Mr. Justice Sutherland of the United States Supreme Court in an opinion upholding the validity of a statute of the State of Washington levying a tax upon the sale of oleomargarine:

Except in rare and special instances, the due process of law clause contained in the Fifth Amendment is not a limitation upon the taxing power conferred upon Congress by the Constitution. * * * And no reason exists for applying a different rule against a state in the case of the Fourteenth Amendment. * * * That clause is applicable to a taxing statute such as the one here assailed only if the act be so arbitrary as to compel the conclusion that it does not involve an exertion of the taxing power, but constitutes, in substance and effect, the direct exertion of a different and forbidden power, as, for example, the confiscation of property. * * * Collateral purposes or motives of a Legislature in levying a tax of a kind within the reach of its lawful powers are matters beyond the scope of judicial inquiry. * * * Nor may a tax within the lawful power of a state be judicially stricken down under the due process clause simply because its enforcement may or will result in restricting or even destroying particular occupations or businesses, * * * unless, indeed, as already indicated, its necessary interpretation and effect be such as plainly to demonstrate that the form of taxation was adopted as a mere disguise, under which there was exercised, in reality, another and different power denied by the Federal Constitution to the state.

A. Magnano Co. v. Hamilton, 292 U.S. 40, 54 S.Ct. 599, 601, 78 L.Ed. 1109.

Garrett Freight Lines, 135 P.2d 523, at 527.

Courts have, however, considered retrospective tax legislation unconstitutional as a violation of the due process clause when, as Welch concludes, in light of "the nature of the tax and the circumstances in which it is laid," the legislation is "so harsh and oppressive as to transgress [that] constitutional limitation." Welch v. Henry, 305 U.S. 134, 59 S.Ct. 121, 83 L.Ed. 87, at 93. The question is typically one of the degree of harshness, based upon consideration of factors such as (1) the effect of the retroactive application of legislation amending a tax on a taxpayer's voluntary act that was influenced by the taxpayer's understanding of tax incidence or consequence at the time of that act, especially if the tax to be imposed or amended is "novel," (2) the sufficient certainty of the taxpayer's expectation of money that is jeopardized by the retroactive legislation, (3) the length of the period of the legislation's retrospective application, and (4) the importance of the public purpose to be served by the action. The first three elements are, to some degree, based on the taxpayer's expectations, while the fourth involves a determination of a public interest that necessitated the actual enactment.

Computation and payment of the severance tax is not greatly determinative of taxpayers' taxable activities that generate the tax liability, nor does this proposed legislation seem to strike at activities of a taxpayer that reasonably relied on the current severance tax rates before this bill proposed amendment of that tax. It is the length of the period of the legislation's retrospective application and the importance of the public purpose to be served that need be most carefully considered.

State due process and equal protection considerations:

Nothing in my quick research suggested that an analysis under the state's "due process" clause, article I, section 7, would reach a conclusion at variance with the decisions based on the comparable federal provision discussed above.

State "equal protection" analysis differs, though the conclusion reached under that analysis is consistent with the conclusions reached under the analysis applicable to the federal provisions. In State v. Erickson, 574 P.2d 1 (Alaska, 1976), the court established a "single test"

Senator Arliss Sturgulewski
Page 9
April 21, 1989

approach for state-constitution based equal protection analysis, essentially requiring that the court (1) ascertain the purposes of the legislation to determine whether they are legitimate; (2) determine whether the means chosen to accomplish the objectives actually do so; and (3) balance the importance of the state's interest against the constitutional right involved. The state has plenary authority to tax. Assuming an adequate record, adding to tax liability on the income and severance taxes payable by major producers seems to bear a strong correlation to the state's efforts to impose a tax burden on those who are principally responsible for conducting marine operations in a way that is environmentally safe. By that analysis, if the retrospective application of the change is reasonable, the court should reject any state constitutional equal protection-based claim.

JC:gc
WKG9/099

Enclosure

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SENATE FINANCE COMMITTEE REPORT

DATE: 3/29/90

FURTHER:

DATE TURNED INTO OFFICE: _____

The Finance Committee considered

SSSB 304

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

and recommended:

- replace with _____ CS _____ same title
- or adopt _____ CS _____ new title
- attached amendment(s) technical title change (HB only)
- _____ letter of intent adopted

- do pass *Hearings 4-23-90*
- do not pass *4-24-90*
- no recommendation *4-25-90*

- individual recommendations *Bill subsequently died in committee.*
- further referral to _____

ATTACHES NEW FISCAL NOTE(S): Dept/Date:

- fiscal note(s) _____
- zero fiscal note(s) _____

APPROVES PREVIOUS: Dept/Date:

- fiscal note(s) _____
- zero fiscal note(s) _____

appropriation-no fiscal note

SIGNING DO PASS:

OTHER RECOMMENDATIONS:

1. _____ 2. _____

Co-Chairs: Signatures and Recommendations

SENATE COMMITTEE REPORT

DATE: 3/1/90

FURTHER: Finance

DATE TURNED INTO OFFICE: 3/29/90

H E S S

Committee considered

SSSB 304

SPONSOR SUBSTITUTE FOR SENATE BILL NO. 304

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

and recommends L+C CS be adopted and reports it back with no amendments

and recommended:

[] replace with _____ CS
[] or adopt L+C CS

for SSSB 304

[] same title
[] new title
[] technical title change (HB only)

[] attached amendment(s)

[] _____ letter of intent adopted

[] do pass

[] do not pass

[] no recommendation

[X] individual recommendations

[] further referral to _____

ATTACHES NEW FISCAL NOTE(S):

Dept/Date:

[X] fiscal note(s) Attached

APPROVES PREVIOUS:

Dept/Date:

[X] fiscal note(s) Attached. DCIEC

[] zero fiscal note(s)

[] zero fiscal note(s)

[] appropriation-no fiscal note

[] Governor's bill w/fiscal note

SIGNING DO PASS:

OTHER RECOMMENDATIONS:

Blank lines for signing do pass

1 L. Gardner (No Rec)
1 C. Adams (No Rec)
1 Tim Kelly (No Rec)
1 J. ... (No Rec)

1 Paul ... (No Rec)

Chair: Signature and Recommendation

SENATE COMMITTEE REPORT
FIRST COMMITTEE OF REFERRAL

6-1231#19
c

DATE: 1/25/90

FURTHER: HESS
Finance

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

DATE TURNED INTO OFFICE: 3/1/90

L & C Committee considered SSSB 304

Act relating to disability insurance; efd.

and recommended:

- replace with _____ CS SS SB 304 (L+C) same title new title
- attached amendment(s) + maj of 1 Cmte re dp
- _____ letter of intent adopted

do pass

do not pass

no recommendation

individual recommendations

further referral to _____

FN

ATTACHES NEW FISCAL NOTE(S):

Department(s)/Date:

Department(s)/Date:

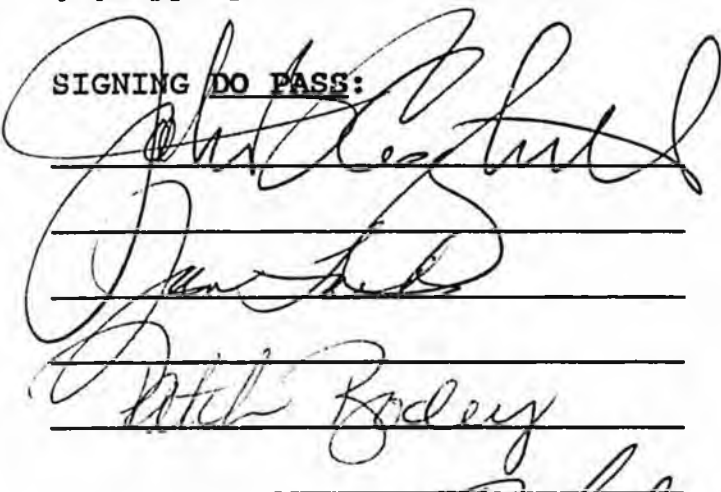
fiscal note(s) Dept of Commerce 2/23/90
(for SSSB 304 + CS SSSB 304(L+C))

zero fiscal note(s) _____

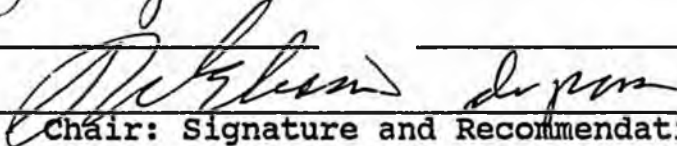
appropriation-no fiscal note

Governor's bill w/fiscal note

SIGNING DO PASS:



OTHER RECOMMENDATIONS:


Chair: Signature and Recommendation

SENATE COMMITTEE REPORT

FIRST COMMITTEE OF REFERRAL

Date of 5-DAY NOTICE _____
IN ACCORDANCE WITH UNIFORM RULE 23

**FISCAL NOTE(S) MUST BE ATTACHED
IN ACCORDANCE WITH AS 24.08.035

4/25/89

FURTHER

HESS
FIN

DATE TURNED INTO OFFICE _____

Mr. President:

L&C

Committee considered

SB 304

disability insurance; efd

and recommended:

replace with CS _____ same title

attached amendment(s) and new title

_____ letter of intent adopted

do pass

do not pass

no recommendation

individual recommendations

further referral to _____

FISCAL NOTE(S) attached zero

appropriation no FN attached

fiscal impact

Gov. FN introduced w/ bill

MEMBERS SIGNING DO PASS

OTHER RECOMMENDATIONS

Chair: _____ signature and recommendation

Committee backup attached

FISCAL NOTE

Attached to Bill

REQUEST:

Revision Date: _____
Title: An Act relating to disability insurance

Agency Affected: Commerce & Economic Development
BRU: Insurance

Sponsor: Coghill
Requestor: Senate Labor & Commerce

Components: Operations

EXPENDITURES/REVENUES: (Thousands of Dollars)

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

FUNDING: (Thousands of Dollars)

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

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

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

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

Approved by Commissioner: Larry Mercurieff *Gary Bell for* Date: 2/23/90
Agency: Department of Commerce & Economic Development

Distribution (by preparer):

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

) Changes in CS SSSB³⁰⁴ (Lac) have no fiscal impact. This fiscal note is appropriate.

FISCAL NOTE ANALYSIS - SSSB 304

Personal Services: Funding for a new PFT position, Chief of Operations, \$65.4, is included.

Travel: The director is an ex-officio board member of the Comprehensive Disability Insurance Association. The seven members of the board will be from out-of-state insurance companies and hospital or medical service corporations. The travel estimate is based on the director or the director's designee attending eight out-of-state board meetings in the first year of operation and four in each subsequent year at an estimated cost of \$1,500 for each.

Contractual: Each year, the division will have to contract with an actuary to verify that the rating structures of the association are actuarially sound. The estimate for the annual contract is \$25,000.

In addition, the director may undertake studies or demonstration projects to develop awareness of the benefits of the program. The annual estimate for this is \$8,000.

\$2,000 is also included for the new position's miscellaneous contractual expenditures.

Supplies: The new position's supplies are estimated at \$1,000.

Equipment: A work station and computer are included for the new position at \$10,000.

Revenue: The members of the Comprehensive Disability Insurance Association are entitled to receive a credit against taxes levied by the state on disability insurance premiums. The maximum potential loss of state revenue is equal to the total tax collected on disability insurance premiums. It is impossible to predict what the actual tax revenue loss will be. However, using 1987 premium data as a benchmark, the state could lose \$4.2 million.

\$144,444.0	1987 disability premiums of insurers
<u> x 2.7%</u>	Tax rate
\$ 3,900.0	Tax revenue
\$ 61,189.0	1987 disability premiums of hospital and medical service corporations
<u>[55,610.0]</u>	Less claims
\$ 5,579.0	Taxable premiums
<u> x 6.0%</u>	Tax rate
\$ 334.7	Tax revenue
\$ 3,900.0	
<u>+ 334.7</u>	
\$ 4,234.7	1987 total disability insurance tax revenue

Furthermore, an insurer whose assessment exceeds their tax liability can carry forward the excess credit to be applied against future years' tax liabilities.

6-1231J

Ford

4/23/90

Handwritten signature
4/23/90

Original sponsor(s): SEN. COGHILL

1 IN THE SENATE

2 CS FOR SPONSOR SUBSTITUTE FOR SENATE BILL NO. 304 *Finance*

3 IN THE LEGISLATURE OF THE STATE OF ALASKA

4 SIXTEENTH LEGISLATURE - SECOND SESSION

5 A BILL

6 For an Act entitled: "An Act relating to disability insurance; and provid-
7 ing for an effective date."

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

9 * Section 1. LEGISLATIVE INTENT. It is the intent of the legislature
10 to provide access to disability insurance coverage to all residents of the
11 state who are denied adequate disability insurance coverage for any reason
12 or who are otherwise considered uninsurable. It is the further intent of
13 the legislature that AS 21.55 provide a mechanism to ensure the availabil-
14 ity of comprehensive disability insurance to persons unable to obtain
15 disability insurance coverage on either an individual or a group basis
16 under any health plan.

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

18 CHAPTER 55. STATE DISABILITY INSURANCE.

19 ARTICLE 1. COMPREHENSIVE DISABILITY INSURANCE ASSOCIATION.

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

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

19 Sec. 21.55.030. GENERAL POWERS. The association may

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

28 Sec. 21.55.040. PLAN OF OPERATION. (a) The association shall
29 submit to the director a plan of operation and any amendments

1 necessary or suitable to assure the fair, reasonable, and equitable
2 administration of the association. The plan of operation and amend-
3 ments become effective upon approval in writing by the director. If
4 the plan submitted by the association has been twice disapproved by
5 the director, or the association fails to submit a suitable plan of
6 operation by a date that is 180 days after the effective date of this
7 Act, or if at any subsequent time the association fails to submit
8 suitable amendments to the plan, the director may, after notice and
9 hearing, adopt reasonable regulations necessary or advisable to
0 effectuate the provisions of this chapter. The regulations continue
1 in force until modified by the director or superseded by a plan sub-
2 mitted by the association and approved by the director.

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

5 (c) The plan of operation must

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

8 (2) establish procedures for handling assets of the asso-
9 ciation;

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

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

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

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

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

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

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

7 Sec. 21.55.060. TAX EXEMPTION. (a) The association is exempt
 8 from the payment of fees and taxes levied by the state or any of its
 9 political subdivisions except taxes levied on real or personal proper-
 10 ty.

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

14 ARTICLE 2. STATE DISABILITY INSURANCE PLANS.

15 Sec. 21.55.100. TYPES OF INSURANCE PLANS. (a) The association
 16 shall make available to residents eligible under AS 21.55.300 an
 17 individual state plan of disability insurance. The association shall
 18 offer two alternatives related to deductibles as described in AS 21.-
 19 55.120.

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

22 Sec. 21.55.110. MINIMUM BENEFITS OF STATE DISABILITY INSURANCE
 23 PLAN. Except as provided in AS 21.55.120 - 21.55.140, the minimum
 24 standard benefits of a disability insurance plan offered under AS 21.-
 25 55.100(a) must include benefits required under AS 21.42.345 and
 26 21.42.365, and must be benefits with a lifetime maximum of \$500,000
 27 per individual for usual, customary, reasonable, or prevailing charges
 28 for the following medical services performed for an individual covered
 29 by the plan for the diagnosis or treatment of nonoccupational disease

1 or nonoccupational injury:

2 (1) hospital services, subject to the provisions of a
3 preauthorization utilization program;

4 (2) subject to the limitations of AS 21.36.090(d), profes-
5 sional services that are rendered by a physician or by a registered
6 nurse at the physician's direction, other than services for mental or
7 dental conditions;

8 (3) the diagnosis or treatment of mental conditions, as
9 defined in regulations of the director, rendered during the year

10 (A) on an inpatient basis, up to a yearly maximum of
11 30 days; and

12 (B) on an outpatient basis, up to a yearly maximum
13 benefit of \$4,000;

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

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

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

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

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

1 (9) outpatient chemotherapy;

2 (10) oxygen;

3 (11) anesthetics;

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

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

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

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

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

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

26 (18) confinement in a licensed or certified facility estab-
27 lished primarily for the treatment of alcohol or drug abuse or in a
28 part of a hospital used primarily for this treatment, for a period of
29 at least 45 days within any calendar year, up to a yearly maximum

1 benefit of \$7,000 and with a lifetime maximum benefit of \$14,000;

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

4 (20) second surgical opinions;

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

8 Sec. 21.55.120. DEDUCTIBLES AND COPAYMENTS. (a) A state plan
9 may require deductibles of \$1,000 a person or \$5,000 a person. The
10 amount of the deductible may not be greater when a service is rendered
11 on an outpatient basis than when that service is offered on an inpa-
12 tient basis. Expenses incurred during the last three months of a
13 calendar year and actually applied to an individual's deductible for
14 that year shall also be applied to that individual's deductible in the
15 following calendar year. The \$1,000 maximum and the \$5,000 maximum
16 may be adjusted yearly to correspond with the change in the medical
17 care component of the consumer price index, as adjusted by the direc-
18 tor. The base year for the computation is the first full calendar
19 year of operation of the association.

20 (b) A state plan must require a maximum copayment of \$2,000 plus
21 the deductible for charges for all types of medical care.

22 (c) In this section, "consumer price index" means the consumer
23 price index for all urban consumers for the Anchorage Metropolitan
24 Area compiled by the Bureau of Labor Statistics, United States Depart-
25 ment of Labor.

26 Sec. 21.55.130. PREEXISTING CONDITIONS. (a) A state plan may
27 not exclude coverage for a loss due to a preexisting condition for a
28 period greater than 12 months following the effective date of cover-
29 age.

1 (b) A state plan issued to a person whose previous subscriber
2 contract or insurance policy was involuntarily terminated must credit
3 the time covered under the previous contract or policy toward an
4 exclusion for preexisting conditions under the state plan if the
5 previous contract or policy had a similar preexisting condition exclu-
6 sion and the person applies for a state plan within 31 days after
7 termination of the previous contract or policy. If a person covered
8 by this subsection is accepted by the writing carrier and pays a
9 specified premium for retroactive coverage, the state plan is effec-
0 tive retroactively to the date that the person's previous contract or
1 policy terminated.

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

4 (1) care for an injury or disease either

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

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

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

8 (3) travel, other than transportation covered under AS 21.-
9 55.110(17);

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

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

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

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

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

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

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

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

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

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

6 (14) experimental procedures; and

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

9 Sec. 21.55.150. STATE PLAN PREMIUMS. (a) Except as provided in

1 (c) of this section, the association may not charge a rate for cover-
2 age issued by or through the association that is excessive, inade-
3 quate, or unfairly discriminatory.

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

6 (c) The five members of the association that insure, or have
7 subscriber contracts with, the largest number of individuals in the
8 state under plans with benefits substantially equivalent to the state
9 plan benefits shall submit to the association an estimate of the rate
10 that would be actuarially sound for a person who is a standard risk
11 for coverage substantially equivalent to the state plan. The premium
12 for a state plan may not exceed 200 percent of the average of those
13 five estimates.

14 ARTICLE 3. ADMINISTRATION OF PLANS.

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

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

1 three-year period, the association shall invite submissions of policy
2 forms from members of the association, including the writing carrier.
3 The association shall follow the provisions of AS 21.55.200 in
4 selecting a writing carrier for the subsequent three-year period.

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

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

15 (d) Claims shall be paid by the writing carrier. A claim pay-
16 ment must indicate that the claim was paid under a state plan and
17 include a telephone number that can be used for inquiries regarding
18 the claim.

19 (e) The writing carrier shall be reimbursed from the state plan
20 premiums received for its direct and indirect expenses for administer-
21 ing the plan. Direct and indirect expenses must include a pro rata
22 reimbursement for that portion of the writing carrier's administra-
23 tive, printing, claims administration, and management and building
24 overhead expenses that are assignable to the maintenance and adminis-
25 tration of the state plans. The association shall approve cost ac-
26 counting methods to substantiate the writing carrier's cost reports
27 consistent with generally accepted accounting principles. Direct and
28 indirect expenses may not include costs directly related to the origi-
29 nal submission of policy forms before selection as the writing carri-

1 er.

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

4 (g) The writing carrier shall administer a billing system for
5 premium payments and may bill for premiums on a monthly or quarterly
6 basis.

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

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

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

8 (d) The association shall make an annual determination of each
9 member's liability, if any, and may make an annual fiscal year end
0

1 assessment if necessary. The association may also, subject to the
2 approval of the director, provide for interim assessments against the
3 members as may be necessary to assure the financial capability of the
4 association in meeting the incurred or estimated claims expenses of
5 the state plans and operating and administrative expenses of the
6 association until the association's next annual fiscal year end as-
7 sessment. Payment of an assessment is due within 30 days of receipt
8 by a member of written notice of a fiscal year end or interim assess-
9 ment. Failure by a member to tender to the association the assessment
0 within 30 days shall be grounds for revocation of a member's certifi-
1 cate of authority. A member that ceases to do disability insurance
2 business in the state, or ceases to offer subscriber contracts in the
3 state, due to revocation, suspension, or voluntary surrender of its
4 certificate of authority remains liable for assessments through the
5 calendar year that the disability insurance or subscriber contract
6 business ceased. The association may decline to levy an assessment
7 against a member if the assessment would not exceed \$10. Assessments
8 paid by a member are a general expense of the member.

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

3 **ARTICLE 4. ENROLLMENT IN THE STATE DISABILITY INSURANCE PLAN.**

4 **Sec. 21.55.300. ELIGIBILITY FOR STATE DISABILITY INSURANCE. (a)**
5 Except as provided in (b) of this section, a person who is a resident
6 is eligible for coverage upon providing evidence of

7 (1) rejection for medical reasons, a requirement of re-
8 strictive riders, an up-rated premium, or a preexisting conditions
9 limitation on disability insurance, the effect of which is to substan-

1 tially reduce coverage from that received by a person considered a
2 standard risk, by at least one member within six months of the date of
3 application; or

4 (2) involuntary termination of disability insurance cover-
5 age for any reason other than nonpayment of premium.

6 (b) The following persons are not eligible for coverage:

7 (i) a person who is at the time of application eligible for
8 medical assistance;

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

1 (A) 12 months have elapsed since termination; or

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

5 (3) a person on whose behalf the state has paid out
6 \$500,000 in benefits; and

7 (4) inmates of public institutions and persons whose bene-
8 fits are duplicated under public programs.

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

11 Sec. 21.55.310. ENROLLMENT BY AN ELIGIBLE PERSON. A person may
12 enroll in a state plan by applying to the writing carrier. The appli-
13 cation must include the following:

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

16 (2) a designation of the plan desired, including deductible
17 option chosen; and

18 (3) proof of eligibility under the criteria established in
19 AS 21.55.300.

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

6 Sec. 21.55.330. EFFECTIVE DATE OF POLICIES. (a) Except as
7 provided in (b) of this section and AS 21.55.330(b), insurance under a
8 state plan is effective immediately upon receipt of the first quar-
9 terly premium, and is retroactive to the date of the application, if
0 the applicant otherwise complies with the requirements of this chap-
1 ter.

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

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

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

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

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

6 (b) The association shall devise and implement means of main-
7 taining public awareness of the provisions of this chapter regarding
8 the state plans and shall administer this chapter in a manner that
9 facilitates public participation in the state plans. The association

1 shall prepare a brochure outlining the benefits and exclusions of the
2 state plan in plain language.

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

5 (d) An insurer or hospital or medical service corporation that
6 rejects or applies underwriting restrictions to an applicant for a
7 subscriber contract, a disability insurance policy, or a medicare
8 supplement plan in the state shall notify the applicant of the exis-
9 tence of the state plans, the requirements for being accepted, and the
10 procedure for applying.

11 ARTICLE 5. GENERAL PROVISIONS.

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

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

16 (2) contract with the federal government or another unit of
17 government to ensure coordination of the state plans with other gov-
18 ernmental assistance programs; and

19 (3) adopt regulations necessary to administer this chapter.

20 Sec. 21.55.410. STATE NOT LIABLE. The state is not liable for
21 acts or omissions of the association or a writing carrier under this
22 chapter, or for payment of a claim under a state plan issued by a
23 writing carrier.

24 Sec. 21.55.500. DEFINITIONS. In this chapter

25 (1) "association" means the Comprehensive Disability Insur-
26 ance Association created in AS 21.55.010;

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

29 (3) "deductible" means the portion of eligible expenses for

1 which the insured is responsible in each calendar year under AS 21.-
2 55.120(a);

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

6 (5) "home health agency services" means any of the follow-
7 ing services provided upon recommendation of a licensed physician as
8 part of a treatment plan:

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

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

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

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

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

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

7 (7) "major medical coverage" means a disability insurance
8 contract or subscriber contract that provides benefits for hospital
9 and medical care with potential lifetime maximum benefits per insured
10 of \$500,000;

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

19 (9) "resident" means a person who is physically present in
20 the state, has lived in the state for at least the six consecutive
21 months immediately preceding application for a state plan, and intends
22 to remain permanently in the state; "resident" also includes a person
23 who is not physically present in the state if the person lived in the
24 state for at least six of the nine months immediately preceding appli-
25 cation for a state plan and the person's absence from the state is for
26 medical treatment or education; a person ceases to be a resident if
27 the person is absent from the state for more than 90 consecutive days
28 for reasons other than for medical treatment or education;

29 (10) "state plan" means a policy of insurance offered by the

1 association through a writing carrier;

2 (11) "usual, customary, reasonable, or prevailing charge"
3 means a charge that has been approved by the director for a medical
4 care procedure, service, or supply item, and that is the lowest of the
5 following amounts:

6 (A) the billed amount for the medical service pro-
7 vider's actual charge;

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

1 (C) the customary charge, based on a profile of char-
2 ges made for the same medical procedure, service, or supply item
3 in the same geographical area by other providers that have per-
4 formed the same procedure or service or can provide the same
5 supply item; the customary charge may not exceed the 75th percen-
6 tile of the profile of charges;

7 (12) "writing carrier" means the insurer or insurers select-
8 ed by the association and approved by the director to administer a
9 state plan.

* Sec. 3. AS 21.09.210 is amended by adding a new subsection to read:

1 (j) A member of the Comprehensive Disability Insurance Asso-
2 ciation created in AS 21.55.010 may credit against a premium tax
3 imposed against disability insurance premiums under this section, an
4 amount equal to an assessment against the member under AS 21.55.-
5 220(d). Any portion of the credit allowed in this subsection that
6 cannot be taken in a tax year without reducing taxable premiums below
7 zero may be carried forward and credited in successive years until the
8 credit is exhausted.

* Sec. 4. The association established by sec. 2 of this Act shall make

1 available to residents the plans required by AS 21.55.100, enacted in
2 sec. 2 of this Act, by January 1, 1991.

3 * Sec. 5. This Act takes effect immediately under AS 01.10.070(c).
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4/24/90

1 available to residents the plans required by AS 21.55.100, enacted in
2 sec. 2 of this Act, by January 1, 1991.

3 * Sec. 5. AS 21.09.210(j) and AS 21.55 are repealed.

4 * Sec. 6. Section 5 of this Act takes effect July 1, 1995.

5 * Sec. 7. Except for sec. 5 of this Act, this Act takes effect immedi-
6 ately under AS 01.10.070(c).

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STATE OF ALASKA
THE LEGISLATURE

POUCH V STATE CAPITOL
JUNEAU ALASKA 99811
907 465 3800

LEGISLATIVE AFFAIRS AGENCY

MEMORANDUM

March 12, 1990

SUBJECT: Disability insurance - CSSSSB 304(L&C)
TO: Senator Jack Coghill
FROM: Michael F. Ford *M.F.*
Legislative Counsel

The following is a sectional analysis of CSSSSB 304(L&C):

Section 1 - Legislative intent.

Section 2

Sec. 21.55.010 - Establishes the Comprehensive Disability Insurance Association and provides that the purpose of the association is to provide health insurance to eligible residents of the state.

Sec. 21.55.020 - Establishes the board of directors of the health insurance association, and requires the board to use a weighted voting system based on premium income.

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

Sec. 21.55.040 - Requires the association to develop a plan of operation. Provides specific items that must be included in the plan of operation.

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

Sec. 21.55.060 - Exempts the association from all taxes except taxes on real or personal property. Allows a tax credit for members of the association.

Sec. 21.55.100 - Requires the authority to provide health care insurance to eligible residents of the state.

Senator Jack Coghill
Page 2
March 12, 1990

Sec. 21.55.110 - Establishes minimum benefits that must be provided.

Sec. 21.55.120 - Establishes deductible and copayment amounts. Provides for annual adjustment of the deductible.

Sec. 21.55.130 - Establishes criteria for coverage of a pre-existing condition.

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

Sec. 21.55.150 - Establishes limits on the premium charged for state insurance.

Sec. 21.55.200 - Establishes criteria for selection of an insurer to administer the state plan.

Sec. 21.55.210 - Establishes the duties of the insurer who administers the state plan.

Sec. 21.55.220 - Provides for enrollment in the state plan, and for assessment of claims expenses to members of the association.

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

Sec. 21.55.310 - Provides for enrollment in the state plan.

Sec. 21.55.320 - Requires the writing carrier to act on an enrollment application within 30 days.

Sec. 21.55.330 - Establishes the effective date of insurance coverage.

Sec. 21.55.340 - Requires the association to solicit eligible residents for enrollment.

Sec. 21.55.400 - Duties of the director of the division of insurance.

Sec. 21.55.410 - Gives the state immunity for acts or omissions of the association, and for payment of claims.

Sec. 21.55.500 - Definitions.

Senator Jack Coghill
Page 3
March 12, 1990

Section 3 - Establishes a tax credit for members of the association.

Section 4 - Requires the association to make insurance available to residents by January 1, 1991.

Section 5 - Effective date.

MFF:pl
WKP3/037



**STATE OF ALASKA
OFFICE OF THE GOVERNOR
BILL ANALYSIS**

DEPARTMENT Commerce & Econ. Dev.	DIVISION Insurance	BILL NUMBER CSSSSB 304(L&C)	SPONSOR Senator Coghill
SHORT TITLE OF BILL An Act Relating to Disability Insurance			
DEPARTMENT POSITION Neutral			
PREPARED BY Dave Walsh, Director	DATE 3/2/90	COMMISSIONER'S SIGNATURE <i>S. M. [Signature]</i>	DATE 3/5/90

SUMMARY

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

FISCAL IMPACT: NONE FISCAL NOTE ATTACHED

BACKGROUND LEGISLATIVE INTENT

SB 304 provides for a third party medical care financing mechanism for residents who are either marginally insurable or uninsurable or who have involuntarily lost their coverage with the financial ability to pay premiums at a level deemed affordable. This measure is similar to CSHB 589 of the Fourteenth Legislature, and HB 72 and HB 474 of the Fifteenth Legislature. There is the possibility of a substantial loss of premium tax revenues up to \$4.2 million.

ANALYSIS OF BILL PROGRAM EFFECTS

See Attached

AMENDMENTS PROPOSED

None

4076D-1/3290f

PLEASE ATTACH A SEPARATE SHEET FOR ADDITIONAL COMMENTS OR ANALYSIS

ANALYSIS OF BILL/PROGRAM EFFECTS

SECTION 2 AS 21.55.010 - .500

AS 21.55.010

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

AS 21.55.020

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

AS 21.55.030 - .060

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

AS 21.55.100

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

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

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

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

1. a person who, at the time of application, is eligible for medical assistance;
2. a person who terminated coverage under this chapter unless 12 months have elapsed since termination, or that the person can show that other continuous coverage was involuntarily terminated for any reason other than for nonpayment of premium;
3. a person on whose behalf \$500,000 in benefits have been paid; and
4. inmates of public institutions and persons whose benefits are duplicated under public programs.

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

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

AS 21.55.110

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

AS 21.55.120

The two deductible amounts of \$1,000 and \$5,000 are established here. A deductible "carry-over" provision is established for expenses incurred in the last three months of any calendar year used to satisfy the deductible. Those expenses will be used to also satisfy the deductible in the following year.

A copayment maximum is established.

An insured's out-of-pocket costs are limited to \$2,000 as a result of responsibility for the deductible and copayment.

The deductible may be adjusted annually by the director based upon the change in the consumer price index for the Anchorage Metropolitan area.

AS 21.55.130

This section provides the allowable preexisting medical condition provision to be included in the state plans. No coverage is to be provided for the first twelve months of coverage for any preexistent medical conditions.

The state plan must credit time covered under a previous contract which was involuntarily terminated toward satisfaction of the time parameters in which coverage is not provided for a preexisting condition. In such a situation and if the person applies for state plan coverage within 31 days after involuntary termination, the state plan coverage is retroactive to the termination date.

AS 21.55.140

This section provides a list of care and services not to be covered by the state plans.

AS 21.55.150

Standards for the establishment of premium rates are found here. Age banded rates that vary by geographic location of the insured are required. The rates charged by the CDIA are not to be excessive, inadequate, or unfairly discriminatory. However, the maximum rates charged may not exceed 150% of the average of the rates charged for a standard risk by the five insurers with the largest member of Alaskan residents covered under equivalent plans of insurance coverage. The director would need to establish criteria to determine actuarially equivalent plans and collect data regarding the number of persons covered in each plan in order to determine the five members whose rates are going to be solicited. (This data is not currently reported.) Furthermore, each of the five insurer's rates for its actuarially equivalent plans would have to be verified as being actuarially sound by the division. This activity will have a fiscal impact on the division as well as on the insurance industry. A less costly approach would be to determine the five insurers on the basis of total disability premiums written in Alaska. However, the division would still need to contract annually with a qualified actuary to determine the structural compatibility and actuarial soundness of the rate structures.

Testimony on CSHB 589 of the Fourteenth Legislature from the insurance industry indicated that actuarially sound rates for the uninsurable population might exceed standard rates by a factor of three.

AS 21.55.200

Criteria for the selection of the member to administer the state plans is found in this section. Essentially, the criteria entail the proven ability to administer large insurance contracts efficiently. An additional criteria that may wish to be considered would be to require that an administrative, claims payment facility be located in Alaska. However, cost/benefit justification would need to prevail.

AS 21.55.210

This section sets out the duties to be performed by the writing carrier. The duties include those usually performed by any insurer or hospital or medical service corporation.

AS 21.55.220

The material provisions of this section pertain to establishing each member's liability for its proportional share of the costs to operate the state plans and proportional share of claims that exceed the premiums collected. Each member's proportional share is determined by the relationship of its total disability insurance premiums or subscriber fees to the total of all members. Failure by a member to pay an assessment within 30 days from when it is due is grounds for revocation of that member's certificate of authority. Any gains from operations of the state plans are required to be held at interest and be used to offset future claims or to reduce premium rates.

Any assessments paid by a member are considered an expense item for statutory financial reporting purposes.

AS 21.55.300

Eligibility for participation in the state plans is outlined in this section as well as an outline for those persons not eligible. These criteria were discussed previously in the comments on AS 21.55.100.

AS 21.55.310

This section contains the procedure for application for state plan coverage, and a description of the personal information required to be provided. It should also be noted that no premium payment is required to accompany the application.

AS 21.55.320

This section requires the writing carrier to respond to each applicant within 30 days of request of an application. The application is either rejected for noncompliance with AS 21.55.300 and AS 21.55.310, or it is accepted and billing information is provided.

AS 21.55.330

The effective date of coverage under the state plans is governed by this section. The primary criteria for coverage effectuation is the receipt of the appropriate premium by the writing carrier. Generally, coverage is retroactive to the date of the application. However, coverage may be retroactive to the date that a person's previous coverage was terminated if that person:

1. applies for state plan coverage within 60 days after the previous coverage was terminated;
2. is accepted by the writing carrier; and
3. pays a specified premium for the period of retroactive coverage.

One area in need of clarification is what date constitutes the "date of application". Basically, two possible dates could constitute that date:

1. the date the applicant signs the application (under the assumption the application form will have a signature space, and a space for the applicant to date his or her signature). If this is the intended date, it is recommended that each applicant's signature and date of signature be notarized;

OR

2. the date the writing carrier receives a completed application. This would be determined assumedly by a mechanically stamped day/date of receipt on the application itself.

This clarification can be accomplished with adoption of regulations under AS 21.55.400(3).

AS 21.55.340

This section calls for the association to develop and implement a program of public awareness that encourages and facilitates participation in the state plans. Any member that rejects coverage or applies underwriting restrictions is required to inform that person of the existence of the state plans, eligibility requirements, and the application procedures.

The marketing of the state plans, other than by association members or the writing carrier on a direct basis, is limited to licensed disability insurance agents. No mention is made of any compensation for the agent that "sells" a state plan to an eligible person. The issue of compensation for agents may wish to be addressed.

AS 21.55.400

The duties of the director are outlined in this section. One duty (AS 21.55.400(2)) entails the contracting with other governmental entities (state and federal) to coordinate this program with other medical assistance

programs. It is understood that such arrangements are typically accomplished not through contracts, per se, but through "memoranda of agreement".

AS 21.55.410

This section states the state is not liable for the acts of the association in operating this plan.

AS 21.55.500

This section contains the definitions of the operative terms used in this proposal.

The term "major medical" includes the lifetime maximum of \$500,000. It should be noted that an insurer could escape membership in the association by offering plans with maximum benefits of less than \$500,000.

SECTION 3

This section creates an offset equal to any assessment to premium taxes required to be paid by a member. Such credits may be carried forward if the offset in a given year would reduce a member's premium tax liability to less than zero.

This will result in less premium tax receipts for the state depending upon the state plans' financial performance. It should be noted that this credit can be applied against premium taxes associated only with disability insurance premiums.

There may be an inequitable result due to the different premium tax bases for insurers and hospital or medical service corporations.

SECTION 4

This section requires that state plans be available by January 1, 1991. This appears to be a quite short lead time to develop these plans. If this Act is enacted during the first session, it might be more realistic to have the implementation date set at July 1, 1991.

SECTION 5

This Act would take effect immediately.

**COMPARISON OF CONVERSION RATES
TO AETNA MANUAL RATES**

	Aetna Conversion Rates	Aetna Manual Rates (50/50 m/f split)	Relativity
Under 25	758	394	193%
25-29	830	394	211%
30-34	871	448	194%
35-39	915	448	204%
40-44	966	491	197%
46-49	1093	565	193%
50-54	1221	650	168%
55-59	1391	746	187%
60-64	1548	867	179%

SUBURBAN PRINTING

February 6, 1990

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

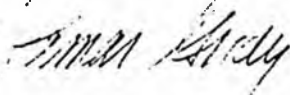
Dear Senator Coghill,

I have a medical condition which apparently makes me uninsurable. I have recently attempted to obtain adequate medical coverage and have been severely ridered because of my current medical condition. I know that there are many others that have the same fate as I.

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

Please contact me for any further support that you might need.

Sincerely,



H. Lamar Gray
7703 Arlene
Anchorage, Alaska 99502

HOMER MEDICAL CLINIC
A PROFESSIONAL CORPORATION
4136 BARTLETT STREET
HOMER, ALASKA 99603
TELEPHONE (907) 235-8586

FEB 0 1980

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STEPHANIE STAUBER, C.N.M., F.N.P.
BETTY ENEBOE, R.N., M.P.H.

Senator John B. Coghill
P.O. Box 55028
North Pole AK 99705

RE: Support of Senate Bill 304 as written

Dear Senator Coghill:

We have employees and patients who have medical conditions which make them un-insurable. They have attempted to obtain adequate medical coverage and have either been rejected or severely ridered because of their circumstances. I understand that there are many Alaskans who share this situation.

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

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

Sincerely,

William H. Bell

Jan Maslyk
2220 Tasha Drive
Anchorage, AK 99502

NOV 27 1989

November 22, 1989

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

Re: Support of Senate Bill 304 as written

Dear Senator Coghill,

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

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

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

Sincerely,

Jan Maslyk

Jan Maslyk

March 27, 1989

To: Senator Jack Coghill
Capital, Room 30
Juneau

From: Jan H. Soloy
P.O. Box 872801
Wasilla, Alaska 99687
376-3813

Subject: High Risk Health Insurance Coverage

I have been an Alaskan resident since 1981, prior to moving here I worked as a Registered Nurse in the speciality areas of Coronary|Intensive Care. The reason I relocated to Alaska was that I married a man that resided here. We have two sons, Matthew is seven and Sam is 3. We own and operate a helicopter company that is based in Wasilla. The past eight years we have built the company from the size of one machine and one employee to five machines and 25 full-time and seasonal employees. Chris and I are active in community youth activity programs and we sponsor youth sports in the area. We also have decided to donate a piece of needed equipment for one of the schools in this area each year that we can. We are firm believers in local business and individuals supporting the community.

For twelve years I have lived with a condition called Multiple Sclerosis. Although I am lucky and have been very stable, living and coping with a disease like MS has been a challenge in many ways. I have had the opportunity to be in large groups for health insurance coverage, that has changed now because of some changes in federal law and company policies of the group we are in. We have group benefits for 17 more months and if it weren't for the fact that our coverage is in Washington and not in Alaska, I would be out-of-luck and be without any comprehensive coverage. Because the Washington legislators saw fit to pass legislation that says that if you lose group coverage you must be guaranteed conversion to an individual plan, regardless of your health status. This goes beyond the COBRA law. Therefore I'm luckier than most with a high risk condition in a non-group situation. I have some basic coverage for general medical care. Nothing for Skilled Nursing Facilities, Hospice, Rehab., no catastrophic coverage at all. I'm grateful for the law in Wa. but I live in Alaska now. I have been turned down for insurance before but went back to work in a large hospital, I have been aware of health insurance problems, now that awareness is reality. I'm one of the 15 million in this country and thousands in this state alone, that because of a preexisting condition is underinsured. The numbers for uninsured are much greater.

I have copies of several pieces of legislation on this topic, that have been introduced in the Alaska legislature this year and one in 1986. Granted this is a national problem but experts agree that we are at least 20 years away from solving it at the national level. Indeed, the trend for solutions is at the State level of government. Twenty states have passed and put into effect laws which have created some version of a High Risk Health Insurance Pool. This number grows each year, fifteen more, including Alaska have introduced bills dealing with this issue. Yes, the states lose money but without this coverage another group of indigents are created. That has a fiscal impact on the state also. Only Multi-millionaires can afford to be without

page 2 of 2
3-27-89
High Risk Insurance

health insurance. One should not have to get a divorce or relinquish all assets to be eligible for medical benefits.

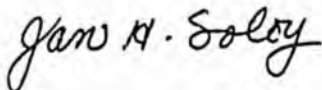
This is a problem that faces many people in Alaska. I have been in contact with the Heart, Diabetes, Lung and Epileptic Associations, MDA; Cancer Society and several Senior Citizens groups among a few. They are all in support of state health insurance for people that have been refused coverage for health reasons. We all realize that this insurance is costly, with large deductibles. I spoke with several that would be able to pay this, with some effort on my part and others you will be hearing from constituents on this. In the meantime, I believe it is time for Alaska to address this problem. I am aware of The Budget problems we face but if 20 going on more states can find ways to resolve this problem despite their varied problems, then I believe Alaska can too and will. Mike Losow of the National MS Society informed me that Alaska had introduced some of the best legislation ever designed to dissolve barriers to health insurance coverage for the chronic condition groups. This made me strangely proud. I told Mike that I felt we would do more than design and consider. The time is now to make this a legislative priority, even in the face of oil prices.

Furthermore, there is no sector of private business that can solve this, we have no one to turn to but our government. Government that was formed, among other things to protect and promote public health for everyone, not just the unfortunate but the middle-class group and upper middle-class.

I support state sponsored and created High Risk Health Insurance. Please consider introducing or supporting legislation that would allow access to health care for the ones who "fall through the cracks".

I would like to hear from you, your thoughts and how close you feel Alaska is to passing this type of legislation.

Respectfully,



Jan H. Soloy

cc: legislative offices

State Legislative Report



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

SLR 87-16

June 4, 1987

* * SPECIAL * *

RISK POOLS FOR UNINSURABLES

ACKNOWLEDGEMENT

The charts and information provided with this SLR were in part compiled by an organization called Communicating for Agriculture which has been interested in the risk pool issue since 1975. We thank them and the other organizations who have provided information to NALU and who continue to provide information on this important issue.

WHAT ARE RISK POOLS?

Among the uninsured are those who have been denied insurance coverage for reasons of poor health or who have been offered insurance policies with extremely high premiums or with restrictive exclusions for pre-existing conditions. For some of these people, money is not the barrier to health care until such time as large medical bills drain their resources.

In 13 states, high risk individuals now have access to health insurance risk pools. Under such programs, health status is in theory eliminated as a barrier to the availability of health insurance, since insurance is available through the pool.

Clearly, risk pools do not eliminate all barriers to the availability of health insurance, because the insurance obtainable through pools is expensive. Nevertheless, advocates argue that this availability of insurance helps to create a principle that everyone should have the opportunity to purchase health insurance. Second, they argue that health insurance for high risk individuals does address one small segment of the larger population of uninsured individuals.

tes allow a waiver of this waiting period through payment of a premium surcharge.

COST OF INSURANCE

Cost remains the biggest barrier to obtaining health insurance through risk pools, since insurance provided to high risk individuals must obviously be more expensive than that for standard risks.

While these premiums are high, they would be even higher in the absence of state imposed limits that cap premiums at no more than a fixed percentage (usually about 150%) of the standard individual premium in the state.

One state has taken an additional step to make risk pools more accessible to the poor. The Wisconsin legislature in 1985 passed legislation appropriating funds to assist low income policyholders in paying premiums.

PAYING FOR THE POOL

In theory, premiums are to cover the majority of claims paid by the pool. In practice, however, premiums are generally insufficient, because of the premium cap and the poor health status of the insured individuals. Accordingly, the losses incurred are compensated by assessing the members of the pooling association, in proportion to their share of the state health insurance market. In most states, these pool assessments are subsidized through rebates on premium taxes or other state taxes.

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

Three states, Illinois, New Mexico, Washington, enacted pooling laws in 1987. Illinois was a particularly interesting piece of legislation in that the law bases the subsidy on general revenues, not an assessment on insurers.

IN SUMMARY

No one can reasonably claim that risk pools will solve the entire problem of the insured, since the reasons for this lack of coverage are enormously varied. Some people are left vulnerable by limitations in Medicaid eligibility; others are employed by firms that do not offer health insurance; still others are left without insurance after becoming unemployed or losing dependent coverage through a spouse; some take the risk of not purchasing insurance although they can afford it.

STATUS OF LEGISLATION

CREATING COMPREHENSIVE HEALTH INSURANCE POOLS
FOR HIGH-RISK INDIVIDUALS

<u>STATE</u>	<u>STATUS</u>
Alaska	Introduced in 1986 - Failed.
Arizona	Introduced in 1984 - Failed.
California	Introduced in 1984, 1985, 1986 - Failed.
Colorado	Introduced in 1985, 1986 - Failed.
* Connecticut	Program in effect - 1976.
* Florida	Program in effect - October, 1983.
* Illinois	Introduced in 1985, 1986 - Failed. <i>Passed in 1987</i>
* Indiana	Program in effect - July, 1982.
* Iowa	Passed and signed into law - April, 1986 - To become operational in 1987.
Kansas	Legislation passed and signed into law to further study the issue and draft legislation - March, 1986.
Kentucky	Introduced in 1984 - Failed.
Louisiana	Introduced in 1986.
Maine	To study the issue summer of 1986.
Maryland	To study the issue summer of 1986.
Massachusetts	Studying the issue.
* Minnesota	Program in effect - June, 1976.
Mississippi	Introduced in 1984, 1985, 1986 - Failed.
Missouri	Introduced in 1984, 1985, 1986 - Failed.
* Montana	Passed and signed into law - 1985 - To become operational July, 1987.
* Nebraska	Passed and signed into law - 1985 - To become operational late 1986 or early 1987.
* New Mexico	Introduced in 1986 - Failed. <i>Passed in 1987</i>
New York	Introduced in 1985, carried over to 1986 - Failed.
* North Dakota	Program in effect - June, 1981.

CORRECTION

**THIS DOCUMENT
HAS BEEN REPHOTOGRAPHED
TO ASSURE LEGIBILITY**

State Legislative Report



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

SLR 87-16

June 4, 1987

* * SPECIAL * *

RISK POOLS FOR UNINSURABLES

ACKNOWLEDGEMENT

The charts and information provided with this SLR were in part compiled by an organization called Communicating for Agriculture which has been interested in the risk pool issue since 1975. We thank them and the other organizations who have provided information to NALU and who continue to provide information on this important issue.

WHAT ARE RISK POOLS?

Among the uninsured are those who have been denied insurance coverage for reasons of poor health or who have been offered insurance policies with extremely high premiums or with restrictive exclusions for pre-existing conditions. For some of these people, money is not the barrier to health care until such time as large medical bills drain their resources.

In 13 states, high risk individuals now have access to health insurance risk pools. Under such programs, health status is in theory eliminated as a barrier to the availability of health insurance, since insurance is available through the pool.

Clearly, risk pools do not eliminate all barriers to the availability of health insurance, because the insurance obtainable through pools is expensive. Nevertheless, advocates argue that this availability of insurance helps to create a principle that everyone should have the opportunity to purchase health insurance. Second, they argue that health insurance for high risk individuals does address one small segment of the larger population of uninsured individuals.

NALU POLICY

NALU supports the passage of enabling legislation in all states to create reinsurance pools or other mechanisms to fully spread the risks associated with insuring those persons now denied access to adequate health insurance.

RECENT NALU BOARD ACTION

At their April 1987 meeting the NALU Board of Trustees adopted a recommendation to refer the issue of state pools for uninsurables to NALU's State Law and Legislation Committee as a high priority item with the exhortation that the Committee work toward the enactment of legislation creating such pools in all states.

PURPOSE OF THIS SLR

To provide information to all recipients of the State Legislative Report and to urge those states currently not providing a method or mechanism for uninsurables to obtain health insurance to consider taking steps toward the eventual enactment of legislation providing for such pools.

BASIC DESIGN OF A RISK POOL

The basic design of a risk pool is to guarantee availability of adequate health insurance to all individuals, regardless of their physical condition. Although the operation of pools varies considerably from state to state there is a basic pattern. The state generally forms an association of all health insurance companies doing business in the state (proposed federal legislation would permit inclusion of self-insuring business in this association). One organization is selected to administer the plan under the guidelines for benefits, premiums, deductibles, etc. as set forth in the state law. Individuals then are able to purchase insurance from the plan.

COVERAGE

Risk pool policies do provide a fairly comprehensive package of benefits. Unlike many private individual policies that do not cover physician fees, risk pools generally specify a minimum benefit package that includes in-patient hospital services and services rendered by or at the direction of a physician, as well as some skilled nursing care, home health care, and prescription drugs.

Normally a choice of deductibles is offered, ranging from as low as \$150 to as high as \$2000, resulting in substantially different premiums. Some form of pre-existing condition restriction has been deemed necessary, if only to prevent individuals from enrolling for insurance only after they need medical care. Most pools have a six to twelve month waiting period for pre-existing conditions. However, some sta-

tes allow a waiver of this waiting period through payment of a premium surcharge.

COST OF
INSURANCE

Cost remains the biggest barrier to obtaining health insurance through risk pools, since insurance provided to high risk individuals must obviously be more expensive than that for standard risks.

While these premiums are high, they would be even higher in the absence of state imposed limits that cap premiums at no more than a fixed percentage (usually about 150%) of the standard individual premium in the state.

One state has taken an additional step to make risk pools more accessible to the poor. The Wisconsin legislature in 1985 passed legislation appropriating funds to assist low income policyholders in paying premiums.

PAYING FOR THE
POOL

In theory, premiums are to cover the majority of claims paid by the pool. In practice, however, premiums are generally insufficient, because of the premium cap and the poor health status of the insured individuals. Accordingly, the losses incurred are compensated by assessing the members of the pooling association, in proportion to their share of the state health insurance market. In most states, these pool assessments are subsidized through rebates on premium taxes or other state taxes.

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

Three states, Illinois, New Mexico, Washington, enacted pooling laws in 1987. Illinois was a particularly interesting piece of legislation in that the law bases the subsidy on general revenues, not an assessment on insurers.

IN SUMMARY

No one can reasonably claim that risk pools will solve the entire problem of the insured, since the reasons for this lack of coverage are enormously varied. Some people are left vulnerable by limitations in Medicaid eligibility; others are employed by firms that do not offer health insurance; still others are left without insurance after becoming unemployed or losing dependent coverage through a spouse; some take the risk of not purchasing insurance although they can afford it.

Risk pools represent a small step in reducing the uninsured population, or at least that segment of the insured that is not poor but could become poor when faced with major medical expenses. These plans, however, provide no comprehensive solution to the indigent care problem. Risk pools simply encourage and assist individuals in purchasing health insurance. Those who cannot afford to purchase insurance will in most cases not benefit from the pools.

ADDITIONAL
INFORMATION

The remainder of this SLR contains information on specific state programs showing the status of legislation creating comprehensive health insurance pools and describing the main aspects of a particular states pool.

NAIC MODEL
LEGISLATION FOR
CREATING A STATE
HEALTH INSURANCE
POOLING
MECHANISM

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

* * *

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

STATUS OF LEGISLATION

CREATING COMPREHENSIVE HEALTH INSURANCE POOLS

FOR HIGH-RISK INDIVIDUALS

<u>STATE</u>	<u>STATUS</u>
Alaska	Introduced in 1986 - Failed.
Arizona	Introduced in 1984 - Failed.
California	Introduced in 1984, 1985, 1986 - Failed.
Colorado	Introduced in 1985, 1986 - Failed.
* Connecticut	Program in effect - 1976.
* Florida	Program in effect - October, 1983.
* Illinois	Introduced in 1985, 1986 - Failed. <i>Passed in 1987</i>
* Indiana	Program in effect - July, 1982.
* Iowa	Passed and signed into law - April, 1986 - To become operational in 1987.
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Kentucky	Introduced in 1984 - Failed.
Louisiana	Introduced in 1986.
Maine	To study the issue summer of 1986.
Maryland	To study the issue summer of 1986.
Massachusetts	Studying the issue.
* Minnesota	Program in effect - June, 1976.
Mississippi	Introduced in 1984, 1985, 1986 - Failed.
Missouri	Introduced in 1984, 1985, 1986 - Failed.
* Montana	Passed and signed into law - 1985 - To become operational July, 1987.
* Nebraska	Passed and signed into law - 1985 - To become operational late 1986 or early 1987.
* New Mexico	Introduced in 1986 - Failed. <i>Passed in 1987</i>
New York	Introduced in 1985, carried over to 1986 - Failed.
* North Dakota	Program in effect - June, 1981.

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

* Highlighted states have existing plans.

MAXIMUM BENEFITS PROVIDED

<u>STATE</u>	<u>STATUS</u>
Alaska	No Limit In Legislation
Arizona	\$1,000,000 Lifetime Benefit
California	\$1,000,000 Lifetime Benefit
Colorado	\$500,000 Lifetime Benefit
* Connecticut	\$1,000,000 Lifetime Benefit
* Florida	\$500,000 Lifetime Benefit
Illinois	\$500,000 Lifetime Benefit
* Indiana	Plan I - No Limit Plan II - \$50,000 Lifetime Benefit
* Iowa	\$250,000 Lifetime Benefit
Kansas	No Limit in Legislation
Kentucky	\$1,000,000 Lifetime Benefit
Louisiana	\$500,000 Lifetime Benefit
* Minnesota	Regular Plan - \$250,000 Lifetime Benefit Medicare Plan - \$100,000 Lifetime Benefit
Mississippi	\$500,000 Lifetime Maximum
Missouri	\$1,000,000 Lifetime Benefit
* Montana	Not Less Than \$100,000 Lifetime Benefit
* Nebraska	\$500,000 Lifetime Benefit
New Mexico	To be Determined By The Board
New York	\$500,000 Lifetime Benefit
* North Dakota	\$250,000 Lifetime Benefit
Ohio	\$250,000 Lifetime Benefit
Oregon	\$250,000 Lifetime Benefit
South Carolina	\$1,000,000 Lifetime Benefit
South Dakota	\$50,000 Annual - \$250,000 Lifetime Benefit

* Tennessee	\$500,000 Lifetime Benefit
Texas	No Limit in Legislation
Utah	\$250,000 Lifetime Benefit
* Wisconsin	\$250,000 Lifetime Benefit

* Highlighted states have existing plans.

July, 1986

PREMIUM CAPS

STATE

RATE

Alaska

125% Maximum

Arizona

150% Maximum

California

To Be Determined By The Board

Colorado

150% Initial, 200% Maximum

* Connecticut

125% Minimum, 150% Maximum

* Florida

150% Initial, 200% Maximum

Illinois

135% Maximum

* Indiana

150% Maximum

* Iowa

150% Maximum

Kansas

To Be Determined By The Board

Kentucky

150% Initial, 200 Maximum

Louisiana

135% Initial, 165% Maximum

* Minnesota

125% Maximum

Mississippi

150% Initial, 200% Maximum

Missouri

150% Initial, 200% Maximum

* Montana

150% Initial, 400% Maximum

* Nebraska

135% Initial, 165% Maximum

New Mexico

To Be Determined By The Board

New York

150% Maximum

* North Dakota

135% Maximum

Ohio

130% Maximum For First Three Years

Oregon

130% Maximum For First Three Years

South Carolina

150% Initial, No Maximum

South Dakota

125% Initial, 200% Maximum

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

* Highlighted states have existing plans.

July 1, 1986

DEDUCTIBLES

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

<u>STATE</u>	<u>AMOUNT</u>
Alaska	To Be Determined By The Board
Arizona	\$200
California	\$1,000
Colorado	\$250; \$500; \$1,000 and any others Designated By The Board
* Connecticut	\$400; \$1,000; \$1,500
* Florida	\$1,000; \$1,500; \$2,000
Illinois	\$1,000; \$1,500; \$2,000
* Indiana	\$200; \$500; \$1,000
* Iowa	\$500; \$1,000 and any others Designated By The Board
Kansas	To Be Determined By The Board
Kentucky	To Be Determined By The Board
Louisiana	To Be Determined By The Board
* Minnesota	\$500; \$1,000
Mississippi	\$1,000; \$1,500; \$2,000
Missouri	To Be Determined By The Board
* Montana	Not to exceed \$1,000
* Nebraska	To Be Determined By The Board
New Mexico	To Be Determined By The Board
New York	\$500; \$1,000 and any others Designated By The Board
* North Dakota	\$150; \$500; \$1,000
Ohio	\$1,000
Oregon	\$1,000
South Carolina	To Be Determined By The Board
South Dakota	\$500; \$1,000 and any others Designated By The Board

- * Tennessee \$500; \$2,000 and any others Designated By The Board
- Texas \$200
- Utah To Be Determined By The Board
- * Wisconsin \$1,000

* Highlighted states have existing plans.

July, 1986

STOP LOSS/OUT-OF-POCKET EXPENSE LIMITATION

NOTE: Out-of-Pocket expense is the amount each insured will pay each year before the plan begins to pay 100% of eligible expenses.

<u>STATE</u>	<u>AMOUNT</u>																																				
Alaska	To Be Determined By The Board																																				
Arizona	\$1,000/Individual; \$2,000/Family																																				
California	\$3,000/Individual; \$5,000/Family																																				
Colorado	\$1,500/Individual; \$3,000/Family																																				
* Connecticut	\$2,000/Individual; \$4,000/Family																																				
* Florida	<table border="0" style="margin-left: 20px;"> <tr> <td style="text-align: right;"><u>Regular</u></td> <td>Plan I</td> <td>\$2,500/Individual;</td> <td>\$4,000/Family</td> </tr> <tr> <td></td> <td>Plan II</td> <td>\$3,000/Individual;</td> <td>\$4,500/Family</td> </tr> <tr> <td></td> <td>Plan III</td> <td>\$3,500/Individual;</td> <td>\$5,000/Family</td> </tr> <tr> <td></td> <td><u>Medicare</u></td> <td>Plan 1</td> <td>\$1,500/Individual;</td> </tr> <tr> <td></td> <td></td> <td>Plan II</td> <td>\$2,000/Individual;</td> </tr> <tr> <td></td> <td></td> <td>Plan III</td> <td>\$1,500/Individual;</td> </tr> <tr> <td></td> <td></td> <td></td> <td>\$4,000/Family</td> </tr> <tr> <td></td> <td></td> <td></td> <td>\$4,500/Family</td> </tr> <tr> <td></td> <td></td> <td></td> <td>\$5,000/Family</td> </tr> </table>	<u>Regular</u>	Plan I	\$2,500/Individual;	\$4,000/Family		Plan II	\$3,000/Individual;	\$4,500/Family		Plan III	\$3,500/Individual;	\$5,000/Family		<u>Medicare</u>	Plan 1	\$1,500/Individual;			Plan II	\$2,000/Individual;			Plan III	\$1,500/Individual;				\$4,000/Family				\$4,500/Family				\$5,000/Family
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Illinois	\$1,500/Individual; \$3,000/Family; \$500/Medicare																																				
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* North Dakota	\$3,000/Individual																																				

Ohio	\$1,500/Individual; \$3,000/Family		
Oregon	\$1,500/Individual; \$3,000/Family; \$500/Medicare		
South Carolina	To Be Determined By The Board		
South Dakota	\$3,000/Individual		
* Tennessee	A.	\$1,500/Individual;	\$2,500/Family
	B.	\$2,500/Individual;	\$3,500/Family
Texas	\$200 or 10% of insured's adjusted gross income, whichever is greater		
Utah	To Be Determined By The Board		
* Wisconsin	Plan I	\$2,000/Individual	\$4,000/Family
	Plan II	\$500	

* Highlighted states have existing plans.

July, 1986

WAITING PERIOD FOR PRE-EXISTING CONDITION

NOTE: Most plans contain provisions under which coverage is excluded for a certain period of time following the effective date of coverage. This exclusion is based on a pre-existing condition which manifested itself within a certain period of time prior to coverage or medical advice or treatment was recommended or received.

<u>STATE</u>	<u>WAITING PERIOD</u>	<u>CONDITION PERIOD</u>
Alaska	6 Months	6 Months
Arizona	6 Months	6 Months
California	To Be Determined By The Board	
Colorado	6 Months	6 Months
* Connecticut	12 Months	6 Months
* Florida	12 Months	6 Months
Illinois	6 Months	6 Months
* Indiana	6 Months	6 Months
* Iowa	6 Months	6 Months
Kansas	To Be Determined By The Board	
Kentucky	12 Months	6 Months
Louisiana	6 Months	6 Months
* Minnesota	6 Months	90 Days
Mississippi	12 Months	90 Days
Missouri	12 Months	6 Months
* Montana	12 Months	5 Years
* Nebraska	6 Months	6 Months
New Mexico	To Be Determined By The Board	
New York	6 Months	6 Months
* North Dakota	6 Months	90 Days
Ohio	30 Days	6 Months
Oregon	30 Days	6 Months

South Carolina	6 Months	6 Months
South Dakota	12 Months	6 Months
* Tennessee	6 Months	6 Months
Texas	6 Months	6 Months
Utah	12 Months	6 Months
* Wisconsin	6 Months	6 Months

* Highlighted states have existing plans.

July, 1986

POOL FUNDING

NOTE: Because of Federal Law (The Employee Retirement Income Security Act, known as ERISA) self-insurers are not required to become members of a state pool, therefore are not assessed any of the cost. In addition, all state pool legislation allows abatement of assessment if the payment of the assessment would endanger the ability of the member to fulfill his contractual obligations. Also, assessments that are less than an amount determined by the board to justify the cost of collection shall not be considered.

<u>STATE</u>	<u>SOURCE</u>
Alaska	Assessment of losses to participating insurers.
Arizona	Assessment with credit applied against premium tax and income tax. Use formula of approximately 20% per year.
California	The state has created a start-up fund of \$750,000.
Colorado	Assessment with credit applied against premium tax and income tax.
* Connecticut	Assessment of losses to participating insurers.
* Florida	Assessment with credit applied against premium tax and income tax. Maximum assessment of 1% per year on premiums or greater than premium tax. Use formula of approximately 20% per year for offset.
Illinois	Assessment with credit applied against premium tax and income tax. Also allowed to increase rates to offset assessment.
* Indiana	Assessment with credit applied against premium tax and income tax. Also allowed to increase rates to offset assessment.
* Iowa	Assessment with credit applied against premium tax and income tax.
Kansas	To Be Determined By The Board
Louisiana	Assessment with credit applied against premium tax.
* Minnesota	Assessment with credit applied against premium tax and income tax.
Mississippi	Assessment with credit applied against premium taxes, but only for the amount over 20% of total premiums collected by cash insurer.
Missouri	Assessment of losses to participating insurers.
* Montana	Assessment with credit applied against premium tax.
* Nebraska	Assessment with credit applied against premium tax.

New Mexico	To Be Determined.
New York	Assessment to insurers, although state has not determined if tax credit will be allowed.
* North Dakota	Assessment with credit applied against premium tax and income tax.
Ohio	Assessment of losses to participating insurers.
Oregon	Assessment of losses to participating insurers.
South Carolina	Assessment with credit applied against premium tax and income tax.
South Dakota	Assessment with credit applied against premium tax. Use formula of approximately 20% per year for write-off.
* Tennessee	Assessment of losses to participating insurers with credit applied against premium tax.
Texas	Assessment of losses to participating insurers.
Utah	To Be Determined.
* Wisconsin	Assessment of losses to participating insurers plus special fund created by state to subsidize premiums for low-income policyholders.

* Highlighted states have existing plans.