ALASKA LEGISLATURE COMMITTEE FILES 1991-1992 8672
7390 SENATE HEALTH EDUCATION & SOCIAL SERVICES

7-LS0409\D.2
Ford
05/02/92

AMENDMENT #1

OFFERED IN THE SENATE BY SENATORS HALFORD, COLLINS, AND KERTTULA

TO: CSSB 74 (HES)

Page 9, line 1:

Delete "150"

Insert "200"

Page 15, after line 9:

Insert a new bill section to read:

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 AS 21.55 is repealed."

Failed

Renumber the following bill sections accordingly.

Page 15, after line 11:

Insert a new bill section to read:

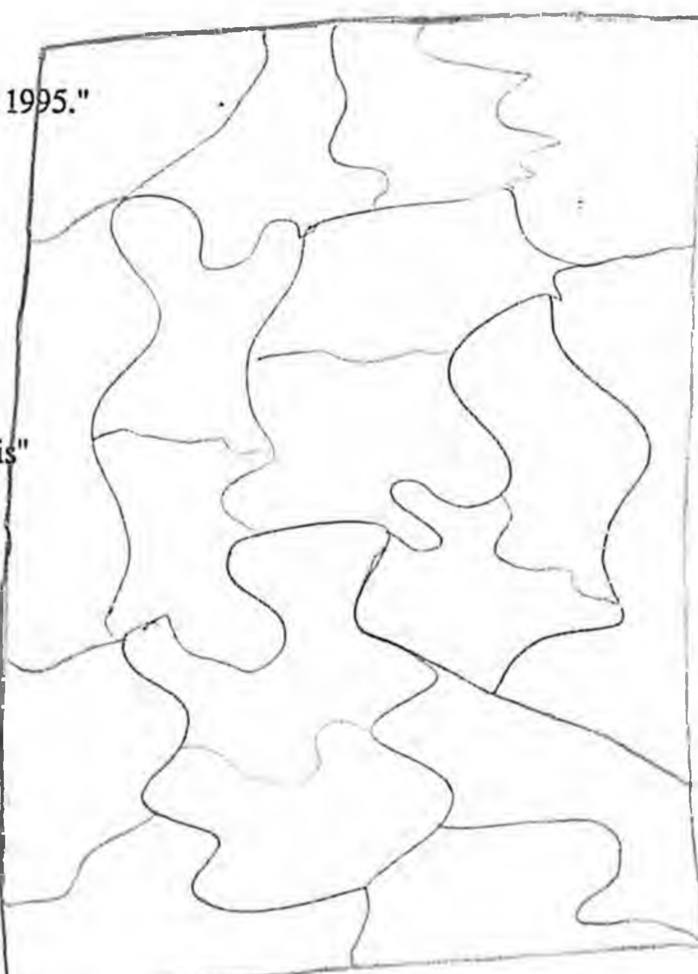
"* Sec. 5. Section 3 of this Act takes effect July 1, 1995."

Renumber the following bill section accordingly.

Page 15, line 12:

Delete "This"

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



SENATE AMENDMENT

BY: Division of Insurance

TO: Page 1, line 10 SENATE BILL NO. SB 74

TO: ______ HOUSE BILL NO. ______

After: "MEMBERSHIP"

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

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

SPONSOR STATEMENT: Provides a consistent language with SB 242.

SENATE AMENDMENT

BY: Division of Insurance

TO: Page 2, line 8 SENATE BILL NO. SB 74

TO: HOUSE BILL NO.

After: "ORGANIZATION"

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

(b) To the extent possible, one board member shall represent a health maintenance organization, one board member shall represent a hospital or medical service corporation, one board member's principal health insurance business shall be in the individual major medical market, and one board member's principal health insurance business shall be in the group major medical market. Members of the board may be reimbursed from the association for expenses incurred by them as members, but may not otherwise be compensated by the association for their services. The costs of conducting meetings of the association and its board of directors shall be borne by the association.

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

Delete: "The board of directors of the association consists of seven individuals selected by participating members, subject to approval of the director. The director or the director's designee shall serve as a nonvoting ex officio member of the board. In determining voting rights at members' meetings, a member is entitled to vote in person or by proxy. The vote shall be a weighted vote based upon the member's premiums for health insurance for major medical coverage on an expense incurred basis, or the member's subscriber fees, derived from or on behalf of state residents in the previous calender year, as determined by the director. In approving members of the board, the director shall consider, among other things, whether all types of participating members are fairly represented. Members of the board other than the director or the director's designee may be reimbursed from the association for their services. The costs of conducting meetings of the association and its board of directors shall be borne by members of the association."

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

SENATE AMENDMENT

BY: Division of Insurance

TO: Page 2, line 23 SENATE BILL NO. SB 74

TO: ______ HOUSE BILL NO. ______

After: "association"

Insert: " (5) take legal action as necessary to avoid the payment of improper claims against the state plan of health insurance;

(6) design the array of health coverage products to be provided to high risk residents;

(7) establish rules, conditions, and procedures pertaining to the insuring of high risk residents

(8) establish actuarial functions appropriate to the operation of the association;

(9) assess members under the provisions of this chapter and make advance interim assessments as may be reasonable and necessary for organizational and interim operating expenses; interim assessments shall be credited as offsets against regular assessments due following the close of the calender year;

(10) appoint appropriate legal, actuarial, and other committees as are necessary to provide technical assistance in the operation of the association, design of a policy or contract, or to assist in other functions of the association;

(11) borrow money to accomplish the purposes of the association; notes or other evidence of indebtedness of the association that are not in default are investments for insurers and may be carried as admitted assets."

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

SENATE AMENDMENT

BY: Division of Insurance

TO: Page 2, line 26 SENATE BILL NO. SB 74

TO: ______ HOUSE BILL NO. ______

After: "association"

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

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

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

SENATE AMENDMENT

BY: Division of Insurance

TO: Page 3, line 3 — SENATE BILL NO. SB 74

TO: ______ — HOUSE BILL NO. ______

After: "operation"

Insert: "must establish procedures for

(1) handling and accounting of program assets and money of the association and for an annual fiscal report to the director;

(2) insuring risks under the provisions of this section;

(3) collecting assessments from all members to provide for claims insured by the state insurance plan and for administrative expenses incurred or estimated to be incurred by the association;

(4) selection of an administering insurer and establishment of the administering insurer's powers and duties; and

(5) provisions necessary or proper for the execution of the powers and duties of the association."

Delete: "shall

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

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

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

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

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

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

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

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

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

SENATE AMENDMENT

BY: Division of Insurance

TO: Page 3, line 26 SENATE BILL NO. SB 74

TO: ______ HOUSE BILL NO. ______

After: "AS 21.55.120"

Insert: "and may offer additional deductible alternatives.

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

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

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

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

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

SENATE AMENDMENT

BY: Division of Insurance

TO: Page 4, line 2 SENATE BILL NO. SB 74

TO: ______ HOUSE BILL NO. ______

After: "Sec. 21.55.110 "

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

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

(2) two members who represent high risk residents;

(3) two members who represent health care providers;

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

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

(2) includes cost containment features such as

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

(B) case management;

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

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

(E) other managed care provisions.

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

(1) benefits with a lifetime maximum of no less than $500,000;

(2) covered medical services performed for an individual covered by the plan for the treatment of nonoccupational disease or nonoccupational injury.

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

(1) hospital services;

(2) professional services that are rendered by a physician or by a registered nurse at the physician's direction, other than services for mental or dental conditions;

(3) the diagnosis or treatment of mental conditions, as defined by the committee, rendered during a benefit year on other than an inpatient basis, up to a benefit yearly maximum of $4000;

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

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

(6) home health agency services up to a maximum of 270 visits in a benefit year if the services commence within seven days following confinement in a hospital or skilled nursing facility of at least three consecutive days for the same condition, except tat 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 calender year;

(8) use of radium or other radioactive materials;

(9) outpatient chemotherapy;

(10) oxygen;

(11) anesthetics;

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

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

(14) diagnostic x-rays and laboratory tests;

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

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

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

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

(19) alternatives to inpatient services; and

(20) second surgical opinions;

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

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

(1) hospital services;

(2) professional services that are rendered by a physician or by a registered nurse at the physician's direction, other than services for mental or dental conditions;

(3) the diagnosis or treatment of mental conditions, as defined by the committee, rendered during a benefit year on other than an inpatient basis, up to a benefit yearly maximum of $4000;

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

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

(6) home health agency services up to a maximum of 270 visits in a benefit year if the services commence within seven days following confinement in a hospital or skilled nursing facility of at least three consecutive days for the same condition, except tat 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 calender year;

(8) use of radium or other radioactive materials;

(9) outpatient chemotherapy;

(10) oxygen;

(11) anesthetics;

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

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

(14) diagnostic x-rays and laboratory tests;

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

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

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

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

(19) alternatives to inpatient services; and

(20) second surgical opinions;

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

SENATE AMENDMENT

BY: Division of Insurance

TO: Page 6, line 6

SENATE BILL NO. SB 74

TO:

HOUSE BILL NO.

After: "for"

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

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

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

SENATE AMENDMENT

BY: Division of Insurance

TO: Page 7, line 7 SENATE BILL NO. SB 74

TO: ______ HOUSE BILL NO. ______

After: "is"

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

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

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

SENATE AMENDMENT

BY: Division of Insurance

TO: Page 7, line 16 SENATE BILL NO. SB 74

TO: ______ HOUSE BILL NO. ______

After: "travel"

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

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

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

SENATE AMENDMENT

BY: Division of Insurance

TO: Page 7, line 3 SENATE BILL NO. SB 74

TO: ______________________ HOUSE BILL NO. __________

After: "Sec. 21.55.140"

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

Delete: "CARE AND SERVICES NOT COVERED."

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

SENATE AMENDMENT

BY: Division of Insurance

TO: Page 8, line 7 SENATE BILL NO. SB 74

TO: HOUSE BILL NO.

After: "charged"

Insert: "AS 21.55.140 is amended by adding a new subsection to read:
(b) A state plan may not provide coverage for persons
(1) eligible for major medical coverage under any law of government including Veterans Administration benefits, native health care, or medicaid; or
"(2) eligible for major medical coverage under any health benefit program including a self-insurance plan, health care trust, or welfare trust.

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

SENATE AMENDMENT

BY: Division of Insurance

TO: Page 8, line 7 SENATE BILL NO. SB 74

TO: ____________ HOUSE BILL NO. ____________

After: "charged"

Insert: "AS 21.55.140 is amended by adding a new subsection to read:
(b) A state plan may not provide coverage for persons
(1) eligible for major medical coverage under any law of government including Veterans Administration benefits, native health care, or medicaid; or
"(2) eligible for major medical coverage under any health benefit program including a self-insurance plan, health care trust, or welfare trust.

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

SENATE AMENDMENT

BY: Division of Insurance

TO: Page 11, line 30 SENATE BILL NO. SB 74

TO: ______ HOUSE BILL NO. ______

After: "to"

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

Delete: "licensed health insurance agents"

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

SENATE AMENDMENT

BY: Division of Insurance

TO: Page 14, line 9   SENATE BILL NO. SB 74

TO: ______   HOUSE BILL NO. ______

After: "rider"

Insert: "that substantially reduces coverage.

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

SENATE AMENDMENT

BY: Division of Insurance

TO: Page 14, line 8 SENATE BILL NO. SB 74

TO: ______ HOUSE BILL NO. ______

After: "plan"

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

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

SENATE AMENDMENT

BY: Division of Insurance

TO: Page 2, line 16 SENATE BILL NO. SB 74

TO: ______________ HOUSE BILL NO. ______________

After: "association."

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

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

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

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

7-LS0409\D
Ford
4/15/92

CS FOR SENATE BILL NO. 74 (HES)

IN THE LEGISLATURE OF THE STATE OF ALASKA

SEVENTEENTH LEGISLATURE - SECOND SESSION

BY THE SENATE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

Offered:
Referred:

Sponsor(s): SENATORS KERTTULA, Cotten, Menard

A BILL

FOR AN ACT ENTITLED

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

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

4 * Section 1. PURPOSE. It is the purpose of this Act to provide access to health insurance to all
5 residents of the state who are presently denied adequate health insurance or who are considered
6 uninsurable.
7 * Sec. 2. AS 21 is amended by adding a new chapter to read:
8 CHAPTER 55. STATE HEALTH INSURANCE.
9 ARTICLE 1. COMPREHENSIVE HEALTH INSURANCE ASSOCIATION.
10 Sec. 21.55.010. CREATION; MEMBERSHIP. There is established a nonprofit
11 incorporated legal entity to be known as the Comprehensive Health Insurance Association.
12 Membership consists of all licensed hospital or medical service corporations in the state that offer
13 subscriber contracts for major medical coverage and all insurers licensed to transact health
14 insurance in the state that offer policies for major medical coverage on an expense incurred basis.

1 All members shall maintain membership in the association as a condition of doing health
2 insurance business, or being able to offer subscriber contracts, in the state.
3 Sec. 21.55.020. BOARD OF DIRECTORS; ORGANIZATION. (a) The board of
4 directors of the association shall be made up of seven individuals. Five board members shall be
5 selected by participating members, subject to approval by the director of the division of
6 insurance, and two board members shall be consumers selected by the director of the division
7 of insurance. The director or the director's designee shall serve as a nonvoting ex officio
8 member of the board. In determining voting rights at members' meetings, a member is entitled
9 to vote in person or proxy. The vote shall be a weighted vote based upon the member's
10 premiums for health insurance for major medical coverage on an expense incurred basis, or the
11 member's subscriber fees, derived from or on behalf of state residents in the previous calendar
12 year, as determined by the director. In approving members of the board, the director shall
13 consider, among other things, whether all types of participating members are fairly represented.
14 Members of the board [~~other than the director or the director's designee~~] may be reimbursed from
15 the association for expenses incurred by them as members, but may not otherwise be
16 compensated by the association for their services. The costs of conducting meetings of the
17 association and its board of directors shall be borne by members of the association.
18 (b) The board shall study and report to the legislature at least once every three years on
19 the effectiveness of this chapter. The report must include an analysis of the effectiveness of this
20 chapter in promoting rate stability, product availability, and affordability of coverage. The report
21 may contain recommendations for legislative or other regulatory action.
22 Sec. 21.55.030. GENERAL POWERS. The association may
23 (1) exercise the powers granted to insurers under the laws of the state;
24 (2) sue or be sued;
25 (3) enter into contracts with insurers, similar associations in other states, or with
26 other persons for the performance of administrative functions;
27 (4) establish administrative and accounting procedures for the operation of the
28 association; and
29 (5) receive funds from sources other than members of the association.
30 Sec. 21.55.040. PLAN OF OPERATION. (a) The association shall submit to the
31 director a plan of operation and amendments necessary or suitable to assure the fair, reasonable,

1 and equitable administration of the association. The plan of operation and amendments become
2 effective upon approval in writing by the director. If the association fails to submit a suitable
3 plan of operation by a date that is 180 days after the effective date of this Act, or if at subsequent
4 time the association fails to submit suitable amendments to the plan, the director may, after notice
5 and hearing, adopt reasonable regulations necessary or advisable to effectuate the provisions of
6 this chapter. These regulations shall continue in force until modified by the director or
7 superseded by a plan submitted by the association and approved by the director.
8 (b) All members of the association shall comply with the plan of operation.
9 (c) The plan of operation shall
10 (1) establish procedures whereby all the powers and duties of the association
11 under this chapter will be performed;
12 (2) establish procedures for handling assets of the association;
13 (3) establish the amount and method of reimbursing members of the board of
14 directors under AS 21.55.020;
15 (4) establish regular places and times for meetings of the board of directors;
16 (5) establish procedures for records to be kept of all financial transactions of the
17 association, its agents, and the board of directors;
18 (6) provide that a member insurer aggrieved by a final action or decision of the
19 association may appeal to the director within 30 days after the action or decision;
20 (7) establish procedures whereby selections for the board of directors will be
21 submitted to the director;
22 (8) contain additional provisions necessary or proper for the execution of the
23 powers and duties of the association.
24 Sec. 21.55.050. ADMINISTRATIVE PROCEDURE ACT. The association is exempt
25 from the Administrative Procedure Act (AS 44.62).
26 Sec. 21.55.060. TAX EXEMPTION. The association is exempt from the payment of fees
27 and taxes levied by the state or any of its political subdivisions except taxes levied on real or
28 personal property.
29 ARTICLE 2. STATE HEALTH INSURANCE PLANS.
30 Sec. 21.55.100. TYPES OF INSURANCE PLANS. (a) The association shall make
31 available to residents who are high risks an individual state plan of health insurance. The

1 association shall offer three alternatives related to deductibles as described in AS 21.55.120 and
2 may offer additional deductible alternatives.
3 (b) The association shall make available to residents who are high risks, eligible for and
4 covered by Medicare, 65 years of age or older, and eligible under this chapter at least one
5 Medicare supplement plan that meets the minimum policy standards and minimum benefit
6 standards established by regulations adopted by the director under AS 21.89.060.
7 (c) The association may not refuse to offer coverage under a state plan to residents who
8 are high risks and who are eligible under this chapter. The association may not refuse coverage
9 under a state plan to residents who are high risks, are eligible under this chapter, apply for
10 coverage, and pay the required premium.
11 Sec. 21.55.110. MINIMUM BENEFITS OF STATE HEALTH INSURANCE PLAN.
12 Except as provided in AS 21.55.120 - 21.55.140, the minimum standard benefits of a health
13 insurance plan offered under AS 21.55.100(a) shall be benefits with a lifetime maximum of
14 $1,000,000 per individual for usual, customary, reasonable, or prevailing charges or, when
15 applicable, the allowance agreed upon between a provider and the writing carrier for charges, for
16 the following medical services performed for an individual covered by the plan for the diagnosis
17 or treatment of nonoccupational disease or nonoccupational injury:
18 (1) hospital services;
19 (2) subject to the limitations of AS 21.36.090(d), professional services that are
20 rendered by a physician or by a registered nurse at the physician's direction, other than services
21 for mental or dental conditions;
22 (3) the diagnosis or treatment of mental conditions, as defined in regulations of
23 the director, rendered during the year on other than an inpatient basis, up to a yearly maximum
24 benefit of $4,000;
25 (4) legend drugs requiring a physician's prescription;
26 (5) services of a skilled nursing facility for not more than 120 days in a policy
27 year;
28 (6) home health agency services up to a maximum of 270 visits in a calendar year
29 if the services commence within seven days following confinement in a hospital or skilled
30 nursing facility of at least three consecutive d[illegible] for the same condition, except that in the case
31 of an individual diagnosed by a physician as t[illegible]inally ill with a prognosis of six months or less

1 to live, the home health agency services may commence irrespective of whether the covered
2 person was previously confined or, if the covered person was confined, irrespective of the seven-
3 day period, and the yearly benefit for medical social services may not exceed $200;
4 (7) hospice services for up to six months in a calendar year;
5 (8) use of radium or other radioactive materials;
6 (9) outpatient chemotherapy;
7 (10) oxygen;
8 (11) anesthetics;
9 (12) nondental prosthesis and maxillo-facial prosthesis used to replace any
10 anatomic structure lost during treatment for head and neck tumors or additional appliances
11 essential for the support of the prosthesis;
12 (13) rental, or purchase if purchase is more cost effective than rental, of durable
13 medical equipment that has no personal use in the absence of the condition for which it was
14 prescribed;
15 (14) diagnostic x-rays and laboratory tests;
16 (15) oral surgery for excision of partially or completely unerupted impacted teeth
17 or excision of a tooth root without the extraction of the entire tooth;
18 (16) services of a licensed physical therapist rendered under the direction of a
19 physician;
20 (17) transportation by a local ambulance operated by licensed or certified
21 personnel to the nearest health care institution for treatment of the illness or injury and round trip
22 transportation by air to the nearest health care institution for treatment of the illness or injury if
23 the treatment is not available locally; if the patient is a child under 12 years of age, the
24 transportation charges of a parent or legal guardian accompanying the child may be paid if the
25 attending physician certifies the need for the accompaniment;
26 (18) confinement in a licensed or certified facility established primarily for the
27 treatment of alcohol or drug abuse or in a part of a hospital used primarily for this treatment, for
28 a period of at least 45 days within any calendar year;
29 (19) alternatives to inpatient services as defined by the association in the state
30 plan benefits;
31 (20) second surgical opinions;

1 (21) other services that are medically necessary in the treatment or diagnosis of
2 an illness or injury as may be designated or approved by the director.
3 Sec. 21.55.120. DEDUCTIBLES AND COPAYMENTS. (a) A state plan other than a
4 Medicare supplement plan may require deductibles of $200 a person, $500 a person, or $1,000
5 a person. The amount of the deductible may not be greater when a service is rendered on an
6 outpatient basis than when that service is offered on an inpatient basis. Expenses incurred during
7 the last three months of a calendar year and actually applied to an individual's deductible for that
8 year shall also be applied to that individual's deductible in the following calendar year. The
9 $200 maximum, the $500 maximum, and the $1,000 maximum may be adjusted yearly to corre-
10 spond with the change in the medical care component of the Consumer Price Index, as adjusted
11 by the director. The base year for the computation shall be the first full calendar year of
12 operation of the association.
13 (b) A state plan other than a Medicare supplement plan shall require a maximum
14 copayment of 20 percent for charges for all types of health care in excess of the deductible and
15 50 percent for services described in AS 21.55.110(3) in excess of the deductible.
16 (c) The sum of the deductible and copayments required in any calendar year under a plan
17 may not exceed a maximum limit of $2,000 per covered individual. Covered expenses incurred
18 after the applicable maximum limit has been reached shall be paid at the rate of 100 percent of
19 usual, customary, reasonable, or prevailing charges, except that expenses incurred for treatment
20 of mental and nervous conditions shall be paid at the rate of 50 percent. The $2,000 maximum
21 shall be adjusted yearly to correspond with the change in the medical care component of the
22 Consumer Price Index as adjusted by the director.
23 (d) In this section, "Consumer Price Index" means the Consumer Price Index for all
24 urban consumers for the Anchorage Metropolitan Area compiled by the Bureau of Labor
25 Statistics, United States Department of Labor.
26 Sec. 21.55.130. PREEXISTING CONDITIONS. (a) A preexisting condition exclusion
27 in a state plan may not exclude coverage of a preexisting condition unless
28 (1) the condition first manifested itself within the period of three months
29 immediately before the effective date of coverage in a manner that would cause a reasonably
30 prudent person to seek diagnosis, care, or treatment; or
31 (2) medical advice or treatment was recommended or received within the period

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

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

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

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

14 (1) care for an injury or disease either

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

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

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

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

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

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

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

1 section;

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

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

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

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

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

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

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

15 (14) experimental procedures; and

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

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

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

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

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

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

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

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

3 ARTICLE 3. ADMINISTRATION OF PLANS.

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

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

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

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

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

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

1 maintenance and administration of the state plans. The association shall approve cost accounting
2 methods to substantiate the writing carrier's cost reports consistent with generally accepted
3 accounting principles. Direct and indirect expenses may not include costs directly related to the
4 original submission of policy forms before selection as the writing carrier.
5 (f) The writing carrier shall at all times when carrying out its duties under this chapter
6 be considered an agent of the association.
7 Sec. 21.55.220. OPERATION OF THE PLAN. (a) Upon notification of eligibility under
8 AS 21.55.320, a person may enroll in a state plan by payment of the appropriate state plan
9 premium to the writing carrier.
10 (b) An employer that has in its employ one or more eligible persons enrolled in a state
11 plan may make all or a portion of a state plan premium payment directly to the writing carrier.
12 (c) Each member of the association shall share the losses due to claims expenses of the
13 state plans issued or approved for issuance by the association, and shall share in the operating
14 and administrative expenses incurred or estimated to be incurred by the association incident to
15 the conduct of its affairs. Claims expenses of the state plan that exceed the premium payments
16 allocated to the payment of benefits shall be the liability of the members. Each member shall
17 share in the claims expense of the state plans and operating and administrative expenses of the
18 association in an amount equal to the ratio of the member's total fees for subscriber contracts or
19 total health insurance premiums, received from or on behalf of state residents, as divided by the
20 total subscriber fees and health insurance premiums received by all members from or on behalf
21 of state residents, as determined by the director.
22 (d) The association shall make an annual determination of each member's liability, if any,
23 and may make an annual fiscal year end assessment if necessary. The association may also,
24 subject to the approval of the director, provide for interim assessments against the members as
25 may be necessary to assure the financial capability of the association in meeting the incurred or
26 estimated claims expenses of the state plans and operating and administrative expenses of the
27 association until the association's next annual fiscal year end assessment. Payment of an
28 assessment is due within 30 days of receipt by a member of written notice of a fiscal year end
29 or interim assessment. Failure by a member to tender to the association the assessment within
30 30 days shall be grounds for revocation of a member's certificate of authority. A member that
31 ceases to do health insurance business in the state, or ceases to offer subscriber contracts in the

1 state, due to revocation, suspension, or voluntary surrender of its certificate of authority remains
2 liable for assessments through the calendar year that the health insurance business ceased. The
3 association may decline to levy an assessment against a member if the assessment would not
4 exceed $10. Assessments paid by a member are a general expense of the member.
5 (e) Net gains, if any, from the operation of the state plans shall be held at interest and
6 used by the association to offset future losses due to claims expenses of a state plan or allocated
7 to reduce state plan premiums.
8 ARTICLE 4. ENROLLMENT IN THE STATE HEALTH INSURANCE PLAN.
9 Sec. 21.55.300. ELIGIBILITY FOR STATE HEALTH INSURANCE. (a) Except as
10 provided in (b) of this section, a state resident who is a high risk is eligible to enroll in a state
11 plan described in AS 21.55.100.
12 (b) A person may not be covered by the state plan while covered by another health
13 insurance policy or subscriber contract. Upon ceasing to be a resident a person is not eligible
14 to purchase or renew coverage under a state plan, but previously purchased coverage remains in
15 effect for the period covered by payments made while a resident.
16 (c) Additional eligibility requirements may not be imposed by the director, the
17 association, or a writing carrier.
18 Sec. 21.55.310. ENROLLMENT BY AN ELIGIBLE PERSON. A person may enroll in
19 a state plan by applying to the writing carrier. The application must include the following:
20 (1) name, address, age, and length of residency of the applicant;
21 (2) a designation of the plan desired, including deductible option chosen;
22 (3) information relevant to whether the person is a high risk.
23 Sec. 21.55.320. WRITING CARRIER'S RESPONSE. Within 30 days after receiving the
24 certificate described in AS 21.55.310, the writing carrier shall either reject the application for
25 failing to comply with the requirements of AS 21.55.300 and 21.55.310 or forward the eligible
26 person a notice of acceptance and billing information.
27 Sec. 21.55.330. EFFECTIVE DATE OF POLICIES. (a) Except as provided in (b) of
28 this section and AS 21.55.130(c), insurance under a state plan is effective immediately upon
29 receipt of the first quarterly premium, and is retroactive to the date of the application, if the
30 applicant otherwise complies with the requirements of this chapter.
31 (b) Insurance under a state plan is effective retroactively to the date that the person's

1 previous contract or policy terminated if the person
2 (1) applies for a state plan within 60 days after the previous contract or policy
3 terminated;
4 (2) is accepted by the writing carrier; and
5 (3) pays a specified premium for the period of retroactive coverage.
6 Sec. 21.55.340. SOLICITATION OF ELIGIBLE PERSONS. (a) The association, under
7 a plan approved by the director, shall disseminate appropriate information to the residents of the
8 state regarding the existence of the state plans and the means of enrollment. Means of
9 communication may include use of the press, radio, and television, as well as publication in
10 appropriate state offices and publications.
11 (b) The association shall devise and implement means of maintaining public awareness
12 of the provisions of this chapter regarding the state plans and shall administer this chapter in a
13 manner that facilitates public participation in the state plans.
14 (c) A person may not sell or market a qualified state plan unless the person is acting *
15 within the scope of a * license issued in this state. health insurance agent may want to add
16 (d) An insurer or hospital or medical service corporation that rejects or applies
17 underwriting restrictions to an applicant for a subscriber contract, a health insurance policy, or
18 a Medicare supplement plan in the state shall notify the applicant of the existence of the state
19 plans, the requirements for being accepted, and the procedure for applying.
20 ARTICLE 5. GENERAL PROVISIONS.
21 Sec. 21.55.400. DUTIES OF DIRECTOR. The director may
22 (1) approve the selection of the writing carrier by the association and approve the
23 association's contract with the writing carrier including the coverages and premiums to be
24 charged;
25 (2) contract with the federal government or another unit of government to ensure
26 coordination of the state plans with other governmental assistance programs;
27 (3) undertake directly or through contracts with other persons studies or
28 demonstration programs to develop awareness of the benefits of this chapter; and
29 (4) adopt regulations necessary to administer this chapter.
30 Sec. 21.55.410. STATE NOT LIABLE. The state is not liable for acts or omissions of
31 the association or a writing carrier under this chapter, nor is the state liable for payment of a

1 claim under a state plan issued by a writing carrier.
2 Sec. 21.55.500. DEFINITIONS. In this chapter
3 (1) "association" means the Comprehensive Health Insurance Association created
4 in AS 21.55.010;
5 (2) "copayment" means the portion of the eligible expenses, in excess of the
6 deductible, for which the insured is responsible;
7 (3) "deductible" means the portion of eligible expenses for which the insured is
8 responsible in each calendar year under AS 21.55.120(a);
9 (4) "health insurance" means an individual or group contract or other plan
10 providing coverage of health care services that is issued by a health insurance company, a
11 hospital service corporation, a medical service corporation, or a health maintenance organization;
12 "health insurance" includes disability insurance under AS 21.12.050;
13 (5) "home health agency services" means any of the following services provided
14 upon recommendation of a licensed physician as part of a treatment plan:
15 (A) intermittent or part-time nursing services of a registered professional
16 nurse or a licensed practical nurse, that are provided to a person under the continued
17 direction of the person's physician and within the limitation of the nurse's license;
18 (B) nursing services that are provided to a person at the person's
19 residence, including a residential care facility or adult boarding home; a hospital, skilled
20 nursing facility or intermediate care facility is not considered a residence;
21 (C) home health aide services that are prescribed by and under the
22 continued direction of a physician and supervised by a professional nurse;
23 (D) home health aide services that are provided to a person at the person's
24 residence, as described in (B) of this paragraph;
25 (E) physical and occupational therapy services, speech pathology, and
26 audiology services that are prescribed by a physician and provided to a person by or
27 under the supervision of a qualified practitioner; these services may be provided to a
28 person who is a patient in an intermediate care facility or skilled nursing facility;
29 (6) "hospice services" means services provided under a coordinated comprehensive
30 program of palliative and supportive care on a 24-hour, seven days per week basis for persons
31 who have been diagnosed as terminally ill and their families by an interdisciplinary team of

1 professionals or volunteers under an incorporated central administration that has a physician as
2 medical director;
3 (7) "major medical coverage" means a health insurance contract, or a subscriber
4 contract, that provides benefits for hospital and medical care with potential lifetime maximum
5 benefits per insured of at least $10,000;
6 (8) "medical social services" means services rendered the patient under the
7 direction of a physician by a qualified social worker holding a master's degree from an accredited
8 school of social work, including assessment of the social, psychological and family problems
9 related to or arising out of the covered person's illness and treatment, appropriate action and
10 utilization of community resources to assist in resolving the problems, and participation in the
11 development of treatment for the covered person;
12 (9) "resident" means a person who is physically present in the state, has lived in
13 the state for at least the six consecutive months immediately preceding application for a state
14 plan, and intends to remain permanently in the state; "resident" also includes a person who is not
15 physically present in the state if the person lived in the state for at least six of the nine months
16 immediately preceding application for a state plan and the person's absence from the state is for
17 medical treatment or education; a person ceases to be a resident if the person is absent from the
18 state for more than 90 consecutive days for reasons other than for medical treatment or education;
19 (10) "residents who are high risks" means residents who
20 (A) have been rejected for medical reasons after applying for a subscriber
21 contract, a policy of health insurance, or a Medicare supplement policy by at least two
22 association members within the six months immediately preceding the date of application
23 for a state plan; medical reasons may include preexisting medical conditions, a family
24 history that predicts future medical conditions, or an occupation that generates a frequency
25 or severity of injury or disease that results in coverage not being generally available; or
26 (B) have had a restrictive rider placed on a subscriber contract, a health
27 insurance policy, or a Medicare supplement policy that substantially reduces coverage;
28 (11) "state plan" means a policy of insurance offered by the association through
29 a writing carrier;
30 (12) "usual, customary, reasonable, or prevailing charge" means the charge for
31 a medical care procedure, service, or supply item that is the lowest of the following amounts:

1 (A) the billed amount for the medical service provider's actual charge;
2 (B) the charge usually made by that provider for performing that procedure
3 or service or for providing the supply item; or
4 (C) the customary charge, based on a profile of charges made for the same
5 medical procedure, service, or supply item in the same geographical area by other
6 providers that have performed the same procedure or service or can provide the same
7 supply item;
8 (13) "writing carrier" means the insurer or insurers selected by the association and
9 approved by the director to administer a state plan.
10 * Sec. 3. The association established by sec. 2 of this Act shall make available to residents the plans
11 required by AS 21.55.100, enacted in sec. 2 of this Act, by January 1, 1993.
12 * Sec. 4. This Act takes effect immediately under AS 01.10.070(c).

SENATE BILL NO. 74

IN THE LEGISLATURE OF THE STATE OF ALASKA

SEVENTEENTH LEGISLATURE - FIRST SESSION

BY SENATOR KERTTULA

Introduced: 1/22/91
Referred: L&C and Finance

A BILL

FOR AN ACT ENTITLED

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

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

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

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

8 CHAPTER 55. STATE HEALTH INSURANCE.

9 ARTICLE 1. COMPREHENSIVE HEALTH INSURANCE ASSOCIATION.

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

New Text Underlined [DELETED TEXT BRACKETED]
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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. The board of directors of the association shall be made up of seven individuals selected by participating members, subject to approval 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 other than the director or the director's designee 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.

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.

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

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

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

3 (c) The plan of operation shall

4 (1) establish procedures whereby all the powers and duties of the association

5 under this chapter will be performed;

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

7 (3) establish the amount and method of reimbursing members of the board of

8 directors under AS 21.55.020;

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

10 (5) establish procedures for records to be kept of all financial transactions of the

11 association, its agents, and the board of directors;

12 (6) provide that a member insurer aggrieved by a final action or decision of the

13 association may appeal to the director within 30 days after the action or decision;

14 (7) establish procedures whereby selections for the board of directors will be

15 submitted to the director;

16 (8) contain additional provisions necessary or proper for the execution of the

17 powers and duties of the association.

18 Sec. 21.55.050. ADMINISTRATIVE PROCEDURE ACT. The association is exempt

19 from the Administrative Procedure Act (AS 44.62).

20 Sec. 21.55.060. TAX EXEMPTION. The association is exempt from the payment of fees

21 and taxes levied by the state or any of its political subdivisions except taxes levied on real or

22 personal property.

23 ARTICLE 2. STATE HEALTH INSURANCE PLANS.

24 Sec. 21.55.100. TYPES OF INSURANCE PLANS. (a) The association shall make

25 available to residents who are high risks an individual state plan of health insurance. The

26 association shall offer three alternatives related to deductibles as described in AS 21.55.120.

27 delete (b) The association shall make available to residents who are high risks and 65 years of

28 age or older a Medicare supplement plan that meets the minimum policy standards and minimum

29 benefit standards established by regulations adopted by the director under AS 21.89.060.

30 (c) The association may not deny coverage under a state plan to a resident who satisfies

31 the requirements of AS 21.55.300 - 21.55.310. The association shall determine whether a person

The Medicare supplement plan Redundant.

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

2 Sec. 21.55.110. MINIMUM BENEFITS OF STATE HEALTH INSURANCE PLAN.
3 Except as provided in AS 21.55.120 - 21.55.140, the minimum standard benefits of a health
4 insurance plan offered under AS 21.55.100(a) shall be benefits with a lifetime maximum of
5 $1,000,000 per individual for usual, customary, reasonable, or prevailing charges or, when
6 applicable, the allowance agreed upon between a provider and the writing carrier for charges, for
7 the following medical services performed for an individual covered by the plan for the diagnosis
8 or treatment of nonoccupational disease or nonoccupational injury:

9 (1) hospital services;

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

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

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

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

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

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

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

28 (9) outpatient chemotherapy;

29 (10) oxygen;

30 (11) anesthetics;

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

1 anatomic structure lost during treatment for head and neck tumors or additional appliances
2 essential for the support of the prosthesis;
3 (13) rental, or purchase if purchase is more cost effective than rental, of durable
4 medical equipment that has no personal use in the absence of the condition for which it was
5 prescribed;
6 (14) diagnostic x-rays and laboratory tests;
7 (15) oral surgery for excision of partially or completely unerupted impacted teeth
8 or excision of a tooth root without the extraction of the entire tooth;
9 (16) services of a licensed physical therapist rendered under the direction of a
10 physician;
11 (17) transportation by a local ambulance operated by licensed or certified
12 personnel to the nearest health care institution for treatment of the illness or injury and round trip
13 transportation by air to the nearest health care institution for treatment of the illness or injury if
14 the treatment is not available locally; if the patient is a child under 12 years of age, the
15 transportation charges of a parent or legal guardian accompanying the child may be paid if the
16 attending physician certifies the need for the accompaniment;
17 (18) confinement in a licensed or certified facility established primarily for the
18 treatment of alcohol or drug abuse or in a part of a hospital used primarily for this treatment, for
19 a period of at least 45 days within any calendar year;
20 (19) alternatives to inpatient services as defined by the association in the state
21 plan benefits;
22 (20) second surgical opinions;
23 (21) other services that are medically necessary in the treatment or diagnosis of
24 an illness or injury as may be designated or approved by the director.
25 Sec. 21.55.120. DEDUCTIBLES AND COPAYMENTS. (a) A state plan other than a
26 Medicare supplement plan may require deductibles of $200 a person, $500 a person, or $1,000
27 a person. The amount of the deductible may not be greater when a service is rendered on an
28 outpatient basis than when that service is offered on an inpatient basis. Expenses incurred during
29 the last three months of a calendar year and actually applied to an individual's deductible for that
30 year shall also be applied to that individual's deductible in the following calendar year. The
31 $200 maximum, the $500 maximum, and the $1,000 maximum may be adjusted yearly to corre-

spond 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. CARE AND SERVICES NOT COVERED. 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 required to be provided under a workers' compensation policy 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;

1 (11) eyeglasses, contact lenses, or hearing aids or the fitting of them;
2 (12) dental care not specifically covered by this chapter;
3 (13) services of a registered nurse who ordinarily resides in the covered
4 individual's home, or who is a member of the covered individual's family or the family of the
5 covered individual's spouse;
6 (14) experimental procedures; and
7 (15) services and supplies for which the patient was not charged.
8 Sec. 21.55.150. STATE PLAN PREMIUMS. (a) The association may not charge a rate
9 for coverage issued by or through the association that is excessive, inadequate, or unfairly
10 discriminatory.
11 (b) The association shall use separate scales of premium rates based on age and
12 geographic location of the insured.
13 (c) The five members of the association that insure, or have subscriber contracts with,
14 the largest number of individuals in the state under plans with benefits substantially equivalent
15 to the state plan benefits shall submit to the association an estimate of the rate that would be
16 actuarially sound for a person who is a standard risk for coverage substantially equivalent to the
17 state plan. The premium for a state plan may not exceed 125 percent of the average of those five
18 estimates.
19 ARTICLE 3. ADMINISTRATION OF PLANS.
20 Sec. 21.55.200. SELECTION OF WRITING CARRIERS. The association shall develop
21 bid specifications for members that wish to be selected as a writing carrier to administer a state
22 plan. The selection of the writing carrier shall be based upon criteria including the member's
23 proven ability to handle a large number of health insurance cases or subscriber contracts, efficient
24 claim paying capacity, and the estimate of total charges for administering the plan.
25 Sec. 21.55.210. DUTIES OF WRITING CARRIERS. (a) The writing carrier shall
26 perform the administrative and claims payment functions required by this section. The writing
27 carrier shall provide these services for a period of three years, unless a request to terminate is
28 approved by the director. The director shall approve or deny a request to terminate within 90
29 days of its receipt. A failure to make a final decision on a request to terminate within the
30 specified period shall be considered an approval. Six months before the expiration of each three-
31 year period, the association shall invite submissions of policy forms from members of the

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

New Text Underlined [DELETED TEXT BRACKETED]

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

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

5 ARTICLE 5. GENERAL PROVISIONS.

6 Sec. 21.55.400. DUTIES OF DIRECTOR. The director may
7 (1) approve the selection of the writing carrier by the association and approve the
8 association's contract with the writing carrier including the coverages and premiums to be
9 charged;
10 (2) contract with the federal government or another unit of government to ensure
11 coordination of the state plans with other governmental assistance programs;
12 (3) undertake directly or through contracts with other persons studies or
13 demonstration programs to develop awareness of the benefits of this chapter; and
14 (4) adopt regulations necessary to administer this chapter.
15 Sec. 21.55.410. STATE NOT LIABLE. The state is not liable for acts or omissions of
16 the association or a writing carrier under this chapter, nor is the state liable for payment of a
17 claim under a state plan issued by a writing carrier.
18 Sec. 21.55.500. DEFINITIONS. In this chapter
19 (1) "association" means the Comprehensive Health Insurance Association created
20 in AS 21.55.010;
21 (2) "copayment" means the portion of the eligible expenses, in excess of the
22 deductible, for which the insured is responsible;
23 (3) "deductible" means the portion of eligible expenses for which the insured is
24 responsible in each calendar year under AS 21.55.120(a);
25 (4) "health insurance" means an individual or group contract or other plan
26 providing coverage of health care services that is issued by a health insurance company, a
27 hospital service corporation, a medical service corporation, or a health maintenance organization;
28 "health insurance" includes disability insurance under AS 21.12.050;
29 (5) "home health agency services" means any of the following services provided
30 upon recommendation of a licensed physician as part of a treatment plan:
31 (A) intermittent or part-time nursing services of a registered professional

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

1 immediately preceding application for a state plan and the person's absence from the state is for
2 medical treatment or education; a person ceases to be a resident if the person is absent from the
3 state for more than 90 consecutive days for reasons other than for medical treatment or education;
4 (10) "residents who are high risks" means residents who
5 (A) have been rejected [for medical reasons] after applying for a subscriber
6 contract, a policy of health insurance, or a Medicare supplement policy by at least two
7 association members within the six months immediately preceding the date of application
8 for a state plan; or
9 (B) have had a restrictive rider placed on a subscriber contract, a health
10 insurance policy, or a Medicare supplement policy;
11 (11) "state plan" means a policy of insurance offered by the association through
12 a writing carrier;
13 (12) "usual, customary, reasonable, or prevailing charge" means the charge for
14 a medical care procedure, service, or supply item that is the lowest of the following amounts:
15 (A) the billed amount for the medical service provider's actual charge;
16 (B) the charge usually made by that provider for performing that procedure
17 or service or for providing the supply item; or
18 (C) the customary charge, based on a profile of charges made for the same
19 medical procedure, service, or supply item in the same geographical area by other
20 providers that have performed the same procedure or service or can provide the same
21 supply item;
22 (13) "writing carrier" means the insurer or insurers selected by the association and
23 approved by the director to administer a state plan.
24 * **Sec. 3.** The association established by sec. 2 of this Act shall make available to residents the plans
25 required by AS 21.55.100, enacted in sec. 2 of this Act, by January 1, 1992.
26 * **Sec. 4.** This Act takes effect immediately under AS 01.10.070(c).

STATE OF ALASKA

WALTER J. HICKEL, GOVERNOR

DEPARTMENT OF COMMERCE AND ECONOMIC DEVELOPMENT

DIVISION OF INSURANCE

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

April 10, 1992

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

Dear Ms. Fouse:

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

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

1. Sec. 21.55.040. Plan of Operation. We suggest that language be added stating:

   (a) Provide for and employ cost containment measures and requirements including, but not limited to, preadmission screening, second surgical opinion, concurrent utilization review, and individual case management for the purpose of making the benefit plan more cost effective.

   (b) Design, utilize, contract or otherwise arrange for the delivery of cost effective health care services, including establishing or contracting with preferred provider organizations, health maintenance organizations and other limited network provider arrangements.

   (c) The board shall make an annual report to the director of Insurance which shall also be filed with the legislature. The report shall summarize the activities of the plan in the preceding calendar year, including the net written and earned premiums, plan enrollment, the expense of administration, and the paid and incurred losses.

2. Sec. 21.55.100. Types of Insurance Plans

   Amend section (b) to read: The association shall make available to residents who are high risk and are obtaining Medicare, a Medicare supplement plan that meets the minimum policy standards and minimum benefit standards established by regulations adopted by the director under AS 21.89.060.

3. Sec. 21.55.130(1). Preexisting Condition

   Line 19 and line 23, increase to six months.

4. Sec. 21.55.150. State Plan Premiums

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

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

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

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

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

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

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

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

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

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

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

(3) the person has previously terminated plan coverage unless twelve (12) months have lapsed since such termination;

(4) the plan has paid out $ (Lifetime maximum) in benefits on behalf of the person;

(5) the person is an inmate or resident of a public institution;

(6) the person's premiums are paid for or reimbursed under any government sponsored program or by any government agency or health care provider, except as an otherwise qualifying full-time employee, or dependent thereof, of a government agency or health care provider.

(e) coverage shall cease:

(1) on the date a person is no longer a resident of this state:

(2) on the date a person requests coverage to end;

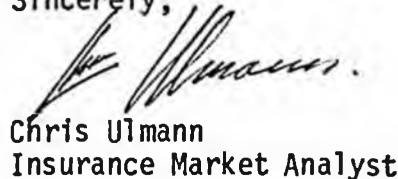
(3) upon the death of the covered person;

(4) on the date state law requires cancellation of the policy; or

(5) at the option of the plan, thirty (30) days after the plan makes any inquiry concerning the person's eligibility or place of residence to which the person does not reply.

(f) Except under the circumstances described in subsection (d), a person who ceases to meet the eligibility requirements of this section may be terminated at the end of the policy period for which the necessary premiums have been paid.

Sincerely,



Chris Ulmann
Insurance Market Analyst

CU/ems6333W
041092c

Proposed Amendments to S.B. 74 (AETNA)

CARVE-OUTS FROM EMPLOYER GROUPS

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

Page 10, line 27 - Insert after the period:

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

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

ELIGIBILITY FOR THE HIGH-RISK PLAN

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

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

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

PREMIUM LEVEL

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

REJECTION FOR MEDICAL REASONS

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

Health Insurance Association of America

April 8, 1992

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

Dear Senator Sturgulewski:

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

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

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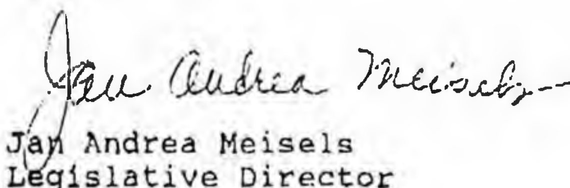
I am also including the pages that discuss the different state funding mechanisms for the expected pool losses. Please note, that a number of states do have some dedicated funding mechanism i.e. a hospital bed tax, an inclusion on the state income tax form, a dedicated funding from a tax on cigarettes,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

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

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

Sincerely,



Jan Andrea Meisels
Legislative Director

JAM/ag

Attachment

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

HIGH RISK POOL PREMIUM CAPS BY STATE

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

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

Comprehensive Health Insurance for High-risk Individuals

A STATE-BY-STATE ANALYSIS
(Fifth Edition)

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

By:
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1-800-445-1525

August 1991

BENEFITS AND CRITERIA FOR EXISTING PLANS

MAXIMUM LIFETIME BENEFITS PROVIDED

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

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

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

DEDUCTIBLES

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

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

WAITING PERIOD
FOR PRE-EXISTING CONDITIONS

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

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

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

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

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

FUNDING MECHANISMS

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

California

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

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

Colorado

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

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

Connecticut

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

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

Florida

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

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

Georgia

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

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

Illinois

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

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

Indiana

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

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

Iowa

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

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

Louisiana

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

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

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

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

Maine

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

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

Minnesota

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

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

Mississippi

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

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

Missouri

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

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

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

Montana

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

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

Nebraska

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

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

New Mexico

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

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

North Dakota

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

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

Oregon

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

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

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

South Carolina

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

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

Tennessee

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

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

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

Texas

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

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

Utah

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

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

Washington

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

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

Wisconsin

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

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

Wyoming

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

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

Health Insurance Association of America

STATEMENT OF HIAA

ON

SENATE BILL 74

PRESENTED BY

JAN ANDREA MEISELS

LEGISLATIVE DIRECTOR

BEFORE THE

ALASKA SENATE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

April 8, 1992

22111 Clarendon Street, Suite 220
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I am Jan Andrea Meisels, Legislative Director, Health Insurance Association of America. The Health Insurance Association of America (HIAA) is a trade association of the nation's leading commercial insurance carriers that provide health insurance for approximately 95 million Americans.

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

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

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

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

Connecticut - 200 percent

Florida - Exceeded 200 percent in 1990

Indiana - Close to 200 percent in the last several years

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

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

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

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

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

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

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

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

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

> A member of the Comprehensive Disability Insurance Association created in AS21.55.010 may credit against a premium tax imposed against disability insurance premiums under this section, an amount equal to an assessment against the member under AS21.55.220(d). Any portion of the credit allowed in this subsection that cannot be taken in a tax year without reducing taxable premiums below zero may be carried forward and credited in successive years until the credit is exhausted.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

HIAA

Health Insurance Association of America

STATEMENT OF HIAA

ON

SENATE BILL 74

PRESENTED BY

JAN ANDREA MEISELS

STATE AFFAIRS ASSOCIATE

BEFORE THE

ALASKA SENATE COMMITTEE ON LABOR AND COMMERCE

April 19, 1991

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