Leg. Finance-House & Senate Finance Comte Files (1991-1992) 839

section;

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

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

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

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

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

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

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

(14) experimental procedures; and

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

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

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

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

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

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

(c) The five members of the association that insure, or have subscriber contracts with, the largest number of individuals in the state under plans with benefits substantially equivalent to the state plan benefits shall submit to the association an estimate of the rate that would be actuarially sound for a person who is a standard risk for coverage substantially equivalent to the

state plan. The premium for a state plan may not exceed 200 percent of the average of those five estimates. .

ARTICLE 3. ADMINISTRATION OF PLANS.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ARTICLE 4. ENROLLMENT IN THE STATE HEALTH INSURANCE PLAN.

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

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

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

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

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

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

(3) information relevant to whether the person is a high risk.

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

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

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

previous contract or policy terminated if the person

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

(2) is accepted by the writing carrier; and

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

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

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

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

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

ARTICLE 5. GENERAL PROVISIONS.

Sec. 21.55.400. DUTIES OF DIRECTOR. The director may

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

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

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

(4) adopt regulations necessary to administer this chapter.

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

claim under a state plan issued by a writing carrier.

Sec. 21.55.500. DEFINITIONS. In this chapter

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Alaska State Legislature

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

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

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CS FOR SENATE BILL 74 (HESS)

POOLED HIGH RISK HEALTH INSURANCE

CONTENTS OF PACKET

1) SPONSOR STATEMENT

2) SECTIONAL ANALYSIS AND COPY OF BILL AND FISCAL NOTES

3) CONSUMERS REPORT 1990, PAGES OF "THE CRISIS IN HEALTH INSURANCE"

4) WHAT ARE HIGH RISK POOLS AND HOW DO THEY WORK

5) TABLE OF HIGH RISK POOLS IN 25 STATES, HEALTH BENEFITS LETTER

6) HIGH RISK HEALTH INSURANCE PROVISIONS IN STATES, FROM THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

7) LETTERS OF SUPPORT FROM:

UNINSURABLE INDIVIDUALS, THE AMERICAN DIABETES ASSOCIATION, ALASKA AFFILIATE, DR. MELOCHE, THE ALASKA STATE MEDICAL ASSOCIATION, ALASKA STATE HOSPITAL AND NURSING HOME ASSOCIATION, SOUTHERN ALASKA LIFE UNDERWRITERS ASSOCIATION, AND AETNA.

This bill will help that portion of the uninsured who can afford higher cost health insurance but are denied adequate coverage. It will help these individuals avoid financial ruin and the indignity of incurring bad debt which is currently being shifted to all those who currently have insurance. It will allow the uninsurable to purchase health insurance and thus to act responsibly.

Alaskans, like others nationwide, are being dropped from insurance or denied coverage. Others have exclusion riders placed on their policies. All these people would qualify for this high risk pool.

Summary CS for SB 74 (HESS)

Comprehensive Health Insurance Association: The high risk insurance will be provided by an association of private health insurers who form a pool to provide high risk health insurance to Alaskans. Health insurers and medical service corporations are members of the Comprehensive Health Insurance Association as a condition of doing business in Alaska. The Board of Directors of the Association contracts with an insurer to pay claims and administer the plan. The Board is made up of 5 insurers selected by members, and two consumers appointed by the Director of the Division of Insurance.

Benefits: The plan will provide full major medical coverage or medicare supplement coverage to those denied insurance by two insurers.

Premiums: Premiums for the high risk health insurance will cost up to twice the "average" standard risk premium rate (200% cap) to cover the excess risk. At this premium level, losses are unlikely, especially in the early years.

Financial Back-up: If there are any losses, insurers in the state will be assessed in proportion to their share of premiums written in the State. Nationally assessments from mature plans with 150% premium caps average 1% of premiums. By changing the premium cap to 200%, assessments to insurers are expected to be far less. There will be no fiscal impact in the first year of operation (FY 93) and assessments to insurers after that are likely to be very minimal.

Pre-existing Conditions: Those with medical conditions who have had their insurance involuntarily terminated, or who have lost coverage when they changed jobs, will have continued coverage of pre-existing conditions. This is a very important provision which give Alaskans who are currently insured the security they need that they can get insurance should they loose coverage.

The high risk pool will be offered and managed by private enterprise with oversight by the division of insurance as is done for other private insurers. The Comprehensive Health Insurance Association must report back to the legislature every three years.

The Problem

More and more Alaskans are being refused insurance because of a medical condition such as an injured knee, diabetes, cancer, or a chronic ear infection. Those in occupations that are hazardous, more likely to make claims, or in occupations that have high turnover are also excluded. Fry cooks, iron workers, and the clergy are examples of those who are excluded by some insurers. They are on "no quote lists". Between 1/4 and 1/2 of all policies have riders that exclude coverage of a condition such as diabetes or heart disease. Others are dropped from insurance when they develop a medical problem.

In your packets you will find a consumer report article which describes this problem well.

Model Legislation Enacted in Other States

Senate Bill 74 is based on the National Association of Insurance Commissioners Model Legislation.

The twenty six other States that have enacted high risk pools based on the National Association of Insurance Commissioners model include Washington, Oregon, California, New Mexico, Utah, Montana and Wyoming, as well as many mid-western, southern, and eastern states.

Correction of the Negative Impact of Medical Underwriting

High risk insurance is supported by many in the insurance industry because it corrects many of the injustices created by the competitive practice of insuring only those of lower risk of health problems.

Enclosed in your packet you will find a letter from the Southern Alaska Life Underwriters Association Legislative Committee. It states that the association strongly supports SB 74 because it "provides a fiscally responsible mechanism to guarantee these Alaskans coverage." "These people fall through the cracks because they either make too much money or have too large a net worth to qualify for Medicaid".

Why it is Needed

This bill will prevent individuals from having to bankrupt their family or small business in order to pay for needed medical care.

Alaskans need to know that they can change jobs and still get health insurance that covers pre-existing conditions. They need the security that they can get and keep health insurance even though they or a family member may develop a serious health problem. It is time we remove Alaskans' fear of losing their health insurance coverage. This situation has gone on too long. Senate Bill 74 will

guarantee that health insurance will be available for purchase to Alaskans.

The suffering and delay of needed care has got to stop. Alaskans should not have to stay home, suffering, because they are denied health insurance when they need it most.

DIVISION OF LEGAL SERVICES

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MEMORANDUM May 5, 1992

SUBJECT: Pooled Health insurance - CSSB 74 (HES) am

TO: Senator Jay Kerttula

MAY 05 1992

FROM: Michael F. Ford
Legislative Counsel

The following is a sectional analysis of CSSB 74 (HES) am:

Section 1 - Purpose.

Section 2

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

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

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

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

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

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

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

Sec. 21.55.110 - Establishes the minimum benefits that must be offered under a state health insurance plan. Establishes a maximum lifetime benefit of $1,000,000 per individual.

Sec. 21.44.120 - Establishes the deductible and copayment amounts for a state health insurance plan.

Sec. 21.55.130 - Limits the use of a preexisting condition to exclude coverage under state health insurance.

Sec. 21.55.140 - Establishes that certain care and benefits are not covered.

Sec. 21.55.150 - Provides that premium rates for state health insurance may not be excessive, inadequate, or unfairly discriminatory. Requires that premium rates be based on the age and geographic location of the insured. Limits the amount that can be charged as a premium.

Sec. 21.55.200 - Establishes criteria for selection of a writing carrier.

Sec. 21.55.210 - Provides the duties to be performed by the writing carrier and provides for reimbursement of expenses.

Sec. 21.55.220 - Provides for enrollment, for sharing losses, and for determining each member's liability.

Sec. 21.55.300 - Provides that a state resident who is a high risk is eligible to enroll in the state insurance plan. Prohibits enrollment if other coverage exists.

Sec. 21.55.310 - Specifies the procedure for enrollment and the contents of the application.

Sec. 21.55.320 - Requires acceptance or rejection of an enrollment application within 30 days.

Sec. 21.55.330 - Establishes the date that insurance will become effective.

Sec. 21.55.340 - Requires the association to solicit eligible persons for enrollment, by increasing public awareness of the state health insurance plan.

Sec. 21.55.400 - Establishes the duties of the director of the division of insurance.

Sec. 21.55.410 - Provides that the state is not liable for acts of the association.

Sec. 21.55.500 - Definitions.

Section 3 - Requires the association to make insurance available to eligible residents by January 1, 1993.

Section 4 - Effective date.

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High Risk Pools in 25 States

High Risk Pools - General Information						
	Effective Date	Pre-X Waiting Period	Premium Cap	Funding Source	Tax Offset	Plan Administrator
CA	1991	90 Days	125%	Tobacco Tax	n/a	BCBS
CO	1991	6 Months	175%	Income Tax Surcharge	n/a	BCBS
CT	1976	12 Months	150%	Insurer Assessment	No	Travelers
FL	1983	12 Months	300%	Insurer Assessment	No	BCBS
GA	note 1	6 Months	150%	General Revenue	n/a	n/a
IL	1989	6 Months	135%	General Revenue	n/a	Mutual of Omaha
IN	1982	6 Months	150%	Insurer Assessment	Yes	ASGC, Inc.
IA	1987	6 Months	150%	Insurer Assessment	Partial	Mutual of Omaha
LA	1992	6 Months	200%	Lottery & Hospital Tax	n/a	n/a
ME	1988	90 Days	150%	Hospital Tax	n/a	Mutual of Omaha
MN	1976	6 Months	125%	Insurer Assessment	No	BCBS
MS	1992	12 Months	175%	note 2	No	n/a
MO	1991	12 Months	200%	Insurer Assessment	Yes	BCBS
MT	1987	12 Months	400%	Insurer Assessment	Yes	BCBS
NE	1986	6 Months	165%	Insurer Assessment	Yes	BCBS
NM	1988	6 Months	150%	Insurer Assessment	Partial	BCBS
ND	1981	6 Months	135%	Insurer Assessment	Yes	BCBS
OR	1990	6 Months	150%	note 2	No	BCBS
SC	1990	6 Months	300%	Insurer Assessment	Yes	BCBS
TN	1987	6 Months	150%	Gen'l Rev. & Insur. Assmt.	No	BCBS
TX	note 1	6 Months	200%	Insurer Assessment	Yes	BCBS
UT	1991	6 Months	200%	General Revenue	n/a	BCBS
WA	1988	6 Months	150%	Insurer Assessment	Yes	Mutual of Omaha
WI	1981	6 Months	150%	Insurer Assessment	No	Mutual of Omaha
WY	1991	6 Months	200%	Insurer Assessment	Partial	BCBS

NOTES: (1) Effective dates in GA and TX depend upon additional legislative action. (2) MS and OR both assess payers, including reinsurers and TPAs, on a per capita basis. Source, Communicating for Agriculture

THE FOLLOWING DOCUMENT HAS NOT BEEN FILMED BUT IS AVAILABLE IN THE ORIGINAL FILE.

PLEASE MICROFILM TOP PAGE ONLY

THE CRISIS IN HEALTH INSURANCE

In the U.S., the ticket to health care is insurance. If you are in good health and have a well-paying job with a large firm, chances are you have a ticket, and your employer pays for it. But if you work for yourself, have a low-paying job, or are sick, chances are you'll have to pay for the ticket yourself—if you can buy one at all.

Tickets are becoming harder to get. Between 31 million and 37 million people have no health insurance, either because they can't afford it or because insurance companies refuse to sell them a policy at any price.

Others lose their tickets. People who once had insurance may suddenly find themselves without it when employers discontinue health-care coverage or go out of business; or when insurance companies cancel policies or become insolvent.

Millions more have no protection against a catastrophic illness. They may have some insurance, but lack coverage for the very conditions that will one day require unusually heavy expenditures.

"If the employed population knew how vulnerable they were, they'd be up in arms demanding national health insurance," says Bonnie Burns, a counselor with California's insurance counseling program. "Most of these people are three paychecks away from disaster."

The health-insurance crisis is a fairly recent phenomenon. At the beginning of World War II, few Americans owned a health-insurance policy. As recently as 1965, most had coverage only for hospital stays. The health-insurance system as we know it today evolved in the 1960s and 1970s. Under that system, workers came to expect their employers to supply medical coverage for them, with employers and employees splitting the cost.

That worked well for a while. More workers had health insurance, and their coverage broadened to include doctors' visits, prescription drugs, and even treatment for mental illness. But now the system stitched together over the last 50 years is unraveling, and people are being deprived of needed health care.

In this, the first of a two-part report, we look at why people lose their health coverage, and we rate the major-medical and hospital-surgical policies that are available to individuals—a temporary remedy for some people. Next month we will examine some possible cures for the health-insurance crisis.

WHO LOSES IT? WHAT HAPPENS?

People without health insurance include men and women who work for small businesses, the self-employed, part-time workers, young people just starting their careers, the disabled, the divorced, and those taking early retirement but still too young for Medicare. Some of the uninsured are also poor. Medicaid, the Federal and state program that covers medical expenses for the indigent, currently pays the bills for only 38 percent of the nation's poor.

People without health insurance may not get medical care. One million families each year try to obtain care when they are sick, but cannot afford to pay for it. Even if they are not ill, people without insurance postpone preventive care until more costly treatment is necessary—or until it's too late.

Two-thirds of all people with hypertension fail to have their disease controlled, largely because they can't afford medications. Half of those with hypertension haven't seen a doctor within the past year. A Roper poll has found that the proportion of Americans going to doctors in any one month has fallen to a 15-year low.

Women are particularly at risk. Uninsured women are much less likely than insured women to have screening tests for breast and cervical cancer or for glaucoma. If they are pregnant, they often do without prenatal care. Some five million women between the ages of 15 and 44 are covered by private health-insurance policies that don't include maternity coverage.

THE FOLLOWING DOCUMENT HAS NOT BEEN FILMED BUT IS AVAILABLE IN THE ORIGINAL FILE.

PLEASE MICROFILM TOP PAGE ONLY

HEALTH INSURANCE
POOLING PROVISIONS IN STATES

	CALIFORNIA	COLORADO	CONNECTICUT	DELAWARE
Cite	§§ 12700 to 12739.4 (1990)	§§ 10-8-501 to 10-8-531 (1990)	§ 38-376 (1975/1982)	No action to date
Based on NAIC Model?	No	No	No	
Eligibility Requirements	Rejected by at least one private plan, resident of state	Rejected by at least one private plan, resident of state	Resident of state	
Maximum Benefits	None specified	$500,00	Not specified in statute	
Premium Cap	125% of standard risk individual rates	Initial rates 150% standard risk, subsequent rates shall cover expenses, but not exceed 175% standard risk	Not less than 125% nor more than 150% group rate	
Additional Financing	Cigarette and Tobacco Products Surtax Fund	Income Tax Surcharge $2/$4 where AGI > $15,000	Assessment of all insurers and self-insurers in state	
Cost Containment Provisions	Plan shall include cost containment incentives	None specified	None specified	
Preexisting Condition Limitation	No coverage for 6 mo. for conditions had within last 6 mo.	No coverage for 6 mo. for conditions manifested prior 12 mo. or treated last 6 mo.	None specified	
Benefit Package	Major medical coverage	Major medical coverage	No provision	
When Eligible for Medicare:	No longer eligible	Secondary to Medicare	No longer eligible	
Miscellaneous	Parts of Business, Transportation and Housing Agency			

SB 74

SENATE FINANCE COMMITTEE REPORT

DATE: 4/17/92 FURTHER:

DATE TURNED INTO OFFICE: 4-23-92

The Finance Committee considered SENATE BILL NO. 74

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

and recommends:

[ ] replace with _____ CS _____(FINANCE)

or [ ] adopt previous_____ CS SB 74 (HES)

[ ] attaches amendment(s)

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

[ ] adopts _____Letter of Intent

[ ] further referral to the _____

[ ] do pass

[ ] do not pass

[ ] no recommendation

[✓] individual recommendations

NEW FISCAL NOTES:	**Dept/Date**	**PREVIOUS FISCAL NOTES:**	**Dept/Date**
[ ] **zero** fiscal notes		[✓] **zero** fiscal notes DHES	4-7-92
[ ] fiscal notes		[✓] fiscal notes DCED 9.4	1-10-92

[ ] **appropriation**--no fiscal note

DO PASS:

OTHER RECOMMENDATIONS:

Duncan - NO REC

Rick Cha (NO REC)

1. _____ DO PASS
Co-Chair: Signature/Recommendation

2. _____
Co-Chair: Signature/Recommendation

FISCAL NOTE No. 4

Bill Version: SB 74

STATE OF ALASKA
1992 LEGISLATIVE SESSION

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

Revision Date: 4/7/92 Department Affected: Health & Social Services

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

Component: Medicaid Non-Facility

Sponsor: Kertulla

Requestor: Senate HESS **COMPONENT SERIAL NO.** 2 2 9

EXPENDITURES/REVENUES: (Thousands of Dollars)

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

FUNDING (Thousands of Dollars)

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

POSITIONS:

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

Estimate of current year impact:

ANALYSIS: (Attach a separate page if necessary.)

See attached note

Changes in CSSB74 (HES) have no fiscal impact. This fiscal note is appropriate.

4/17/92 date — Comte Aide (initial)

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

Division: Medical Assistance Date: April 7, 1992

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

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

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

FISCAL NOTE ATTACHMENT 4/7/92

SB 74

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

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

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

FISCAL NOTE

No. 3

STATE OF ALASKA
1992 LEGISLATIVE SESSION

Bill Version: SB 74

(S) Publish Date: 4-17-92

Revision Date: 12/27/91 1.2.92

Department Affected: Commerce & Econ. Dev.

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

BRU: Insurance

Component: Operations

Sponsor: Senator Kerttula

Requestor: Senator Kerttula

COMPONENT SERIAL NO. 0354

EXPENDITURES/REVENUES: (Thousands of Dollars)

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

FUNDING: (Thousands of Dollars)

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

POSITIONS:

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

Estimate of current year impact:

ANALYSIS (Attach a separate page if necessary.)

SEE ATTACHED

Changes in CSSB74 (FIN) have no fiscal impact. This fiscal note is appropriate.

1/3/1992 date — Comte Aide (initial)

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

Division: Insurance — Date: 1/2/92

Approved by Commissioner: Glenn A. Olds for — Date: 1.10.92

Agency: Department of Commerce & Economic Development

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

DK/dg19052D-1/122691a

(Rev. 12/91)

FISCAL NOTE - SB 74

ANALYSIS:

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

9052D

CS FOR SENATE BILL NO. 74 (HES)

IN THE LEGISLATURE OF THE STATE OF ALASKA

SEVENTEENTH LEGISLATURE - SECOND SESSION

BY THE SENATE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

Offered: 4/17/92
Referred: Finance

Sponsor(s): SENATORS KERTTULA, Cotten, Menard

A BILL

FOR AN ACT ENTITLED

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

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

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

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

CHAPTER 55. STATE HEALTH INSURANCE.

ARTICLE 1. COMPREHENSIVE HEALTH INSURANCE ASSOCIATION.

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

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

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

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

Sec. 21.55.030. GENERAL POWERS. The association may

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

(2) sue or be sued;

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

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

(5) receive funds from sources other than members of the association.

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

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

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

(c) The plan of operation shall

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

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

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

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

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

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

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

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

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

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

ARTICLE 2. STATE HEALTH INSURANCE PLANS.

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

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

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

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

Sec. 21.55.110. MINIMUM BENEFITS OF STATE HEALTH INSURANCE PLAN. Except as provided in AS 21.55.120 - 21.55.140, the minimum standard benefits of a health insurance plan offered under AS 21.55.100(a) shall be benefits with a lifetime maximum of $1,000,000 per individual for usual, customary, reasonable, or prevailing charges or, when applicable, the allowance agreed upon between a provider and the writing carrier for charges, for the following medical services performed for an individual covered by the plan for the diagnosis or treatment of nonoccupational disease or nonoccupational injury:

(1) hospital services;

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

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

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

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

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

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

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

(8) use of radium or other radioactive materials;

(9) outpatient chemotherapy;

(10) oxygen;

(11) anesthetics;

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

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

(14) diagnostic x-rays and laboratory tests;

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

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

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

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

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

(20) second surgical opinions;

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

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

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

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

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

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

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

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

of three months immediately before the effective date of coverage.

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

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

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

(1) care for an injury or disease either

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

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

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

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

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

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

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

section;

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

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

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

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

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

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

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

(14) experimental procedures; and

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

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

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

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

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

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

(c) The five members of the association that insure, or have subscriber contracts with, the largest number of individuals in the state under plans with benefits substantially equivalent to the state plan benefits shall submit to the association an estimate of the rate that would be actuarially sound for a person who is a standard risk for coverage substantially equivalent to the

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

ARTICLE 3. ADMINISTRATION OF PLANS.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ARTICLE 4. ENROLLMENT IN THE STATE HEALTH INSURANCE PLAN.

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

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

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

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

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

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

(3) information relevant to whether the person is a high risk.

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

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

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

previous contract or policy terminated if the person

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

(2) is accepted by the writing carrier; and

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

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

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

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

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

ARTICLE 5. GENERAL PROVISIONS.

Sec. 21.55.400. DUTIES OF DIRECTOR. The director may

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

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

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

(4) adopt regulations necessary to administer this chapter.

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

claim under a state plan issued by a writing carrier.

Sec. 21.55.500. DEFINITIONS. In this chapter

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Alaska State Legislature

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

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

Senate Finance Committee

State Capitol
Juneau, AK 99801-1182
(907) 465-1200
(907) 463-3066 Fax

Box 1009
Palmer, AK 99645
(907) 376-2675
(907) 376-0315 Fax

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3) LETTER OF SUPPORT FROM DR. E. MELOCHE

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Available upon request.

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Sponsor Statement

Senate Bill 74

High Risk Health Insurance

Senate Bill 74 creates high risk insurance for those who are denied health insurance by the private market. It works very much like high risk automobile insurance. It is time that Alaska join the other 26 states that have enacted this high risk health insurance legislation.

The Health Resources and Access Task Force recommended that the State Legislature pass a bill to establish a high risk health insurance pool in Alaska. This was recommended as an important mechanism to increase access to medical care in the State. It is a very important piece of the puzzle that will significantly improve access for all Alaskans, especially those who can pay for insurance but are denied coverage. This legislation complements the other legislation recommended by the Task Force.

The beauty of this insurance is that it does not require State funding. It will be offered and managed by private enterprise.

The high risk insurance will be provided by an association of private health insurers who form a pool to provide high risk health insurance to Alaskans.

Alaskans, like others nationwide, are being dropped from insurance. Others have exclusion riders placed on their policies. All these people would qualify for this high risk pool.

More and more Alaskans are being refused insurance because of a medical condition such as an injured knee, diabetes, cancer, or a chronic ear infection. Those in occupations that are hazardous, more likely to make claims, or in occupations that have high turnover are also excluded. Fry cooks, iron workers, and the clergy are examples of those who are excluded by some insurers. They are on "no quote lists".

In your packets you will find news articles which describe this problem well.

Senate Bill 74 is based on the National Association of Insurance Commissioners Model Legislation.

The twenty six other States that have enacted high risk pools based

on the NAIC model include Washington, Oregon, California, New Mexico, Utah, Montana and Wyoming, as well as many mid-western, southern, and eastern states.

Premiums for the high risk health insurance will cost up to 150% more than the standard risk premium. As you can see from data on the last page of the report from Consulting Services Inc in your packet, these premiums should pay all or most of the cost of claims. Therefore, high risk individuals bear most of the increased cost of their own coverage. There is a mechanism to pay for any shortfalls if, at some point, claims exceed the premiums brought in. Any losses due to claims and administrative expenses in excess of premiums paid will be spread among the health insurers in proportion to their share of premiums written in the state.

This bill is supported by many in the insurance industry because it corrects many of the injustices created by the competitive practice of insuring only those of lower risk of health problems.

Enclosed in your packet you will find a letter from the Southern Alaska Life Underwriters Association Legislative Committee. It states that the association strongly supports SB 74 because it "provides a fiscally responsible mechanism to guarantee these Alaskans coverage." "These people fall through the cracks because they either make too much money or have too large a net worth to qualify for Medicaid".

The high risk pool will be offered and managed by private enterprise with oversight by the division of insurance as is done for other private insurers.

This bill will prevent individuals from having to bankrupt their family or small business in order to stay alive.

> Alaskans need to know that they can change jobs and still get health insurance that covers pre-existing conditions. They need the security that they can get and keep health insurance even though they or a family member may develop a serious health problem. It is time we remove Alaskans' fear of losing their health insurance coverage. This situation has gone on too long. Senate Bill 74 will guarantee that health insurance will be available for purchase to all Alaskans.

The suffering and delay of needed care has got to stop. Alaskans should not have to stay home, suffering, because they can't get health insurance.

DIVISION OF LEGAL SERVICES

LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

P.O. Box Y, Juneau, Alaska 99811
(907) 465-3867 or 465-2450
FAX (907) 465-2029

Deliveries to: 240 Main Street
Court Plaza, Room 500
Mail Stop 3101

MEMORANDUM January 24, 1991

SUBJECT: Pooled Health insurance - SB 74

TO: Senator Jay Kerttula

FROM: Michael F. Ford
Legislative Counsel

The following is a sectional analysis of SB 74:

Section 1 - Purpose.

Section 2

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

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

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

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

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

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

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

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

Section 4 - Effective date.

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Insurers Weeding Out the Sick

Even in large group plans, those with problems can lose coverage

By Gina Kolata
New York Times

New York

In a new practice, some health insurance companies are starting to divide the sick from the well, even in large groups that were once a bastion of security in a tumultuous industry.

Families in large groups had always felt that if they had been part of the group for at least six months or a year, their medical costs would be covered and their premiums would remain stable. But now, some insurance companies are drastically raising rates for sick people, and even for people they think may become sick.

The result, said Dr. Norman Daniels, an ethicist at Tufts University who is an expert on health insurance, is that "no one in this country with private health insurance coverage who is in any kind of group plan is free from the kind of uncertainty that competition is producing."

One Family's Story

No one knows how common it is for insurance companies to raise the rates for the sick in large groups, which usually consist of employees at big corporations or members of special-interest organizations. But the experience of Kathleen Renshaw of Leucadia, Calif., and others shows that the problem, once thought to be limited to small groups, is spreading to large groups as well.

Renshaw finally admitted defeat in her struggle to keep group health insurance for her family when the annual premium reached $16,000 a year. Her problem is her 8-year-old daughter, Marisa, an exuberant child who swims on a team and takes singing lessons.

But Marisa has only one kidney, and it does not fully function. She needs regular checkups and may face kidney failure in the future. When the family's insurance company learned of the problem, which doctors discovered when Marisa was 3, it began doubling the family's health insurance premiums each year, the maximum increase allowed by California law.

Finally, the family could no longer pay, and no other company would insure them. Along with Marisa, Renshaw, her husband, William Harvey, and their 4-year-old daughter, Kirsten, who has no medical problems, were out in the cold.

Renshaw and Harvey never thought they would be without health insurance. They both have jobs, they bought group health insurance through the alumni association at the University of California at San Diego, and they always paid their premiums.

"I thought that when you pay insurance, the insurance companies will pay for you when you get sick," Renshaw said.

'Spiral of Exclusion'

Donald Light, a sociologist who is professor of health policy at the University of Medicine and Dentistry of New Jersey, said the family's experience is "a tragic example of the spiral of exclusion that is spreading through the entire health care industry."

Light said the practice of raising rates for people who are sick or have pre-existing conditions began in small groups, like self-insured small businesses, in the mid- to late 1980s. Although it is still most common in small groups, he said, it is spreading to larger and larger groups. The group Renshaw and Harvey joined has thousands of families.

Donald B. White, a spokesman for the Health Insurance Association of America, which represents commercial insurance companies, said that what happened to Renshaw's family is unacceptable. He said it is because of cases like hers that "we and everyone else are proposing reforms that would change the laws so that could not happen again."

White said most problems are with small groups, so the insurance association has proposed legislation to change that market. It wants federal laws to guarantee that high-risk people in small groups can buy insurance at a cost that is no more than 50 percent more than the average premium.

Legislation

Senator Lloyd Bentsen, D-Texas, has introduced a bill in Congress that would prevent the exclusion of sicker people from health insurance coverage sold to small businesses and would prevent small groups from canceling policies of sicker people.

But these remedies do not address the situation Renshaw and Harvey faced because they were not insured with a small group.

Through a catastrophic health insurance plan of the California Children Services, Marisa is now covered for major problems with her kidney, but nothing else.

And Renshaw said this coverage is available only if a family of four has an income of $40,000 or less. But if Renshaw, now a substitute teacher, gets a full-time teaching job, which she has been seeking, the family would be disqualified. In that case, she said, "our next option is a divorce."

STAYING AHEAD *Jane Bryant Quinn*

Having Health Insurance Is No Guarantee of Coverage

Americans who have health insurance may complacently ignore the terrors of the people without.

But there's a mounting risk your health insurer will fail, leaving you with unpayable bills. The toll is cutting across every kind of medical-payment group.

■ According to Standard & Poor's, 121 life and health insurance companies went broke in the past three years.

■ Blue Cross and Blue Shield of Charleston, W.Va., collapsed in 1990, leaving some $41 million in unpaid bills.

■ At least 131 Health Maintenance Organizations failed between 1986 and 1990, says Jon Christianson, a professor in the School of Public Health, University of Minnesota.

■ Unknown numbers of multiple employer welfare arrangements have gone broke, often through fraud. MEWAs sign up small companies that can't afford coverage from the major insurers. Some MEWAs are legitimate, but others collect premiums and then skip.

So serious is the carnage that, in some states, doctors and hospitals require their patients to agree, in writing, to pay any bill that their insurer defaults on.

When looking for a sound insurance company, all you can go by is its safety rating. You want an A+ from A.M. Best and AAA from at least one of the other major rating firms — Moody's, Standard & Poor's or Duff and Phelps. S&P also passes out "q" ratings for insurers it hasn't examined in full — the highest being BBBq. Such a company might be an AAA had S&P examined its books.

No rating system covers HMOs. A.M. Best doesn't rate the Blues, either, although a few are rated by S&P. To get the current financial statement of any Blue plan, call its public information department or your state's insurance commission. Look to see if it's making or losing money.

With MEWAs, the sign of a high-risk plan is lower monthly premiums than the competition offers. Employers shouldn't buy into a MEWA without asking their state insurance commission if the plan is licensed for sale there and whether there have been any complaints. Avoid new MEWAs.

The sign of a high-risk plan is lower monthly premiums than the competition offers

If your insurer fails, leaving you with unpaid bills, you might be caught by one of the following safety nets:

■ "Hold-harmless" clauses. These stop doctors and hospitals from dunning individuals for bills that should have been paid by their medical-service plans. All federally qualified HMOs have them, as do HMOs in 33 states. Some states also require them of the Blues and of regular insurance plans. Some doctors ignore hold-harmless clauses and bill their patients anyway (ask your state insurance department if you have to pay). If you sign an agreement to pay when you enter a hospital you might, in some states, lose the protection of a hold-harmless clause.

■ State guaranty funds. All the states — the only exception being the District of Columbia — now provide guaranty funds for individual policies. They cover up to $100,000 of medical expenses (more in some states) for insurers licensed to sell in the state. Most group-health plans aren't included, however, nor are MEWAs. Eighteen funds now cover the Blues; seven cover HMOs.

In general, the funds guarantee (up to the dollar limits of state law) all your back bills, all your current bills, and all future bills until you find another insurer or your policy comes up for renewal, which may be anytime from tomorrow to 12 months. Starting from the time your insurer failed, you have to pay premiums to the guaranty fund, perhaps at a higher rate than you paid before.

■ Insurance-agent liability. If your agent sold you a policy from a company not licensed in your state, the agent may be liable for any bills the company defaults on. Pennsylvania, which is vigorously pursuing MEWA cases, has collected more than $70,000 from agents on behalf of consumers, says Linda Wells, chief counsel for the state insurance department. Some states hold agents liable if they knew or should have known that the company was insolvent, says Washington, D.C., attorney Gregory Luce.

If you work for a big company whose insurer fails, the chances are good that your employer will cover your bills. Smaller companies, however, may not be able to afford it. Sometimes doctors and hospitals don't bill patients whose insurers collapse, but that's not a sure thing, either. You have to get lucky, which is no way to run a health-insurance system.

Health Benefits Letter #18

...covering state, federal and private-sector developments in health benefits reform

Blues Release New Health Insurance Reform Proposal

In testimony before the House Ways and Means Committee, Bernard Tresnowski, President of the Blue Cross Blue Shield Association, presented a new health reform proposal that, he said, had been unanimously approved by his board of directors just days before. He said,"we must create a new insurance environment — patterned on the Blue Cross and Blue Shield organization's historic practices."

The proposal would eliminate most existing health insurance companies by allowing tax deductions only for benefits purchased from "qualified carriers." To become qualified, an insurer would have to meet federally imposed standards that would include the use of participating provider arrangements and managed care techniques. "Under our approach, we would stop rewarding insurance companies that are principally claims processors and medical underwriters," Mr. Tresnowski told the committee.

He said qualified carriers, "must demonstrate proven records of managing health care costs effectively, including a capacity to perform utilization management, selective provider contracting and uniform billing and data collection."

Mr. Tresnowski said this emphasis on managed care, combined with with reform of the medical malpractice system would control health care costs better than regulatory approaches could.

For assuring universal coverage, Mr. Tresnowski proposed requiring small employers to offer, but not pay for, employee coverage. Those who do not fund coverage "would be subject to an assessment which would be significantly less than the cost of contributing to coverage."

Employees would be required to "accept" the coverage, and be required to pay for it unless their employer could be persuaded to pick up the tab.

Mr. Tresnowski does not directly discuss the cost impact on individual employees, except to say "substantial tax subsidies" would be made available to low income employees, and "most employees" would have most of their premium paid by their

(Please turn to page 2)

Twenty-five States Now Have Enacted High Risk Pools

Twenty-five states have enacted insurance pools for their high risk populations. According to information compiled by Communicating for Agriculture (CA) these pools (also known as "Comprehensive Health Insurance Plans" or CHIPs) enroll 76,973 people (see charts on pages 4 and 5).

The pools are intended to provide subsidized coverage to individuals with existing medical conditions who are unable to obtain insurance in the private market. They typically provide major medical benefits with substantial deductibles and copayments. They also charge from 125% to 400% of the standard premium for similar benefits within the state. At these rates the pools are clearly not intended to help people of limited means, but are aimed at those with financial resources who are otherwise uninsurable.

While the pools do not cover large numbers of people, they have an effect well in excess of raw enrollment figures because of the high use of services by those who are enrolled. According to the most recent available numbers, the seventeen state pools which have been active long enough to pay claims, pay over $185 million per year for 67,972 enrollees - an average payment of $2,726.30. For this coverage enrollees pay premiums averaging $1,583.24 per person per year. The difference is made up for by any one of several subsidy approaches.

NAIC Model Revisions

How to subsidize the pools for losses in excess of premium income has been the biggest issue of contention for those states that have not yet adopted a pool. The National Association of Insurance Commissioners

(Please turn to page 4)

High Risk Pools in 25 States

(Continued from page 1)

(NAIC) has had a working group of regulators, chaired by South Dakota's Director of Insurance Mary Jane Cleary, looking into this and several other issues for the past two years. This working group is about to release a revised model act for public comment with the hope that it will be adopted at the December NAIC meeting in Houston.

Other issues considered by the NAIC group were benefit structure, pool administration, and whether group plans should be allowed to refer high-risk employees to the pool. Discussion of each of these issues follows.

Financing

States have adopted a wide range of financing mechanisms for their high-risk pools. Nearly all of the early ones were viewed as industry-based residual market mechanisms that were organized, operated and financed by the health insurance industry. The industry was assessed for any excess losses but could take the assessments as a credit against their premium tax obligation.

More recently pools have been seen as public programs, usually with broad-based boards of directors and broad-based funding. Several are now financed through general revenues, others use dedicated taxes on tobacco or hospital services. The new NAIC model act references all the available financing mechanisms without recommending reliance on any one of them. Director Cleary says the model lays out the following funding sources:

- Premiums from enrollees
- Health insurer assessments with full or partial tax offsets
- Per capita assessments on insurers and reinsurers

High Risk Pools - Financial Experience

	Enrollment	Premiums Collected	Per Person Premium	Claims Paid	Per Person Claims
CA	8,901	n/a	n/a	n/a	n/a
CO	n/a	n/a	n/a	n/a	n/a
CT	2,200	$ 4,495,872	$ 2,043.58	$ 10,438,000	$ 4,744.55
FL	5,934	$ 12,443,960	$ 2,097.06	$ 17,425,025	$ 2,936.47
GA	n/a	n/a	n/a	n/a	n/a
IL	4,370	$ 11,951,968	$ 2,735.00	$ 24,138,119	$ 5,523.60
IN	3,080	$ 8,376,736	$ 2,719.72	$ 16,978,462	$ 5,512.49
IA	1,971	$ 4,574,013	$ 2,320.66	$ 5,053,843	$ 2,564.10
LA	n/a	n/a	n/a	n/a	n/a
ME	400	$ 515,525	$ 1,288.81	$ 1,154,193	$ 2,885.48
MN	25,272	$ 25,734,981	$ 1,018.32	$ 49,469,692	$ 1,957.49
MS	n/a	n/a	n/a	n/a	n/a
MO	n/a	n/a	n/a	n/a	n/a
MT	304	$ 629,463	$ 2,070.60	$ 569,834	$ 1,874.45
NE	2,904	$ 4,422,717	$ 1,522.97	$ 6,760,239	$ 2,327.91
ND	1,303	$ 2,571,307	$ 1,973.37	$ 4,312,535	$ 3,309.70
NM	1,656	$ 2,854,825	$ 1,723.93	$ 4,205,865	$ 2,539.77
OR	1,211	$ 1,332,469	$ 1,100.30	$ 1,132,952	$ 935.55
SC	1,072	$ 1,636,144	$ 1,526.25	$ 1,794,927	$ 1,674.37
TN	4,121	$ 10,775,374	$ 2,614.75	$17,121,200	$ 4,154.62
TX	n/a	n/a	n/a	n/a	n/a
UT	n/a	n/a	n/a	n/a	n/a
WA	2,793	$ 4,718,231	$ 1,689.31	$ 7,186,956	$ 2,573.20
WI	9,287	$ 10,561,456	$ 1,137.23	$ 17,569,449	$ 1,891.83
WY	94	$ 20,690	$ 220.11	$ 548	$ 5.83
	76,873	$107,615,731	$ 1,583.24	$185,311,839	$ 2,726.30

NOTES: All figures are year end 1990 except, CT and FI (1989), OR (6/90), and WY (4/91). Per capita averages exclude California enrollment. Source, Communicating for Agriculture

High Risk Pools - General Information

	Effective Date	Pre-X Waiting Period	Premium Cap	Funding Source	Tax Offset	Plan Administrator
CA	1991	90 Days	125%	Tobacco Tax	n/a	BCBS
CO	1991	6 Months	175%	Income Tax Surcharge	n/a	BCBS
CT	1976	12 Months	150%	Insurer Assessment	No	Travelers
FL	1983	12 Months	300%	Insurer Assessment	No	BCBS
GA	note 1	6 Months	150%	General Revenue	n/a	n/a
IL	1989	6 Months	135%	General Revenue	n/a	Mutual of Omaha
IN	1982	6 Months	150%	Insurer Assessment	Yes	ASGC, Inc.
IA	1987	6 Months	150%	Insurer Assessment	Partial	Mutual of Omaha
LA	1992	6 Months	200%	Lottery & Hospital Tax	n/a	n/a
ME	1988	90 Days	150%	Hospital Tax	n/a	Mutual of Omaha
MN	1976	6 Months	125%	Insurer Assessment	No	BCBS
MS	1992	12 Months	175%	note 2	No	n/a
MO	1991	12 Months	200%	Insurer Assessment	Yes	BCBS
MT	1987	12 Months	400%	Insurer Assessment	Yes	BCBS
NE	1986	6 Months	165%	Insurer Assessment	Yes	BCBS
NM	1988	6 Months	150%	Insurer Assessment	Partial	BCBS
ND	1981	6 Months	135%	Insurer Assessment	Yes	BCBS
OR	1990	6 Months	150%	note 2	No	BCBS
SC	1990	6 Months	300%	Insurer Assessment	Yes	BCBS
TN	1987	6 Months	150%	Gen'l Rev. & Insur. Assmt.	No	BCBS
TX	note 1	6 Months	200%	Insurer Assessment	Yes	BCBS
UT	1991	6 Months	200%	General Revenue	n/a	BCBS
WA	1988	6 Months	150%	Insurer Assessment	Yes	Mutual of Omaha
WI	1981	6 Months	150%	Insurer Assessment	No	Mutual of Omaha
WY	1991	6 Months	200%	Insurer Assessment	Partial	BCBS

NOTES: (1) Effective dates in GA and TX depend upon additional legislative action. (2) MS and OR both assess payers, including reinsurers and TPAs, on a per capita basis. Source, Communicating for Agriculture

High Risk Pools in 25 States

(Continued from previous page)

- Hospital fees on admissions or outpatient services when paid by a third party
- General revenues
- Dedicated revenues from alcohol and tobacco taxes, per-employee payroll taxes, income tax surcharges, and state lottery proceeds.

Each of these approaches is in effect somewhere. Which approach is most acceptable depends on the political and economic status of the particular state.

Administration

As public financing becomes more prevalent, so does public administration of the pool. The new model will suggest that board members be appointed by the insurance commissioner in those states where the commissioner is elected, or by the governor in states where the commissioner is appointed. In either case the board should have a majority of public members and should be chaired by the insurance commissioner.

The pool boards will continue to select an insurer or other entity to perform administrative services for the pool.

Benefits

Generally, covered benefits in the existing pools are very comprehensive. They are structured as major medical programs with high deductibles and copayments. Deductibles range from $200 to $2,000 for individuals and stop-loss levels may be as high as $5,000.

Most pools give enrollees a choice of coverage options and set premiums according to the level of coverage

(Please turn to page 6)

High Risk Pools in 25 States

(Continued from page 5)

chosen. Maximum lifetime benefits may be as low as $250,000 or as high as $1 million.

The NAIC working group had two concerns about benefits. One was whether to include benefits that are mandated for inclusion in private insurance contracts, and the other concern was on how to encourage the use of managed care and other cost containment programs. The revised model continues to reference a major medical approach to benefits but suggests that the final decisions on benefit structure and cost controls should be left to the board.

Enrollment

Several states have had problems with employer groups "dumping" their high-risk employees into the pool as a way of lowering the cost of coverage for the rest of the group, or of making the whole group insurable when it otherwise would not be.

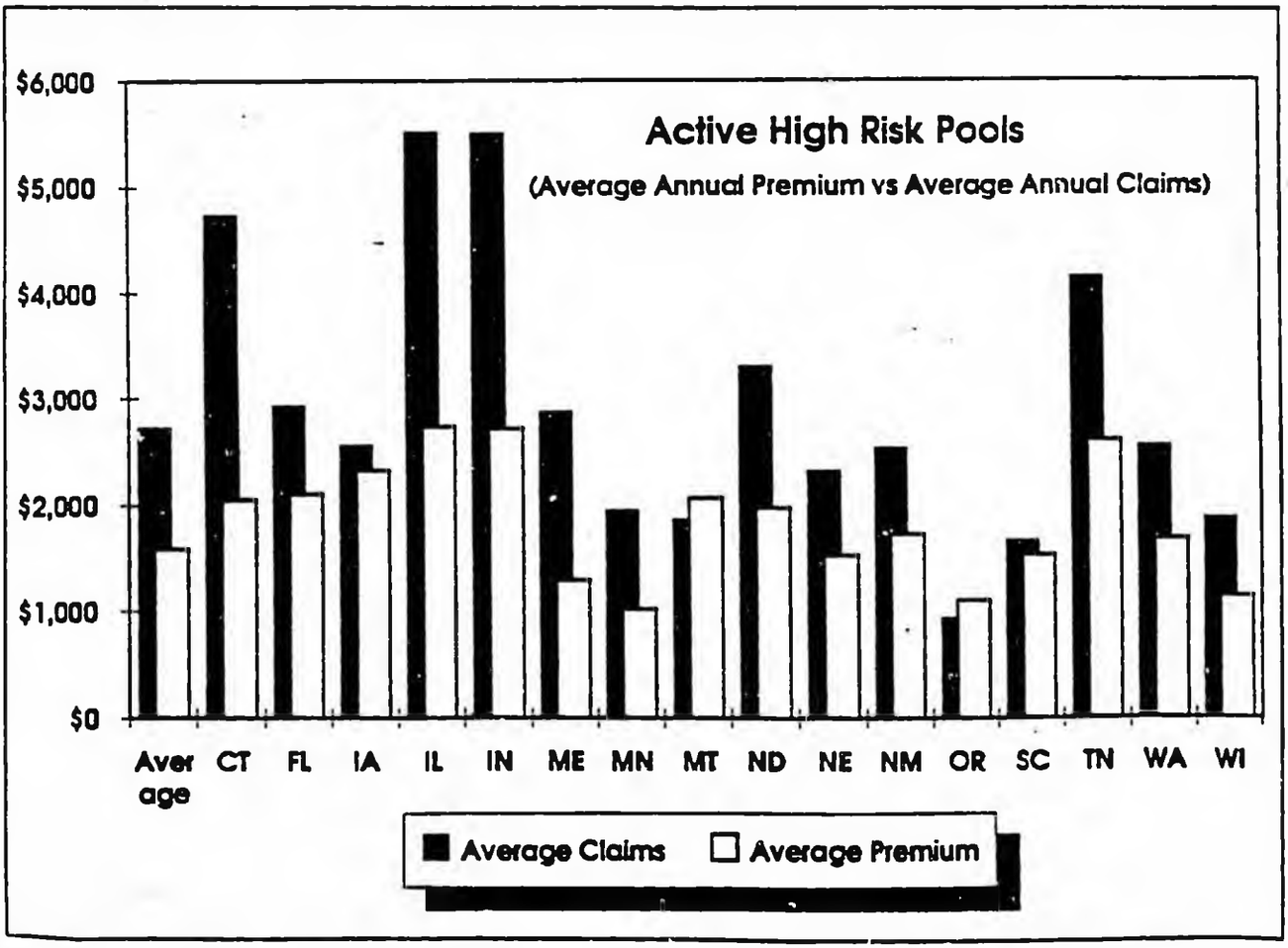
Some people maintain that this use of a pool is a legitimate strategy for simultaneously covering people with medical conditions, and making small group coverage more affordable for standard-risk employer groups.

Most states enacted pools only for individuals, and did not anticipate this use by employers. The administrators in several of these states are alarmed that pool enrollment (and pool losses) has exceeded projections because of this use by employers.

Director Cleary said the new model will include language taken from the California legislation which prohibits dumping. The language calls it an unfair trade practice for insurers, employers or agents to refer someone to the pool for the purpose of separating them from employment-based coverage.

The adoption of the new NAIC model in December is likely to renew efforts to enact pools in those states that have come close to adopting them in the past. Notable among these states are Ohio, North Carolina, Oklahoma, New Hampshire and Arizona. Director Cleary said that in her own state of South Dakota a pool bill is likely to pass next year, but it will need to have funding other than straight general revenues or the governor will veto it.

The report from Communicating for Agriculture is available for $24 by calling 612-854-9005



Consulting Services, Inc.

C. Keith Powell, ASA, MAAA
Consulting Actuary

10-2
10-29

September 28, 1990

Office of the Director
Department of Insurance
Juneau, Alaska 99811

Dear Sir:

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

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

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

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

Sincerely yours,

C. Keith Powell

C. Keith Powell, ASA, MAAA
Consulting Actuary

22

9245 North Meridian Street, Suite 206, Indianapolis, Indiana 46260 317-575-3384

STATE POOLS FOR THE UNINSURABLE.

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

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

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

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

Now, to the results of the survey.

(1) Eligibility Requirements.

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

(2) Financial Results.

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

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

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

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

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

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

The high loss ratio of 172% for 1989 comes from right here in Indiana. This resulted from some very special circumstances. The Indiana plan tried to get approval for an incredibly large rate increase to be effective 7/1/89. The DOI challenged the rate increase all over the place, and it was finally approved under the Indiana deemer provision effective 12/1/89. The effect of this delay contributed to the high loss ratio in Indiana for 1989. Just as a footnote to this story, as some of the Indiana participants might know, the incredibly high set of rates was rescinded in 1990 and the state plan agreed to make partial refunds of the excessive portion of the premiums.

Again, the purpose of this detail is to present an argument that most of the plans tend to have cash loss ratios in the range of 125% to 150%. As you might expect, the results by state are all over the place due to such factors are rate of growth, the pre-existing condition exclusion provisions, and the plan position in its rating cycle.

On additional thought bridging design and pricing is that there is surprisingly little exclusive provider design in these plans. This could be the one angle that could really contribute to bringing

down the loss ratios somewhat. It should be possible to get some excellent discounts from hospital and physician providers by promising them these very high using populations.

(3) Funding Mechanism.

Premiums are most often set at 125% to 150% of the some version of an average price for underwritten products in the state. This price reason pops up for many reasons.

At the low end of the 125% to 150% range, it is probably a friendly gesture to the insurance industry to try to keep the price above 125% of the average hot selling underwritten rate. By keeping the rate 25% over the average selling rate for underwritten products, it is safe to assume that there will be little or no loss of private sector underwritten business to the pools. Notice that but for this point of wanting to protect the private sector you could logically justify holding the pool rate below 125% of the average selling rate for an underwritten product. Recall that the underwritten rates generally target 50% to 70% loss ratios, so a pool rate based on 125% of the average underwritten selling rate means that the pool is allocating twice as high a percent of premium to benefit costs as the private sector product does.

If you go much higher than this range of 125% to 150% of the average underwritten selling rate a look at claims distributions and almost any reasonable guesses about antiselection show that the product will be priced well above "reasonable" for a very large portion of the people needing the product. This would discourage purchase of pool products by not only a large number of the people who need it but also by the very people who do not tend to contribute large losses to the pool.

The linkage between this 125% to 150% and the emerging loss ratios of 125% to 150% mentioned earlier is very tenuous. There actually might be a little bit of a linkage, but it is pretty far out there and it is probably best to think of them as unrelated concepts.

Remaining costs (in addition to premiums) are usually paid by either (i) the insurance industry in the state or (ii) local health care providers, and there is often some kind of tax offset that ultimately brings it to roost on general revenues.

(4) National Health Insurance Implications.

In 1989, 13 states (representing roughly 20% of the U. S. population) paid $112,000,000 in health benefit costs to providers, $9,000,000 for administration mainly to the insurance industry, for a total cost of $121,000,000. This was offset by $68,000,000 in premiums collected, for a net cost of $53,000,000. With all kinds

of caveats, extrapolating that to the entire U. S. would have cost less than $300,000,000. These numbers relate to programs that are almost exclusively freedom of choice arrangements that have made very little effort to get the savings from exclusive provider arrangements; and proper use of exclusive provider arrangements could introduce an element of savings. Again, with still more caveats, it had no direct impact on the federal deficit.

Note how nicely these pools dovetail with existing public and private health insurance programs.

Medicare and Medicaid are the major social insurance programs in this country. Medicare people generally do not need the pool benefits because the Medicare program itself is so comprehensive. Medicaid people generally already have some kind of half way decent benefits. They are not as generous as those in the state pools, but then Medicaid people generally pay nothing for their benefits.

I am going to try to summarize the value of this concept of national health insurance to the insurance industry, at the risk of getting up on the soap box.

Over the last half century the private health insurance industry has proved itself totally incapable of providing significant medical expense benefits on an individual basis to people with serious health problems, in spite of the fact that these people beg for our products and are willing to pay almost anything asked for the benefits. At least for freedom of choice insurers there is no reason to believe that this is changing, and in fact the problem seems to be worsening each year health care costs grow faster than other costs. While this is a very serious indictment of our industry, it does point out that the people that we are losing to these pools are the very people that we could not handle anyway. In fact, the payments that the health insurance industry receives to administer the benefits for these people probably exceeds aggregate premiums that the industry could collect from them for meaningful medical expense benefits; and absent state legislation making the cost fall directly on insurers, it comes without underwriting losses or significant financial risks.

These pools leave with the health industry the very people that the health insurance most wants and takes the people that they do not want.

With caveats, I would like to suggest that this may be the feasible approach to national health that is kindest to the health insurance industry.

State	Prems. Col.	Claims Paid	Admin. Paid	Loss Ratio	Admin (% Claims)
Connecticut					
1983	3134889	3442223	272550	109.80%	7.92%
1984	3473145	4454451	315450	128.25%	7.08%
1985	3285762	4579461	276379	139.37%	6.04%
1986	3532941	4203833	246156	118.99%	5.86%
1987	3186476	6663081	337235	209.11%	5.06%
1988	3460337	7293434	412942	210.77%	5.66%
1989	4495872	10438000	567826	232.17%	5.44%
Comment - These results may not be typical due to the presence of a Blue Cross plan in the process of being phased out.					
Florida					
1983	23759	0	0	0.00%	ERR
1984	505798	141430	69114	27.96%	48.87%
1985	1107581	774174	103946	69.90%	13.43%
1986	1770171	1686195	184889	95.26%	10.96%
1987	2858173	3963710	357017	138.68%	9.01%
1988	5294446	8581468	1134991	162.08%	13.23%
1989	12443960	17425025	2810723	140.03%	16.13%
Indiana					
1983	2352179	217878	56512	9.26%	25.94%
1984	6356995	6843691	256462	107.66%	3.75%
1985	7505144	9518759	253524	126.83%	2.66%
1986	7197774	11552494	443791	160.50%	3.84%
1987	6301707	11564602	459462	183.52%	3.97%
1988	5607908	9640519	500643	171.91%	5.19%
1989	6210701	10690610	670565	172.13%	6.27%
Comment -The Indiana loss ratios for the last few years are held artificially low due to the reluctance of the pool to raise rates.					
Iowa					
1987	164995	56725	16560	34.38%	29.19%
1988	1008691	1249159	82560	123.84%	6.61%
1989	2876251	3232227	339660	112.38%	10.51%
Comment -The Indiana loss ratios for the last few years are held artificially low due to the reluctance of the pool to raise rates.					

State	Prems. Col.	Claims Paid	Admin. Paid	Loss Ratio	Admin (% Claims)
Maine					
1988	15179	0	33960	0.00%	ERR
1989	228189	290179	81265	127.17%	28.01%
Minnesota					
1983	4082351	6981967	383741	171.03%	5.50%
1984	6413829	9761835	665100	152.20%	6.81%
1985	9492438	13324992	984514	140.37%	7.39%
1986	10772454	18913879	904886	175.58%	4.78%
1987	11407281	21893358	928773	191.92%	4.24%
1988	14197219	27098596	1340562	190.87%	4.95%
1989	18459482	38373578	2115892	207.88%	5.51%
Montana					
1987	9870	0	9759	0.00%	ERR
1988	97026	65374	14675	67.38%	22.45%
1989	316276	395050	24523	124.91%	6.21%
Nebraska					
1986	8414	0	11558	0.00%	ERR
1987	458857	443238	14600	96.60%	3.29%
1988	1221792	1808813	57097	148.05%	3.16%
1989	2572213	4088816	128223	158.96%	3.14%
New Mexico					
1988	233053	127399	103475	54.67%	81.22%
1989	1222400	1565229	157945	128.05%	10.09%
North Dakota					
1983	138666	345918	25305	249.46%	7.32%
1984	455874	1058694	35904	232.23%	3.39%
1985	894701	1704988	56756	190.57%	3.33%
1986	1321991	2863886	108756	216.63%	3.80%
1987	1626970	3389229	174130	208.32%	5.14%
1988	1937903	3340441	234984	172.37%	7.03%
1989	2261638	3691487	278007	163.22%	7.53%
Tennessee					
1987	556763	17450	0	3.13%	0.00%
1988	3236204	2807338	317930	86.75%	11.32%
1989	8433944	10212644	623744	121.09%	6.11%

State	Prems. Col.	Claims Paid	Admin. Paid	Loss Ratio	Admin (% Claims)
Washington	Earned	Incurred			
1988	124260	74121	78575	59.65%	106.01%
1989	1940334	2543839	204221	131.10%	8.03%
Wisconsin					
1983	1232352	2463703	156964	199.92%	6.37%
1984	2079996	3104604	196338	149.26%	6.32%
1985	2600586	3265492	210646	125.57%	6.45%
1986	2856286	3336087	284500	116.80%	8.53%
1987	2959861	3956056	366245	133.66%	9.26%
1988	4056671	5518189	906550	136.03%	16.43%
1989	6676614	9754103	885383	146.09%	9.08%
Comment - Participating insurers are not permitted any kind of credit against premium or income taxes.					
Total					
1983	10964196	13451689	895072	122.69%	6.65%
1984	19285637	25364705	1538368	131.52%	6.06%
1985	24886212	33167866	1885765	133.28%	5.69%
1986	27460031	42556374	2184536	154.98%	5.13%
1987	29530953	51947449	2663781	175.91%	5.13%
1988	40490689	67604851	5218944	166.96%	7.72%
1989	68137874	112700787	8887977	165.40%	7.89%
Total - Minus Connecticut and Minnesota					
1983	3746956	3027499	238781	80.80%	7.89%
1984	9398663	11148419	557818	118.62%	5.00%
1985	12108012	15263413	624872	126.06%	4.09%
1986	13154636	19438662	1033494	147.77%	5.32%
1987	14937196	23391010	1397773	156.60%	5.98%
1988	22833133	33212821	3465440	145.46%	10.43%
1989	45182520	63889209	6204259	141.40%	9.71%

What are high risk pools and how do they work?

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 21 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 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 subset of the larger group of uninsured individuals.

Basic Design

The basic design of a risk pool is to guarantee availability of adequate health insurance to all individuals, regardless of their physical condition. While 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 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 $2,000, resulting in substantially different premiums. Some form of pre-existing condition restriction has been deemed necessary, if only to prevent individuals from "gaming" the system by enrolling for insurance only after they need medical care. Most pools have a six month waiting period for pre-existing conditions. However, some states allow a waiver of this waiting period through payment of a premium surcharge.

Cost of Insurance

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

While these premiums are high, they would be even higher in the absence of state-imposed limits that cap premiums at no more than a fixed percentage (usually between 125% and 150%) of the standard individual premium in the state.

SYNOPSIS OF HEALTH INSURANCE POOL MODEL LEGISLATION

PREPARED BY COMMUNICATING FOR AGRICULTURE

The purpose of the model bill is to establish a mechanism through which adequate levels of health insurance coverages can be made available to residents of the state who are otherwise considered uninsurable. The bill would establish a state "association" or "pool" in which all health care financing mechanisms (insurers, HMOs and others if declared valid) would be members.

Pool coverage consists of very broad comprehensive benefits with a choice of deductibles. Each state is cautioned that the scope of coverage may not be appropriate. In such a case, the benefit levels should be adjusted. A state can also consider allowing the Board to develop the minimum benefits to be provided, rather than addressing these benefits within the statute.

By definition, a pool consisting of uninsurable risks will necessitate premium rates substantially greater than applicable for standard risks. The bill establishes an initial maximum rate of 150% of applicable standard risk rates. Thereafter, rates are expected to fluctuate according to experience; however, in no event shall rates exceed 200% of standard risk rates.

Admittedly, the initial maximum rate of 150% is inadequate for the risks insured, and the 200% maximum will prevent the rates from becoming prohibitive. Pool losses in excess of the premiums collected will be assessed to each member of the pool in proportion to the volume of business done in the state. This assessment is allowed as a future tax credit to offset the cost to the members. Other options exist for funding the pool. Those being used by existing pools can be found by section on funding mechanisms found elsewhere in this edition. However, at the end of the model bill is wording for one of the newer options.

Eligibility for pool coverage is limited to those individuals unable to locate coverage in the private market. For obvious cost containment provisions, pool coverage is the coverage of "last resort" and it does not duplicate coverage from any other source, private or public.

This model bill incorporates several new provisions from previous models, including, but not limited to, a reciprocity agreement among state pools, cost containment provisions, employer responsibilities, and additional definitions.

Following this model legislation is a second model bill, authored by the National Association of Insurance Commissioners in 1984.

POSITION PAPER

4/23/92
D. Walsh

SB 74: "An Act relating to pooled health insurance for individuals who are uninsured or denied adequate coverage; and providing for an effective date."

With resolution of the issues below, the administration can support this legislation.

One of the more challenging issues facing this country and Alaska is the ever-increasing number of people unable to afford or even find health care insurance. Persons deemed "high risk" find themselves, in too many cases, uninsurable.

This legislation attempts to provide "high risk" individuals health care coverage by establishing a health insurance pool run by private insurers for the benefit of uninsured, high-risk state residents.

Pooled health insurance for individuals should be administratively consolidated with the small employer health insurance program in SB 242. The associations basically would incorporate the same membership, seek to provide coverage for separate groups currently unable to secure coverage, and seek to provide a viable insurance mechanism by spreading risk to a large pool of insureds.

It would be inappropriate for a regulator to define eligibility for participation in the plan. The public policy of the state in determining whether a person is in a high risk category should be set in statute. Also codified should be the services that should be provided in terms of medically necessary treatments or diagnosis of illness or injury. The Division of Insurance, as a regulator, oversees the operation of the comprehensive health insurance association and its insurance plans.

Cost-containment measures, such as those contained in Senate Bill 242, should be incorporated in this legislation. In lieu of the proposed mandate of usual, customary, reasonable or prevailing charges, it would be preferable to promote the use of various case-management programs, preferred provider contracts, health maintenance organizations, or limited network of provider arrangements - all proven cost savers.

AS 21.55.150 and AS 21.55.220 should provide that this program shall not shift costs to other insured persons or to the state.

AS 21.55.220(b) should be deleted to avoid employers dumping high-risk individuals into the pool. SB 242 addresses the problem of high-risk individuals for small employers with its separate pooling mechanism.

Consideration should be given to whether persons eligible for COBRA should have the option to purchase COBRA benefits or participate in this pool. Currently, the premium for COBRA benefits is unaffordably high because of adverse selection. The health care benefits under COBRA are not necessarily the same as those that will be available under the pooled health insurance program.

The definition of "residents who are high risks" and Article 4 which addresses eligibility and enrollment in the plan should better define those eligible to participate in the plan and those ineligible. The plan should not provide coverage that would allow the federal government to shift costs to the pooled health insurance program for care the federal government should be responsible for such as Veteran's Administration benefits and native health care. Similarly, existence of this plan should not operate to transfer state and federal obligations such as Medicaid to the pooled health insurance plan. Consideration should be given to language that would preclude a person who can secure affordable coverage from access to the plan merely because the individual secures declinations from two insurers.

The Legislature should review the operation of the program in three years to evaluate the effectiveness of the program on the target market as well as its effect on the overall market for health insurance. A "sunset" or similar provision to assure the continued effectiveness of the program should be included.

The administration can support this legislation with resolution of the above issues.

_____
Nancy Bear Usera, Commissioner
Department of Administration

_____
Theodore A. Mala, Commissioner
Department of Health and Social Services

_____
Glenn A. Olds, Commissioner
Department of Commerce and Economic Development

Date: _____

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4-23-92
G. Evans

COMMENTS BY GORDON E. EVANS
ON BEHALF OF HEALTH INSURANCE ASSOCIATION OF AMERICA
at
Senate Finance Committee
Hearing on Senate Bill 74
April 23, 1992

Mr. Chairman, Members of the Committee:

My name is Gordon Evans and I represent the Health Insurance Association of America ("HIAA"), which is a national, voluntary trade association of 300 private health insurance companies which provide health insurance for over 95 million Americans. Blue Cross and Blue Shield are not HIAA members.

HIAA has long supported state uninsurable risk pools. These risk pools are included as one of the major components in our program of "Financing Health Care for All Americans". Uninsurable risk pools address accessible health coverage for those who are otherwise considered medically uninsurable. Incidentally, in your deliberations I would ask you to realize that only nine private insurance companies and Blue Cross write health insurance in Alaska at this time.

While HIAA does support the goals of SB 74, the bill, as it is presently drafted, does have some serious flaws which HIAA believes will result both in underfunding of the program and in allowing inappropriate accessibility to the program. We have prepared, and present for the committee's consideration, seven amendments addressing the private health insurance industry's concerns with SB 74 in its present state.

With your consent I would like to briefly address each of the amendments. We have added a short sponsor's statement at the bottom of each amendment, which supports or explains why HIAA believes the amendment is necessary and important.

CS FOR SENATE BILL NO. 74 (HES)

AMENDMENT NO. 1

Page 15, Line 10: Add new Section 3 as follows and renumber following sections accordingly.

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

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

SPONSOR'S STATEMENT: HIAA and its members companies are very willing to work with the Legislature in developing a workable, affordable, uninsurable risk pool that will be to the benefit of Alaska's medically uninsurable residents. Participation by health insurers in the uninsurable risk pool is required as a privilege of doing business in Alaska. However, the absence of a broad-based financing mechanism or a premium tax offset for the claims-incurred losses to pay the residual losses will result in a failed system, with severe financial implications to the insurers licensed in Alaska. Some type of public financing is necessary -- the medically uninsurable are a <u>societal</u> problem, not just an insurance industry problem. Of the 25 states which

(continued)

currently have state uninsurable risk pools, a number do have some form of dedicated funding mechanism, i.e., a hospital bed tax, a state income tax surcharge, a tax against hospital revenues, and a cigarette and tobacco tax. We recognize that the Alaska Constitution does not permit dedicated funding.

However, other states provide partial funding through general revenue appropriations combined with premiums and assessments against the insurers. Most of these place a cap on the amount of general revenue or assessments. More than half of the states provide for assessments against the insurers in proportion to their share of the total health insurance premiums received in the state during the year, with the assessments offset against premium or income taxes paid by the insurers.

Earlier testimony on SB 74 by Chris Ullmann of the Division of Insurance indicated that the trend in recent years has been for more and more businesses to self-insure; thus, the losses resulting from claims losses of uninsurable risk pools have become a "tax" on a smaller and smaller insured base, raising the costs to the remaining insureds.

CS FOR SENATE BILL NO. 74 (HES)

AMENDMENT NO. 2

Page 10, Lines 10-11: Delete all language and renumber subsequent subsections

SPONSOR'S STATEMENT; Section 21.55.220(b) allows an employer who has one or more eligible persons enrolled in a state plan to pay for the premiums of that person. HIAA is concerned that such a provision will allow employers to "dump" higher risk emplcyees into a state pool which is available only for individuals who are medically uninsured, i.e., those who have been declined health insurance. The purpose of the uninsurable risk pool is not to reduce the cost of an employer's overall premium for their employees -- by being able to eliminate a higher risk employee from the group -- but to provide access to health insurance for medically uninsurable individuals. HIAA recognizes that some small employers have been declined insurance because one or more employees have proven to be uninsurable. However, that problem will be precluded from occurring by SB 242, which is presently in this committee, and <u>all</u> employees of a small employer will be covered. Those provisions in SB 242 negate the need to find high-risk employees an alternative to their group plan. Employers should not be encouraged nor given the opportunity to "dump" higher risk employees into a state uninsurable risk pool.

CS FOR SENATE BILL NO. 74 (HES)

AMENDMENT NO. 3

Page 11, Lines 12-15: Delete all language and insert the following language:

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

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

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

(A) 12 months have elapsed since termination; or

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

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

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

SPONSOR'S STATEMENT: It is imperative to list not only those who are eligible for coverage, but those who are specifically <u>not</u> eligible for coverage. These would include a person who at the time of application is eligible for medical assistance; a person who terminated coverage under the chapter in the previous 12 months; a person on whose behalf the pool has paid out the maximum lifetime benefits; or persons who are either inmates of public institutions or whose benefits are duplicated under public programs.

CS FOR SENATE BILL NO. 74 (HES)

AMENDMENT NO. 4

Page 4, Lines 3-6: Delete all language and renumber subsequent subsections.

SPONSOR'S STATEMENT: Section 21.55.100(b) of SB 74 (on page 4) includes Medicare-eligible persons within the uninsurable risk pool, allowing the pool to act as a Medicare supplement plan. HIAA opposes this inclusion, as the purpose of the uninsurable risk pool is to provide coverage for those <u>without</u> any insurance. People covered under Medicare have coverage, and they are also eligible to purchase Medicare supplement insurance! Medicare supplement policies are available in Alaska. Congress provided in the Omnibus Budget Reconcilation Act of 1990, better known as OBRA, that Medicare supplementary policies must meet specific standards set by the National Association of Insurance Commissioners (NAIC). NAIC has developed those 10 variations, and the Alaska Division of Insurance has proposed regulations which comply with those congressionally-required standards. Therefore, we do not see the need for inclusion of Medicare supplement coverage within the uninsurable risk pool and urge this committee to remove that provision.

CS FOR SENATE BILL NO. 74 (HES)

AMENDMENT NO. 5

Page 11, Lines 27-28: Delete "(b) of this section and"

Page 11, Line 31, and Page 12, Lines 1-5: Delete all language

SPONSOR'S STATEMENT: The purpose of insurance is to provide coverage for some unexpected, future event. Allowing applicants to pay retroactively for coverage back to when their previous contract was terminated is a violation of the principle of insurance. Coverage should be based on a prospective, not a retrospective basis. Therefore, we strongly urge that Section 21.55.330(b) be deleted.