ALASKA LEGISLATURE COMMITTEE FILES 1991-1992 8672
7532 SENATE LABOR & COMMERCE

HIAA

ON

HEALTH CARE

FINANCING

FOR ALL

AMERICANS

HIAA SUMMARY RESPONSE TO CANADIAN-STYLE PUBLIC HEALTH INSURANCE

Many groups are advocating the adoption of Canadian-style public health insurance. In Canada, public health insurance plans run by the provinces cover all residents and are the sole payers for hospital and physician care. Patients have free choice of doctors and hospitals and face no out-of-pocket costs at the time of service. Financing comes almost entirely from taxes.

Public health insurance advocates like Canada's universal coverage, and they claim that Canada has controlled health care costs more effectively than the United States because Canada spends only 9 percent of its gross national product (GNP) on health care, as compared to 11 percent of GNP spent in the United States.

- **Despite these claims, Canada has not controlled health care cost escalation.**

If trends in health care costs per capita are analyzed, it becomes clear that Canada has not fared better than the United States at controlling cost escalation. Over the past 10 years (1977 to 1987), real health care costs per capita grew at an average rate of 4.3 percent per year in Canada, compared to 3.9 percent per year in the United States. The percent of GNP devoted to health care grew more slowly in Canada than in the United States not because Canada controlled health care spending, but because Canada's economy grew faster than ours. Between 1977 and 1987, Canada's GNP per capita grew an average of 2.1 percent per year in real terms, compared to the 1.6 percent per year growth in the United States.

- **Government is bigger in Canada.**

Canadians pay a high price for their public health insurance system and other government-funded services. Excluding defense, the public sector consumes a 30 percent larger share of the total economy in Canada than in the United States (36.7 percent of GNP compared to 28.3 percent of GNP). The net government deficit (across all levels of government) is almost 50 percent larger in Canada when compared to total economic output (Canada's is 3.6 percent of GNP, while the United States' is 2.4 percent of GNP). These statistics are from 1987 figures.

- **Canadians endure long waits for major surgery, and the standard of care is beginning to fall behind current available technologies.**

More importantly, Canadians have to put up with the health care consequences of government attempts to control costs. Because there are no charges to patients, access to care for "sniffles, sneezes, and splinters" is no problem in Canada, but some patients in need of serious surgery have to wait many months for their operations, due to lack of facilities. Modern diagnostic equipment is also in short supply in some provinces, which leads to long waits for such tests as computerized

tomography scans and mammograms. Provincial authorities tacitly have admitted that waiting lines for heart surgery are too long, since they agree to pay for Canadians to have surgery in U.S. hospitals.

This "rationing by queue" is the inevitable result of government attempts to control costs by restricting health care budgets while publicly espousing a commitment to universal access. Because anything new represents an additional cost, bureaucratic budget control discourages innovation, perpetuates existing inefficiencies, and leads to obsolescence.

The strength of the American health care system is its ability to adapt quickly to changing needs and to develop and rapidly employ new and better ways of treating illness. Such responsiveness is clearly not possible when all major resource allocation decisions are made by a government, particularly a government concerned primarily with cost control.

- **Controlling health care budgets does not eliminate unnecessary care and waste in the health care system.**

While arbitrarily restricting access to expensive high-technology procedures, Canada's provincial health plans make no attempt to determine whether care ordered by physicians is really necessary, despite the large volume of evidence (in the U.S. and elsewhere) that a significant proportion of services ordered by physicians are unnecessary, ineffective, or actually counter-indicated. Inappropriate care, which may constitute as much as 25-30 percent of all care rendered according to some estimates, is the real cause of waste and excess expense in the health care system.

- **Canadians are stuck with a "one size fits all" system.**

Canadians lack choices—not of specific doctors and hospitals, but of the overall delivery system and the extent of coverage. In the United States, if an employment-based group chooses to reduce its current outlays for insurance premiums and protect themselves only against very major medical bills, for example, they can buy lower-cost insurance.

These choices are not available to Canadian citizens. All must belong to the same system and accept its deficiencies as well as its benefits, unless they choose to be restricted to the very few private hospitals and physicians or to seek care outside the country. Thus, if the government seeks to control costs by restricting the availability of hospital beds or new equipment, citizens who need care must either wait for service or pay privately to go outside the system.

- **The Canadian system would be in worse shape if it did not have the U.S. health care system right next door.**

First, Canadians need not spend large sums developing new medical technology—they can wait for the United States to develop it and reap the benefits when it is ready.

Second, the United States relieves the pressures that would otherwise build requiring expansion of the Canadian system and additional spending. For example, with few exceptions (e.g., cataract surgery), it is almost impossible for individuals to shorten their waiting periods for surgery within Canada because there are virtually no private hospitals; but Canadians who are willing and able to pay privately to obtain care sooner can come to U.S. hospitals and clinics. The provinces had no other short-term alternative for reducing surgical waiting lists. If the United States were to adopt the Canadian system, this safety valve for Canadians would no longer exist, nor would there exist one for Americans.

• Conclusion

Clearly, the United States must work to assure access to health care for all Americans. Equally clearly, we must do a better job of containing health care cost increases, while we also maintain quality of care. But public insurance based upon the Canadian model is not an approach that would work well in the United States.

The U.S. private market is responding to the growing demand for cost containment and quality assurance and is moving aggressively to implement and improve managed care systems that will meet this dual need. Private insurers also recognize the need for universal availability of health care coverage and have developed specific proposals to make coverage available to the broad spectrum of Americans who currently are without.

June 1990

Health Insurance Association of America

1025 Connecticut Avenue N.W., Washington, DC 20036 202-223-7780 FAX 202-223-7807

HIAA

ON

HEALTH CARE

FINANCING

FOR ALL

AMERICANS

HIAA SUMMARY RESPONSE TO S. 768; THE BASIC HEALTH BENEFITS FOR ALL AMERICANS ACT

HIAA agrees that proposals to address the uninsured must include significant expansion of public coverage. Such expansion should be targeted to those populations most in need — the poor and near poor populations.

- **HIAA agrees that special tax subsidies and exceptions for small employers are necessary and appropriate**. HIAA supports providing financial assistance to small employers who face a substantial burden when they try to provide private coverage. We also support extending the 100 percent income tax deduction to self-employed individuals. Finally, HIAA supports the concept of making lower cost tailored plans available to very young firms.
- **HIAA supports the concept of assisting low income workers in their achieving the cost sharing and premium contributions associated with employer-based coverage**.
- **HIAA supports an Employee Reduction Income Security Act (ERISA) preemption of state benefit mandates**.
- **HIAA opposes employer mandates or other efforts to compel employers to provide health benefits through tax penalties**. We are concerned with the negative employment effects associated with employer mandates and believe that large scale expansion of the employer-based system must be met with successful efforts to contain rising health care costs.
- **HIAA believes that the uniform regional/state rates envisioned under the bill would create major market distortions and would prove to be poor economic policy**. This structure would (a) create tremendous cross-subsidization from areas with lower health care costs to areas with higher health care costs; (b) break the link between costs generated by health care use and health care premiums, thereby eliminating incentives for employers to seek out the most efficient local financing and delivery systems and also to maintain a safe work environment; and, (c) reduce employer economic incentives to locate in lower cost, nonmetropolitan regions. We recommend another approach, which is outlined under HIAA policy.
- **HIAA believes that the current structure of the public program would result in an undesirable, unnecessary, and costly shift of individuals from private to public coverage**. When fully phased in, the public coverage under S. 768 would be available to anyone who does not have employer-based coverage, regardless of income or whether coverage is available through a private source. Further, the open-ended structure would, in all likelihood, exacerbate enrollment problems and create fiscal difficulties (due to adverse selection). It will also instigate perverse incentives for states to make fiscal decisions based

Health Insurance Association of America

1025 Connecticut Avenue N.W., Washington, DC 20036 — 202-223-7780 — FAX 202-223-7897

upon actions by neighboring states. In other words, if voters perceive that they are subsidizing the public coverage of neighboring states (indirectly through federal matching funds), they may be inclined to expand their own program beyond what is believed to be necessary or financially prudent. This phenomenon would be more likely under the broad-based program envisioned by the Act than under the current Medicaid program.

- **While HIAA recognizes the need for appropriate reform of the insurance marketplace, we oppose the responsibilities delegated to the U.S. Secretary of Health and Human Services under the bill.** There already exists, at the state level, a highly developed regulatory structure which carries out many of the functions which would be placed under the control of the U.S. Secretary of Health and Human Services.

Initiatives to address the access to health care coverage issue should build and improve upon the existing public/private system without promoting large scale and unnecessary substitution of existing sources of coverage. Proposals to expand private coverage should not hastily mandate or compel employers to provide health benefits, but should instead focus on making coverage more available and affordable. Such efforts should include introducing a range of small employer insurance market reforms; establishing a reinsurance mechanism to guarantee availability of coverage and making the small employer market reforms feasible; making lower cost prototype benefit plans possible; and assisting financially needy employer groups and individuals with their purchase of private coverage. For more details regarding the above, see the HIAA Summary of Recommendations on Expanding and Improving the Health Care Financing System.

HIAA

ON

HEALTH CARE

FINANCING

FOR ALL

AMERICANS

HIAA SUMMARY RESPONSE TO THE PEPPER COMMISSION'S RECOMMENDATIONS FOR THE UNDER 65 POPULATION

The Bipartisan Pepper Commission released a series of recommendations for reforming our nation's health care system. The report makes a number of positive recommendations which HIAA supports.

For instance, HIAA supports the Pepper Commission proposals to expand government coverage to poor and near poor individuals and to target tax subsidies to small employers. HIAA also supports targeted government assistance to low income workers to help them pay the premium contributions and cost sharing associated with their health plan. HIAA supports the concept of a federal preemption of state benefits and provider mandates and many of the underlying concepts for reform of the small employer health benefit market. HIAA also supports a number of the suggestions for constraining growth in health care costs and for assuring the delivery of quality care through managed care and other initiatives aimed at establishing better practice guidelines and standards of care, including the study and demonstrations on medical malpractice reform.

However, the report also includes elements which are politically and economically unfeasible, elements that HIAA cannot support.

- It is HIAA's belief that scarce public funds and assistance should go first and foremost to the needy. The proposal unnecessarily makes public coverage available on a very broad scale.

  The program's structure would likely lead to costly substitution of public coverage for existing private coverage. One would expect employers in high cost regions and higher cost employers to buy disproportionately into the public plan (since under the public plan the employer's costs are capped at a defined percentage of payroll). For employers buying into the public plan, the plan eliminates any linkage between the cost of coverage and the true health care costs incurred by the employer (which therefore eliminates incentives to increase efficiency and to maintain healthy work environments). Further, the concentration of high cost employers in the public plan would lead to large public sector losses which would necessitate either (a) an infusion of public dollars funded by increasing tax revenues to subsidize the high cost employers, or (b) efforts to enlist lower cost employers in the public plan (e.g., by lowering the payroll tax). The problem with alternative "a" is that the American public appears unwilling to accept a major tax increase (particularly when revenues will assist other individuals). A major problem with alternative "b" is that it would institute an inflexible public program for a larger segment of the population, something that neither employers nor the American public wants.

Health Insurance Association of America

1025 Connecticut Avenue N.W., Washington, DC 20036 202-223-7780 FAX 202-223-7897

In almost any scenario, employers located in regions with lower health care costs would wind up cross subsidizing, through public funds, those employers in higher cost regions that have opted into the public plan.

Employers in many cases would find it advantageous to provide private coverage for higher income employees and cover lower income employees (e.g., part-time or temporary) with the public plan. From a labor standpoint this may be viewed as unfair and discriminatory.

Employees' preferences and needs would be subject to an arbitrary decision by the employer, who would determine whether it was more advantageous to pay for public or private coverage.

HIAA statistics strongly suggest that the public program will severely limit its provider payment rates, thereby forcing a cross subsidy from other payers.

- While HIAA supports the general direction being taken in small employer market reform, specific requirements that coverage be sold on "the same terms to all employers" are troubling. This implies a crude form of community rating, which is highly problematic for a number of reasons. One, it would lead to more employers that pay higher premiums. Their number would be substantially greater than the employers that received lower premiums. Two, making coverage substantially more costly for the majority of small employers may cause many employers to drop coverage or seek refuge in self insurance. Three, it entirely breaks the link between an employer's true health care costs and the premiums which employers pay. This mitigates an employer's incentive to seek out more efficient financing and more efficient delivery systems in order to maintain a safe and healthy work environment.

- The "basic" benefit package identified in the Commission's proposal needs to be more basic. Perhaps most importantly, the "limited" mental health benefit could prove to be very costly.

HIAA SUMMARY RESPONSE TO THE HERITAGE FOUNDATION PROPOSAL FOR HEALTH SYSTEM REFORM

The Heritage Foundation proposal for health system reform and cost containment makes several valid points. Perverse incentives (though not just consumer incentives) are a main cause of cost escalation. Consumers do need incentives to be concerned about costs of care. Government price and budget controls can produce undesirable consequences. A market-based strategy must be a major part of the solution.

On the other hand, the Heritage Foundation proposal is inadequate in several important ways.

- The proposal places far too much reliance on the individual consumer's ability to solve their coverage problems and unwisely eliminates employer-based coverage. Employers, unlike consumers, have the clout to negotiate with providers to change the system. Because they have both the incentive and the leverage to bring about system changes, employers are critical actors in the effort to bring costs under control. Moreover, the administrative and marketing costs for employment-based plans are much less than if all plans were sold to individuals. Simply giving individual consumers incentives to choose a low-cost plan will not control costs. With so many different plans and the complexity of many benefit structures, most consumers would not have the time or the skill to make reasoned judgments about the level of benefits that would best suit them, about the adequacy of coverage, about the value of the benefits relative to the price, and about the quality of providers' services. The screening process that employers now provide to help decide which plans to offer employees greatly reduces the complexity of the task.

- The proposal totally ignores the critical role that providers, especially physicians, play in determining resource mix and cost of care. The assumption is that if consumers have proper incentives, then that will be enough to force providers to become more efficient and less costly. Given the highly technical nature of medicine, the cost-increasing incentives of fee-for-service physician reimbursement, and the natural reluctance of physicians to change the way they deliver care, this assumption is unrealistic.

- The proposal offers no details of any kind to illustrate the process by which consumer incentives will be translated into efficient delivery systems designed to produce high-quality, low-cost care. The argument assumes that making consumers cost-conscious will produce the desired outcome. Yet, major structural changes are required if costs are to be contained; these changes do not just happen. We believe that managed care systems are a major part of the answer. Attention must be addressed to the conditions and mechanisms that are necessary to produce managed care systems and the other system changes that are necessary.

Health Insurance Association of America
1025 Connecticut Avenue N.W., Washington, DC 20036 — 202-223-7780 — FAX 202-223-7897

- The proposal vastly underestimates the problems of adverse selection. If consumers have a choice of many different plans, rather than just a few, competitive pressures will force the plans to compete not by trying to provide services more efficiently, but by trying to attract healthy individuals. Healthy individuals, with low probability of high expenses, will naturally want to join a plan that insures similar low-risk individuals, since the cost will also be much lower. The advantage to be gained by underwriting low-risk individuals will overwhelm any savings that could be realized through providing services more efficiently. Even with the tax-credit subsidy, the high-risk people will find the cost of insurance very burdensome. If the Heritage approach is not the answer to cost control, what is? The solution is to be found in the development of improved managed care. Managed care systems, of which HMOs and PPOs are the best-known examples, are designed to monitor treatment decisions to assure that care is appropriate and efficiently provided. They provide comprehensive, integrated care through selected panels of providers who are chosen because they are known to be cost-effective, and who agree to practice within defined constraints to assure quality and efficiency. The closed nature of the provider panel and the incentives for consumers to use panel providers creates an environment where standards to assure appropriate cost-effective care can be developed, implemented, and accepted by both providers and patients. For physicians, the attraction of managed care systems is an assured supply of patients. For purchasers, the attraction is high-quality, less costly care. The insurance industry has made a major commitment to the development of such systems and believes that they must be a major part of any plan for health system reform.

HIAA

ON HEALTH CARE FINANCING FOR ALL AMERICANS

MANAGED CARE

BACKGROUND: The high cost of health care is a major problem for the United States. All who pay—employers, individuals, and government—are burdened by continual increases in health expenditures. Moreover, escalation of health costs greatly complicates the task of finding ways to provide coverage for the large number of Americans who are without either public or private health insurance.

Although cost escalation has many causes, research shows that one key problem is that patients receive much care that is not appropriate for their condition. Some get care that is more intense and expensive than necessary. Others receive care that is not beneficial and may even be harmful. Eliminating such inefficiencies—which may account for 25 percent or more of medical expenditures—is clearly a critical objective, both as a way of reducing costs and improving quality of care.

Payers of health care are aware of such inefficiencies and are demanding more accountability and better performance from those who make health care decisions in order to assure that patients receive good value for money spent. Increasingly, managed care is recognized as the best mechanism for carrying out such improvements. The key objective of managed care is to assure that patients receive appropriate care, that is, high quality care efficiently provided in the least costly setting.

DEFINITION: Because it is still evolving, managed care embraces a variety of existing and developing structures. It may be defined as systems that integrate the financing and delivery of appropriate health care services to covered individuals by means of the following basic elements:

- Arrangements with selected providers to furnish a comprehensive set of health care services to members;
- Explicit standards for the selection of health care providers;
- Formal programs for ongoing quality assurance and utilization review; and
- Significant financial incentives for members to use providers and procedures associated with the plan.

Managed care organizational structures are evolving in response to marketplace demands and will continue to do so. Today's structures include health maintenance organizations (HMOs), preferred provider organizations (PPOs), and exclusive provider organizations (EPOs), as well as mixed arrangements that combine elements of HMOs, PPOs and indemnity plans to accommodate employer and operating environment requirements.

Health Insurance Association of America
1025 Connecticut Avenue N.W., Washington, DC 20036 • 202/223-7780 • FAX 202/223-7897

Managed care plans arrange with selected providers to furnish health care services to plan members. Explicit criteria are used for the selection of providers, and formal programs for ongoing review of the quality and appropriateness of services are incorporated into the plan.

Plans provide financial incentives for covered individuals to use providers who deliver appropriate quality care. In some managed care plans, the cost of services is covered only when health care is received from selected providers. Other managed care plans provide individuals more latitude in the choice of providers. Out-of-pocket costs, however, are usually higher when out-of-plan providers are chosen.

Some state legislators are concerned that managed care, including both contracting arrangements with providers and utilization review techniques, could adversely affect the quality of health care. Their concerns have been encouraged by some associations of providers representing hospitals, physicians, dentists, pharmacists and allied health professions. These groups have drafted and advocated state legislative proposals that would restrict or prohibit the operation of managed care programs.

HIAA POSITION: HIAA is firmly committed to the expansion of managed care programs and techniques in order to assure high-quality, cost-effective health care. Managed care systems have the means to avoid unnecessary and inappropriate care.

Therefore, HIAA is opposed to legislation or regulations that would impose barriers to the development and implementation of managed care in its current and evolving forms. Legislation or regulation that unduly limits insurers' ability to carry out rigorous utilization review is one such barrier. Legislation that opposes utilization review takes many forms, but generally seeks to put inappropriate restrictions on who can conduct reviews and what can be reviewed.

HIAA is also opposed to legislation that would restrict an insurer's freedom to form networks or contract selectively with providers. Legislation that opposes networking also takes many forms, but generally seeks to put restrictions on the ability to pay providers anything but their usual and customary fees, or to contract with a limited number of providers.

HIAA believes:

- Insurers should be free to negotiate whatever price they can with providers. One important way to reduce costs is to be able to buy provider services at lower prices, and managed care systems need to have freedom to negotiate lower prices. On the other hand, in some instances plans may wish to offer higher-than-usual fees to especially efficient providers.
- Insurers should be able to pay providers in ways that create appropriate incentives. If provider reimbursement systems reward high-cost medical practice, it will be very difficult to reduce costs. Managed care systems need to be able to alter reimbursement incentives to reward efficient providers. Severe restrictions on capitation payment, for example, are inappropriate and unwarranted.
- State laws should not place artificial limits on the amount of consumer cost sharing that can be imposed on PPO plan enrollees who choose to get care from off-panel providers. If a PPO has a panel of providers that can provide

needed high-quality services more efficiently than other providers, it is entirely appropriate to require consumers who choose not to use these efficient providers to pay the extra costs. HMOs, which all states allow, do not pay anything when consumers receive care from non-HMO providers.

- Legislation should not establish inappropriate barriers to insurer efforts to establish effective utilization review programs and should require providers to make available, at a reasonable cost, patient records and other information necessary to monitor cost and quality of care. Monitoring medical practice patterns is critical to managing care. If reviewers cannot get access to medical records at reasonable cost, or if excessive restrictions are put in place to limit who does utilization review or what the process will be, managed care plans cannot accomplish the critical task of encouraging providers to become more efficient.
- Insurers who are negotiating to form provider panels should not be compelled to enroll every provider who wishes to be included. A key mechanism that managed care plans use to constrain costs is to contract only with efficient providers. If plans are required to include on their panels all willing providers, this critical element of control is eliminated.
- States should not mandate that insurers cover services and categories of care, since doing so often adds to costs and limits the plan's ability to develop cost-effective benefit packages. Research evidence shows that legislation that requires coverage of certain provider categories or particular services generally causes a net increase in costs. The buyers of insurance plans, not state government, should be the ones who decide what services and provider groups should be covered. Legislation mandating coverage of particular provider groups is often simply a reflection of that group's desire to create demand for their own services as a way of enhancing income.

HIAA supports the concept of physician peer review as a method of determining appropriateness of care. In doing peer review, however, it is not appropriate to rely solely on local peer assessment. Studies of differences in patterns of medical practice from area to area within a state demonstrate that the typical method of treatment in one community is often significantly different from that in another community even though the conditions of the patients are essentially identical. The differences, in other words, are not medically justified. Thus, local habit or customary practice is not necessarily the best standard for assessing medical appropriateness or necessity for a given treatment.

The collective judgment of physicians who are experts in a given field and who have done a systematic study of the scientific research must ultimately form the basis for determining what is appropriate care in a given situation. It is for this reason that HIAA supports the development of medical practice guidelines and protocols. When developed, these can form a rigorous, scientifically defensible standard for educating physicians about the best medical practice and for judging the appropriateness of care.

GLOSSARY: Below is a list of some of the current managed care structures now available:

Health Maintenance Organization (HMO): This was the original managed care arrangement, first emerging as prepaid group practices in the 1930s. The

name "health maintenance organization" was coined in the early 1970s, and was given to 1973 federal legislation promoting its development. HMOs provide:

- An organized system for providing health care in a certain geographic area, as well as responsibility for providing or otherwise assuring delivery of that care;
- An agreed-on set of basic and supplemental health maintenance and treatment services; and
- A voluntarily enrolled group of people.

In exchange for a set amount of premium or dues, HMOs provide all the agreed-on health services to their enrollees; there are generally no deductibles and no or minimal copayments. The HMO bears the risk if the cost of providing the care exceeds the premium received. There are now several types of HMOs:

- The staff model, where providers are directly employed by the HMO;
- The group model, where medical groups contract with the HMO (Kaiser plans are the best-known example of this type);
- The independent practice association (IPA), where the HMO contracts with physicians in independent practice, or with associations of independent physicians. IPA physicians frequently have arrangements with more than one HMO; and
- The network model, which contracts with two or more independent group practices.

Preferred Provider Organization (PPO). A PPO consists of groups of hospitals and providers that contract with employers, insurers, third-party administrators or other sponsoring groups to provide health care services to covered persons and accept negotiated fee schedules as payment for services rendered. There are different sponsoring arrangements:

- Hospital-sponsored PPOs, which often include a network of institutions in order to cover a wider geographic area, as well as many of the physicians on their medical staffs;
- Physician-sponsored PPOs, which are developed by local medical societies, other local professional associations or clinics, or groups of physicians;
- Third-party payer-sponsored PPOs, which include those initiated by commercial insurers and Blue Cross and Blue Shield plans;
- Entrepreneur-sponsored PPOs, which create a broker relationship with the entrepreneur acting as an intermediary between the provider and payer of service;
- Employer- or labor-sponsored PPOs, which contract directly with providers on behalf of their employees or members;
- Other provider-sponsored PPOs, which are developed by nonhospital and nonphysician providers, such as dentists, optometrists, pharmacists, chiropractors and podiatrists, through their professional associations, local groups or clinics.

Exclusive Provider Organization (EPO). People belonging to an EPO must receive their care from affiliated providers; services rendered by unaffiliated providers are not reimbursed.

Point-of-Service Plans. Also known as open-ended HMOs or PPOs, these plans permit insureds to choose providers outside the plan at any time yet are designed to encourage the use of network providers. If a provider is affiliated with the HMO or PPO, the service is covered (perhaps after a modest copayment). If an out-of-network provider is chosen, reimbursement may be significantly reduced.

A number of managed care techniques are used to assure quality and appropriate care. These include, but are not limited to, quality assurance, utilization review, case management and use of a primary care physician. Although the combination of elements will differ among plans, each managed care plan operates as an organized system where patient services are subject to review and coordination by health professionals.

- Quality assurance is a process by which a managed care plan monitors and takes action as necessary to assure that quality care is delivered by selected providers. The process measures the extent to which quality has been attained and periodically reevaluates health care to assure that established standards are being met.
- Utilization review is a system of reviewing the medical necessity and appropriateness of patient services within guidelines developed by physicians. Performed by health care professionals, it is comprised of several processes and may be used for both inpatient and outpatient services. Processes may include preadmission certification, application of practice guidelines, continued stay review, discharge planning, second surgical opinion and retrospective review. Because of the explosion of costs in all aspects of ambulatory care in recent years, programs to require preauthorization of ambulatory procedures are now evolving.
- Preadmission certification is a process in which a health care professional (such as a registered nurse) evaluates an attending physician's request for a patient's admission to a hospital by using established medical criteria.
- Continued stay review, also called concurrent review, is a process whereby a review organization continues to examine medical information during a patient's hospital confinement to determine the need for continued hospitalization.
- Discharge planning is a process in which a health care professional from a review organization works with an attending physician and hospital staff to arrange for appropriate discharge of a patient from the hospital, including a plan for the patient's subsequent care. Its purpose is to determine when patients are ready to go home, perhaps with the support of a nurse or other home health provider, or are able to be transferred to a nursing home.
- Second surgical opinion programs require patients to seek a second surgeon's opinion if elective surgery is recommended for certain conditions. Elective surgery is defined as that which can be avoided or delayed without undue risk to the patient and which allows sufficient time to seek another opinion.

- Retrospective review provides for the establishment of a utilization profile of inapproppriate care for monitoring trends and addressing excessive use or cost.

Other managed care techniques include case management, which is a process that provides a comprehensive plan of care and rehabilitation for people suffering from severe conditions such as trauma, premature birth or AIDS. Through flexible interpretation of plan provisions, case management coordinates the use of all appropriate types of therapy and equipment in the most appropriate setting. Case management often supports alternatives to institutional care, such as physical therapy and other services delivered in the home, that achieve better patient outcomes at lower cost.

In many managed care plans, a primary care physician serves as the initial screening, testing, treatment and referral source for a patient. This physician oversees health care services rendered to patients by other providers and assumes continuing responsibility for the overall course of treatment.

Aetna

Corporate Affairs
151 Farmington Avenue - MA64
Hartford, CT 06156

Judith T. Hyfield-Starr
Manager
(203) 636-2259

June 1989

Dear Editor:

You're hearing a lot these days about a new concept in health care called *managed care*. It's basically a simple concept -- bringing together the doctor, patient, employer and insurer to manage the use of health care. But it's revolutionary compared to the traditional view of health care.

No longer does a patient rely solely on the doctor for a course of treatment. That treatment today might be influenced by a second opinion, or other cost-saving alternatives established by the employer or the insurance company. It's a true partnership guiding the use of health care resources.

This kit explains the driving forces behind managed care, as well as its many facets. You may want to use elements of it for individual stories, or just keep it on file for future reference.

Aetna is a responsive and knowledgeable news source on health-related issues. Our medical claims data base is the largest in the world (we insure 10 million Americans), and we frequently provide journalists with extensive information on topics ranging from treatment trends to medical costs.

When you need more information on this or any other health care topic, please give us a call.

Sincerely,

Judith Hyfield-Starr

Judith T. Hyfield-Starr
(203) 636-2259

Aetna LIFE & CASUALTY

NEWS

For Release:

MANAGED CARE: THE PARTNERS

Aetna's managed care effort brings together its strength as one of the largest private health insurers with the resources of a national not-for-profit hospital system in a unique partnership.

***

AETNA is one of the 15 largest U.S. corporations and is the nation's largest investor-owned insurance company underwriter and administrator of group insurance benefits, based on premiums of $11 billion.

Providing health insurance coverage for 11 million Americans, Aetna has been providing employee benefits since 1913.

***

PARTNERS National Health Plans is a joint venture developed in 1985 between Aetna and VHA Enterprises, Inc., the equity arm of Voluntary Hospitals of America, Inc., to develop a national managed health care system.

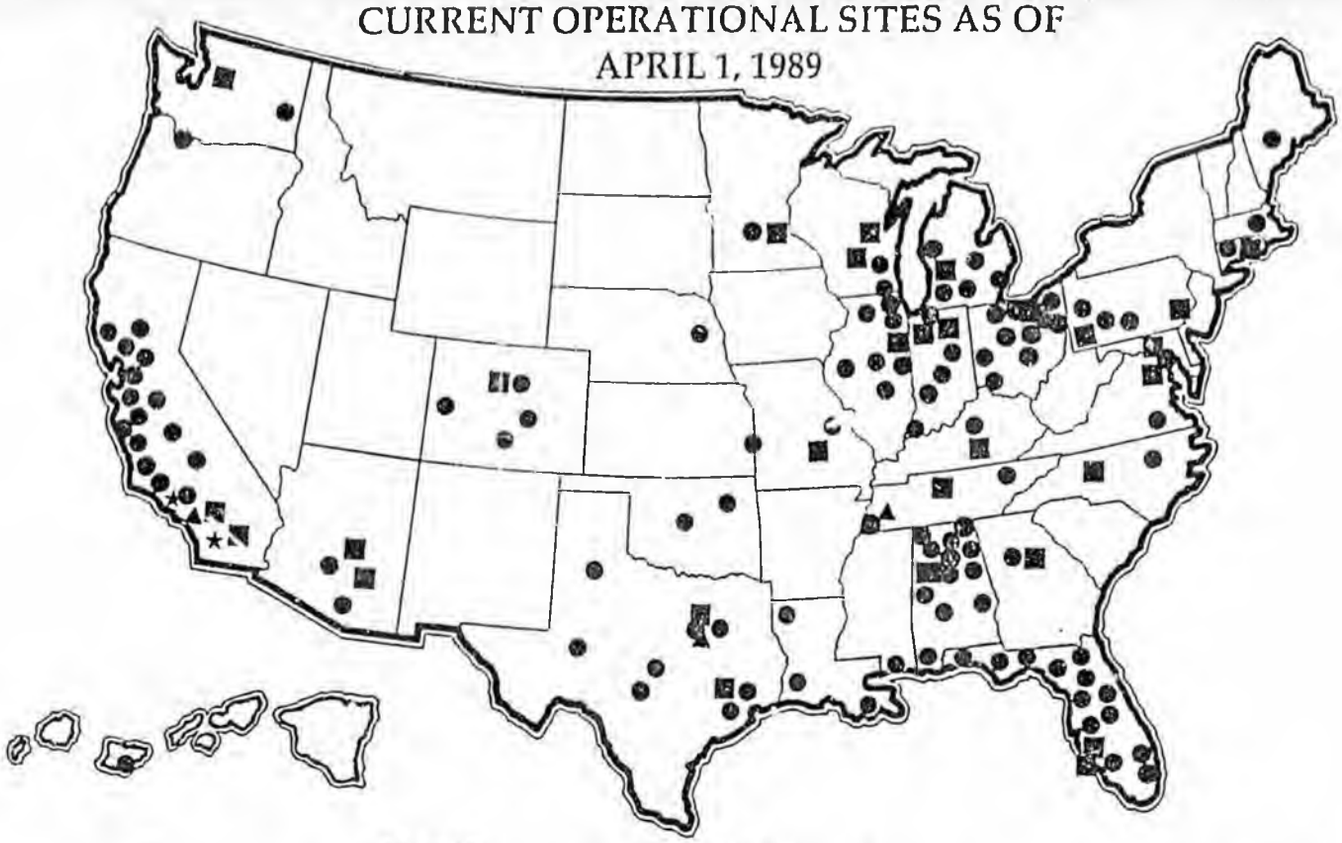
PARTNERS provides employers and their employees with preferred provider organizations (PPOs), health maintenance organizations (HMOs) and other managed health care programs, marketed through Aetna employee benefit representatives, their local brokers and agents and PARTNERS representatives. At the end of 1988, more than 1.7 million members were enrolled in PARTNERS programs.

***

VOLUNTARY HOSPITALS OF AMERICA, INC., founded in 1977, is the largest alliance of not-for-profit hospitals in the nation, with 662 hospitals and their 172 affiliates operating in 47 states and the District of Columbia.

VHA hospitals generally are grouped into 29 regional health care systems built around one or more VHA shareholder hospitals. These regional health care systems, organized into six divisions across the U.S., are licensed by VHA and operate as independent not-for-profit corporations.

CURRENT OPERATIONAL SITES AS OF APRIL 1, 1989



● PPO ■ HMO ▲ TPCM Claims Center ★ CHAMPUS

ALABAMA
- Anniston - PPO
- Birmingham - HMO, PPO
- Bridgeport/Centre/Fort Payne - PPO
- Cullman - PPO
- Fayette - PPO
- Florence - PPO
- Gadsden - PPO
- Huntsville/N. Alabama - PPO
- Jasper - PPO
- Mobile - PPO
- Montgomery - PPO
- Phenix City - PPO
- Tuscaloosa - PPO

ARIZONA
- Phoenix - HMO, PPO
- Tucson - HMO, PPO

CALIFORNIA
- Central Valley
  (Fresno/Bakersfield/Modesto) - PPO
- Greater Los Angeles
  (Anaheim/Santa Ana, Long Beach, Oxnard/Ventura, Riverside/San Bernardino, Santa Barbara/Santa Maria/Lompoc) - HMO, PPO, TPCM Claims Center, CHAMPUS
- Northern California
  (Oakland, Sacramento, San Francisco, San Jose, Santa Rosa/Petaluma, Stockton, Vallejo/Fairfield/Napa) - PPO
- San Diego - CHAMPUS, HMO

COLORADO
- Colorado Springs - PPO
- Denver
  (Boulder/Longmont) - HMO, PPO
- Grand Junction/Montrose - PPO

CONNECTICUT
- New Britain - PPO
- Southern New England
  (Hamden) - HMO

FLORIDA
- Brevard County - PPO
- Daytona Beach - PPO
- Fort Myers - PPO
- Gainesville - PPO
- Inverness - PPO
- Jacksonville - PPO
- Martin County - PPO
- Ocala - PPO
- Orlando - PPO
- Panama City - PPO
- Pensacola - PPO
- Tallahassee - PPO
- Tampa - Two HMOs, PPO
- West Palm Beach/Boca Raton - PPO

GEORGIA
- Atlanta - HMO, PPO

HAWAII
- Honolulu - PPO

ILLINOIS
- Champaign - PPO
- Chicago
  (Aurora/Elgin, Lake County) - HMO, PPO
- Joliet - PPO
- Kankakee - PPO
- Peoria - PPO
- Rockford - PPO

INDIANA
- Evansville - PPO
- Fort Wayne - PPO
- Gary/Munster - HMO, PPO
- Indianapolis - PPO
- South Bend - HMO
- Terre Haute - PPO

KANSAS
- Kansas City - PPO

KENTUCKY
- Louisville - HMO, PPO

LOUISIANA
- Lake Charles - PPO
- New Orleans - PPO
- Shreveport - PPO

MAINE
- Lewiston - PPO

MASSACHUSETTS
- Boston
  (Brockton, Fitchburg/Leominster, Lawrence/Haverhill, Lowell, New Bedford, Salem/Gloucester, Worchester) - PPO

MICHIGAN
- Detroit/Port Huron - PPO
- Grand Rapids - HMO, PPO
- Lansing - PPO
- Muskegon - PPO
- Saginaw/Bay City - PPO

MINNESOTA
- Minneapolis/St. Paul - HMO, PPO

MISSISSIPPI
- Biloxi/Gulfport - PPO

MISSOURI
- Kansas City - PPO
- St. Louis - HMO, PPO

NEBRASKA
- Omaha/Council Bluffs - PPO

NORTH CAROLINA
- Raleigh-Durham - PPO
- Winston-Salem - HMO

OHIO
- Akron - PPO
- Cincinnati
  (Hamilton/Middletown) - PPO
- Cleveland - HMO, PPO
  (Lorain/Elyria) - PPO
- Columbus - PPO
- Dayton/Springfield/Xenia - PPO
- Toledo - PPO
- Youngstown - PPO

OKLAHOMA
- Oklahoma City - PPO
- Tulsa - PPO

OREGON
- Portland - PPO

PENNSYLVANIA
- Johnstown - PPO
- Philadelphia - HMO
- Pittsburgh - HMO, PPO
  (Beaver County) - PPO

TENNESSEE
- Knoxville - PPO
- Memphis - PPO, TPCM Claims Center
- Nashville - HMO

TEXAS
- Amarillo - PPO
- Austin - PPO
- Dallas
  (Fort Worth/Arlington) - HMO, PPO, TPCM Claims Center
- Houston - HMO, PPO
  (Brazoria) - PPO
- Midland - PPO
- San Antonio - PPO

VIRGINIA
- Fairfax - HMO
- Norfolk/Virginia Beach/Newport News - PPO

WASHINGTON
- Seattle - HMO
- Spokane - PPO

WASHINGTON, D.C. - HMO

WISCONSIN
- Appleton - HMO
- Kenosha - PPO
- Milwaukee - HMO, PPO

Aetna LIFE & CASUALTY

NEWS

For Release:

Immediate

Contact: Judith Hyfield-Starr
(203) 636-2259

Background on Managed Care

Just 10 years ago, a new employee received a booklet of benefits, glanced at it briefly and tucked it away, safe in the knowledge that it was a standard package.

Today, the employee faces a wide array of alternatives -- PPO or HMO? Which one? Maybe a traditional indemnity plan? What level of coverage?

Just 10 years ago, the employee visited the family doctor for an ailment and followed that doctor's advice without question.

Today, that employee seeks advice from his employer, his insurance company and possibly another doctor before the best course of treatment is determined.

Just 10 years ago, an employee with a catastrophic illness or a psychiatric problem spent months or years in a hospital or institution, with bills often mounting into the millions.

Today, that patient is evaluated by a group of professionals, and treatment -- possibly in an alternative setting -- is customized for the individual medical problem.

***

Patient knowledge and responsibility are at the core of this new approach to health care -- called *managed care*. Managed care is a partnership of the patient, doctor, employer and insurer working together to make effective use of health care resources.

Today, 74 percent of people with employer-sponsored health insurance are covered by at least some form of cost management, up from virtually none at the beginning of the decade, according to the Health Insurance Association of America.

The concept has its roots in the late 1970s and early 1980s, when employers began facing seriously escalating health care costs due to the frequent use of inpatient care and the advent of new and costly procedures.

The health care service industry responded quickly to the cost spiral, offering an array of cost-management strategies, including second surgical opinions, preadmission certification and the encouragement of outpatient services for many procedures once done in the hospital.

While these strategies worked in reducing inpatient stays and surgeries, the cost balloon bulged in other areas. Outpatient costs jumped dramatically and hospital beds began filling up with mental health and substance abuse cases. And, second surgical opinions too frequently confirmed the original opinion and didn't appear to avert unnecessary surgery or reduce costs.

Health care costs continued to soar, with the U.S. health bill at 11.4 percent of GNP in 1988, up from 6 percent in 1965. Costs rose 50 percent just from 1982 to 1987, implying there might have been significant overutilization.

Insurers began to play a far bigger role, using their own nurses, doctors and software systems to help employees identify unnecessary, inappropriate or overly costly procedures. More and more, they began suggesting that some operations not be performed, that alternative care be explored. In addition, insurers began organizing networks of competent and cost-efficient hospitals and doctors, ensuring steady patient flow in return for a reasonable cost structure. It was the advent of managed care.

Managed Care Options

An integral component of managed care involves the use of Preferred Provider Organizations (PPOs) and Health Maintenance Organizations (HMOs) -- networks of health care providers who supply medical care for a set fee.

Under a typical HMO arrangement, the employee pays a set premium in return for complete care from physical exams to hospital coverage. In an HMO, the patient must use participating health care providers; in a PPO, the patient is free to use providers outside the network, but benefits are reduced.

The HMO agrees to limited fees in return for a steady flow of patients. Operating on fixed payments then, they have a strong incentive to study ways to weed out wasteful practices.

Aetna, for example, has a managed health care partnership with Voluntary Hospitals of America (VHA). Using VHA's more than 800 hospitals in 48 states, the partnership has developed an enrollment of more than 1.8 million people through its joint venture, PARTNERS National Health Plans.

Most recently, there has been an effort to integrate the cost-saving advantages of PPOs and HMOs in what is known as a Triple-Option or Integrated Multiple Option (IMO). In an IMO plan, employers can purchase a combination of an indemnity plan, a PPO and an HMO for one experience-rated premium.

Case Management

As inpatient costs soared in the early 1980s, employers paid high prices for hospital care when, many times, employees could have been treated as effectively, and more humanely, in less expensive settings. But they weren't, either because an alternative setting wasn't covered by the benefit plan or because no one was available to arrange the alternative care.

Case management programs solved both issues by identifying cases that could appropriately be treated outside of the hospital, by providing coverage for that care and by counseling patients and their families as to the most appropriate setting.

A typical case management program might involve a patient with a catastrophic illness who could be given skilled nursing care at home -- a more comfortable and less expensive setting. A nurse would act as liaison between the insurer and the policyholder to monitor the quality of care and would get second opinions on medical procedures and case support from an independent team of physicians and specialists.

Aetna, for example, saved its customers almost $122 million in 1987 through its Individual Case Management program, and arranged for customized care for more than 3,000 patients in the form of specialized medical equipment and care, home modifications, nurses, attendants and training for patients' families.

Mental Health Care

Employers today spend $44 billion a year -- or up to 15 percent of their health care dollars -- on mental health care. Drug abuse,

alcoholism and stress-related claims are all on the rise. And, the average hospital stay for these cases is nearly four times longer than the average for all other admissions.

Mental illness no longer carries the stigma it once did, and employees today are more open about seeking treatment and often are encouraged to do so by their employers.

But mental health treatment is expensive and complex, and the duration of treatment has always been difficult to predict. As a result, many employers and insurers once believed costs also were difficult to assess. They thought the only way to control costs was to limit benefits. In efforts to maintain control yet provide what they thought was meaningful coverage, many began to offer full coverage for inpatient care but little or no coverage for the less costly outpatient services. As a result, inpatient care -- and costs -- soared.

In response, many employers have redesigned their benefits packages to cover the appropriate treatment and to help employees find quality treatment opportunities. And some insurance companies are offering new and custom-tailored plans to employers, like Aetna's Focused Psychiatric Review, which encourages use of alternatives to traditional hospital confinement -- day hospitals, halfway houses, intensive outpatient treatment and residential treatment centers.

These new programs frequently feature a case management approach, in which the case manager monitors patient programs, helps the employee locate appropriate treatment and works with the physician to identify and evaluate treatment options.

Precertification Programs

Most Americans with group insurance now are covered by some type of precertification arrangement -- programs that offer the patient a financial incentive to seek review of a procedure before it is performed. This process frequently points out the possibility of outpatient treatment as a cost-effective alternative to hospital admission.

Although the programs have worked well to reduce the number of inpatient procedures, they have boosted the use of outpatient care substantially.

To control these costs and maintain quality care, a few precertification programs have expanded to cover outpatient procedures. Aetna, for example, offers employees financial incentives to seek review of 18 of the most expensive and frequently performed outpatient procedures. The Aetna program is expected to reduce use of inappropriate outpatient services by up to 15 percent.

In further efforts to reduce unnecessary surgery, Aetna also has started a managed second opinion program.

Traditionally, second surgical opinion programs have failed because the confirmation rate has been about 97 percent, despite the fact that research shows up to 30 percent of surgeries may be unnecessary or even harmful. The savings from the averted procedures barely covered the costs of the second opinion.

Managed second opinion uses computer-based standards to determine whether a procedure would benefit from a second opinion. The program is expected to cut down on nonproductive second

opinions since physicians will be aware that patients are being referred because the procedure is being questioned.

Utilization Management

One of the critical ingredients tying together managed care programs is effective utilization management. Utilization management allows an employer to monitor costs and quality of care while providing employees with medical care counseling before, during and after treatment.

The programs have been successful since their inception in the early 1980s, and the use of utilization controls has risen fourfold since 1984.

In a typical utilization review program, a patient anticipating a procedure calls a toll-free number and talks to a registered nurse. The nurse may work with the patient's physician in recommending the best and most cost-effective course of treatment.

Aetna's HEALTHLINE, a toll-free hotline people can call with their questions, covers precertification of procedures, review of emergency admissions, continued-stay review, discharge planning, second surgical opinion, individual case management and retrospective review and analysis.

Conclusion

Managed health care is an evolution whose time has come. In today's environment of choices -- which provider and which procedure, what's covered and what isn't -- employees need the proper tools with which to make the correct decisions.

Managed care helps give employees those tools so they can obtain quality health care at an affordable cost.

The rising costs of health care in America has rapidly become one of our Nation's most important social and economic issues. In 1980, total health care expenditures in the United States was $248.1 billion. By 1986, expenditures had increased to $458 billion. If this trend continues, total annual dollars spent on health care will be $1.5 trillion by the year 2000, or an astounding $5,550/yr per person.

Numerous studies have been done to document the causes for this dramatic increase in cost. The principal inflationary factors include:

* Increases in the cost of hospital personnel and medical equipment;
* Over building of hospitals resulting in low occupancy rates;
* Increases in health care consumption;
* Increases in malpractice suits resulting in higher malpractice insurance costs;
* Increase in the median age of the U.S. population;
* Provision of unnecessary medical services;
* Cost shifting from the federal government to state, municipal and private employers;

No where in the country has the cost of health care services risen as quickly as the State of Alaska. Of All fifty states, Alaska:[1]

---

[1] Statistics from 1989 Source Book of Health Insurance Data and Health United States 1988

	U.S.	Alaska
1) Has the highest average cost per day for hospital care (60% higher than national average)	$538.96	$892.02
2) Has the second highest cost per hospital stay (76% higher than national average)	$3,850.16	$5,056.92
3) Has the fourth highest cost for semi-private room (77% higher than national average).	$254.87	$330.66
4) Has highest percentage of male smokers in the country.		
5) Is among the top five states in per capita expenditures for mental health care.		

6) Has significantly higher than average costs for most medical and dental services.	Seattle	Juneau	Anchorage
(a) dental exam	$22	$40	$35
(b) dental cleaning	$48	$85	$80
(c) dental filling	$50	$80	$80
(d) appendectomy	$975	$1400	$1450
(e) Hernia Repair	$900	$1400	$1325

Alaska also leads the country in alcohol and substance abuse, the treatment for which is expensive due to the length of treatment programs.

Other related trends which have been observed in Alaska by Aetna's Cost Containment Unit include confinements extended for social or family reasons when not medically necessary, extended juvenile confinements for behavioral problems, alcohol and drug abuse patients who return to dysfunctional families which do not provide the necessary support to end the abuse, increase in the use of preventative (i.e., naturopathic) services and over use of diagnostic procedures and durable medical equipment.

As a result of these rapidly increasing expenses, the cost of healthcare insurance is also rising quickly. The cost of a fully insured healthcare program is based on the cost of claims

actually paid in the prior year plus administrative expenses to provide for claim processing, financial reconciliation, and the various administrative tasks required to run the plan. The cost is then increased or decreased based on the projected volume of claims expected for the coming year. Nationally the cost of medical claims is currently increasing at a rate of 20%-25%.

Using the State of Alaska health care policy as an example, the payment for claims filed by active state employees has risen from $25 million in 1983 to $48 million in 1988. The number of claims transactions has increased from 264,854 to 338,889 during the same period and the claim cost per employee has jumped from $2,238 to $3,615. The consequence of this upward trend was a proportional increase in health care insurance cost to the State, and there is no evidence that the trend will end in the near future.

The financial impact of the increasing cost of health care insurance is of great concern to employers, employees and insurers. While it will be extremely difficult to control many of the inflationary factors cited herein, there are some factors which can be modified to achieve lower insurance costs.

The Cowper Administration, The Alaska State Employees Association (ASEA), and the legislature have been working with Aetna to identify changes in the existing health care benefits

package for State employees which will result in lower insurance costs without significantly reducing the benefits to employees. An agreement was recently signed by the Department of Administration and ASEA which will result in a $42.00 per employee/per month reduction in insurance premiums beginning in December, 1989. Some of the cost containment measures included in the agreement are:

Health Care Utilization Review Including Hospital Pre-certification. Offers a financial incentive to the patient to seek review of medical procedures before they are performed.

Second Surgical Opinions. Requires a second opinion in cases where national research indicates that the proposed surgery may be unnecessary or harmful.

Onsite Health Care Review. An onsite nurse in Anchorage monitors a patient's progress to assure an appropriate length of hospital stay and to help arrange out patient care.

Substance Abuse Counseling. Professional Pretreatment guidance to help direct people into the most appropriate treatment that is available.

Co-Insurance in Dental and Vision Services. Insured persons assume a greater share of the cost above certain limits.

Incentives for Use of Generic Drugs. Requires additional payment for brand name drugs where less expensive certified generic drugs are available.

Outpatient Pre-certification. Requires a review of the most expensive and frequently used outpatient procedures to reduce the use of inappropriate services (i.e., tonsillectomy).

Home Health Care. Assistance to provide home vs. hospital care where appropriate.

Skilled and Private Duty Nursing. On staff nurses are available to assist patients in obtaining information, evaluating alternatives, and arranging the appropriate level of care. Aetna currently maintains five registered nurses on staff for this purpose.

A primary thrust of these changes is to permit Aetna to consult with employees prior to treatment to assure that proposed medical care is the most appropriate available. This requires the full cooperation of both employees and medical service providers. Aetna is a leader in these cost containment techniques, and cost containment results, where already implemented for other clients, are very encouraging. Nationwide, Aetna saved its employee benefits customers $1.64 Billion in 1988 or 18.2% of total medical and dental payments.

A "Health Care Cost Containment Task Force" comprised of members of the Alaska State Legislature, the Department of Administration, and representatives of several state and municipal employee unions, is at work to find further acceptable means of reducing the cost of health care insurance to the public sector in Alaska. Senator Tim Kelly is the chairman of the task force and is joined by Senator Jim Duncan, Representative Mike Navarre, and Representative Mark Boyer in representing the Legislature. Executive Branch officials include representatives from the Division of Retirement Benefits, Risk Management, and the Department of Health and Social Services. The Task Force is reviewing Aetna's administration of the State of Alaska health care contract and is considering Aetna's proposed alternatives for cost containment along with advice it has solicited from independent health insurance consultants. Cooperation from the employee unions such as ASEA has been extremely important in adopting the cost saving measures.

Aetna, through its professional staff located in Anchorage and its claims administration unit in Seattle, administers a large number of public and private health care insurance contracts in Alaska. It is proud of its successful record in Alaska, and looks forward to a continuing partnership with the public and private sectors to achieve the best possible coverage for medical services.

Aetna LIFE & CASUALTY

NEWS

For Release:

Immediate

Contact:
Judith Hyfield-Starr
(203) 636-2259

MEDIA BACKGROUNDER

TRENDS IN MENTAL HEALTH TREATMENT: A NATION OF SICK CHILDREN?

Trends in Mental Health Treatment: A Nation of Troubled Children?

The cost of mental health and substance abuse treatment is the number one benefits concern for many employers today, and with good reason. More employees are using their mental health benefits than ever before and the financial impact on employers is alarming. Consider:

- In 1986, mental health care cost the nation $24 billion, according to the National Mental Health Association. (1)

- Large employers spend between 7 percent and 15 percent of their health care dollars on mental health and substance abuse treatment. (2)

- From 20 percent to 30 percent of all claims processed by insurers today are mental health related. (3)

- General spending for psychiatric care is rising at least 10 percent a year. (4)

- Up to 80 percent of all mental health dollars are spent on inpatient hospital care, which can conservatively cost $500 a day (5) and, in many cases, more.

A recent and disturbing trend is the disproportionate use of mental health services by children and adolescents. In general, youngsters under age 19 receive longer treatment and more expensive treatment than other age groups.

Adolescent Psychiatric and Substance Abuse Care

In 1988, Aetna Life Insurance Co., one of the nation's leading administrators of group health benefits covering more than 11 million Americans, examined 1987 psychiatric and substance abuse hospital claims for employees and dependents up to age 65. Here is what it found:

•Persons 18 and younger represented approximately 26 percent of all claimants and accounted for 24.7 percent of all mental health admissions. And, this same group used 39.9 percent of all inpatient mental health days and accounted for 41.8 percent of all inpatient mental health costs.

•The average length of mental health inpatient stay for persons 18 and younger was 40.2 days. This was considerably more than the next highest average length of stay -- 22.1 days for the 19 to 34 age group. It was more than double the average 18-day lengths of stay for age groups 35 to 49 and 50 to 64.

•For every 1,000 persons 18 and younger, there were 5.6 mental health admissions. This rate is consistent with other age groups. But -- for every 1,000 persons ages 18 and younger, 225 hospital days were used, and this rate is much higher than other age groups. The 19 to 34 age group used 158 days per 1,000 persons and the 35 to 49 age group used 120 days per 1,000 persons.

•For persons 18 and younger, psychiatric and substance abuse hospitalizations accounted for 30.6 percent of Aetna's total inpatient expenses (includes medical, surgical and psychiatric) for this age group.

•Of all hospital days used by those 18 and younger, 43.8 percent were for psychiatric and substance abuse confinements.

What does this mean? In general, it means that youngsters are admitted to mental health facilities on a par with other age groups -- but once in treatment, they stay longer and their treatment costs more than other age groups.

Two major questions emerge from these data. Is Aetna's experience similar to other insurers, and if so -- why?

The National Experience

Comparatively little claim data is available that separates the use of psychiatric and substance abuse treatment by youngsters

from other age groups. What is available generally supports Aetna's experience -- more extensive service and higher costs for adolescent treatment.

For example, one large Southern California public utility company reported a fourfold increase in adolescent psychiatric admissions between 1984 and 1985 alone. (6) A California defense contractor found that 66 percent of its hospital claims related to psychiatric disorders and that adolescent stays accounted for a large portion of the total. (7)

A Maryland-based self-funded company paid psychiatric costs of $2.2 million in 1986, representing 21 percent of its health care benefits that year. Of that total, $1.5 million was incurred by 69 teenagers, many of whom were treated extensively for drug abuse. The cost of inpatient care at some psychiatric facilities used was as high as $25,000 a month, almost $1,000 a day. (8)

Nationwide, the picture looks the same, with inpatient admissions for youngsters under age 18 rising 450 percent between 1980 and 1984. (9) Despite this alarming increase, the Congressional Office of Technology Assessment maintains that three quarters of the 7.5 million children who need mental health treatment do not receive it. (10) The American Psychiatric Association estimates that fully 12 percent of all schoolchildren show some level of clinical maladjustment and says the figure is unlikely to change. (11)

In Minnesota, where the youthful population is decreasing, admission of adolescents to hospital psychiatric units increased 25 percent in five years. Ira M. Schwartz of the Humphrey Institute at the University of Minnesota said many of these admissions were youngsters with behavioral or family problems. He noted that it was easy to admit them to a psychiatric unit on only the signature of a parent and an admitting physician. "Juveniles have been spending much longer in the hospital than adults, but there was no evidence that it takes longer to cure juveniles," says Schwartz. (12)

Are We a Nation of Troubled Children?

Why do youngsters receive more care than in the past? Are they more seriously ill, or do social and developmental factors sway their fate?

Today's youth, characterized by some media as living "flat" and colorless lives, are often described as lethargic, unmotivated youngsters who float through days and weeks as "episodes" of life without underlying continuity or purpose. Surrounded by pollution, national debt, homeless families and the possibility of nuclear war, they are publicly acknowledged as a troubled generation.

Troubled, perhaps -- but are they sicker than their predecessors? Growing sentiment among utilization reviewers and third-party payers suggests that a number of youngsters in psychiatric facilities are not mentally ill, but are being treated for behavioral or family problems in psychiatric settings. The spokesman for a large, nationwide provider of health benefits has said, "....children and adolescents were often admitted to psychiatric hospitals for custodial purposes. Now insurers are clamping down because, in some cases, these kids have behavioral problems, but aren't sick enough to need extensive hospitalization." (13)

Then how did the extensive hospitalization trend begin? Experts speculate, but no one seems to know for sure. In general, experts agree that our rapidly changing social environment has a great influence on adolescents, and often cite three specific areas:

Community supports: The demise of community supports -- extended families, church associations, civic clubs and youth affiliations -- means greater isolation for many youngsters. But some of these youngsters are used 'to isolation, coming from one-parent families due to divorce or intact families where both parents work. With less adult guidance at home, fewer adult role models in the community and less structured group activity, some young people

may have trouble developing social behavior that works favorably with peers and adults both.

Schools: Increasingly, parents want schools to play a larger role in guidance and development issues, but schools may not be equipped to expand their educational mission. Behavioral problems acted out at home are easily tranferred to school during the day. While it's not the role of schools to correct disruptive behavior, they must manage it to carry out their daily educational duties. Encouraging professional help for the problem child is a way to do that.

The courts: Today's judicial system is more willing to recommend mental health treatment for antisocial, delinquent or illegal behavior than the courts of 20 years past. In part, the growth of the mental health treatment sector has provided a resource for the judicial system that simply didn't exist two or three decades ago.

Legally, young people have little recourse. Psychiatric treatment need not be court-ordered. In many states, authorization from the child's parent or legal guardian, together with the treating physician, is enough to get the youngster admitted for, at least, clinical evaluation. Once in the system, these youths find abundant resources to treat them.

The Business of Mental Health

More mental health care is available today than ever before. The number of mental health treatment professionals rose from 50,000 in 1981 to 250,000 in 1986, according to the American Psychiatric Association. (14) Psychiatric beds in hospital systems increased 37 percent in 1985 alone. (15) The number of private psychiatric hospitals nationwide increased by almost 40 percent in 15 years, from 180 in 1970 to nearly 250 in 1985. (16)

Past generations avoided psychiatric treatment because of the attached social stigma. But yesterday's stigma is today's red badge of

courage. Now, a generation of babyboomers willingly seeks professional help for a variety of life's problems -- work-related stress, family and financial problems, divorce, death -- viewing it more as a commitment to personal well-being than as a sign of weakness. (17) Supporting the increased utilization is widespread benefits coverage for emotional problems, offered by 95 percent of employers responding to a recent survey on mental health benefits by the International Foundation of Employee Benefit Plans. (18)

But not everyone treated by the mental health system needs mental health treatment. A National Institute of Mental Health (NIMH) study in the early 1980s showed that one-third of all people who seek mental health treatment lack any symptoms that fit a mental health diagnosis, concluding that people now seek treatment for problems once discussed with family members or friends. Similarly, a 1986 poll of therapists by USA Today showed that marital problems are the most frequent reasons people seek treatment, followed by depression, relationships with co-workers and family members, low self-esteem and insecure feelings. More than 90 percent of responding therapists identified stress at home or at work as the key problem (19), indicating that the population at large sees the problems as significant reasons to consult a mental health professional.

Like all businesses, the mental health field has untapped "specialty markets" offering the best potential for attracting new customers. Providers of mental health care openly acknowledge that children and adolescents are a specialty market with high growth potential.

One company that recognized it was the Nashville-based Hospital Corp. of America (HCA), which increased the percent of its youthful inpatient population in 41 hospitals nationwide from 25 percent in 1983 to a full 50 percent three years later. Other provider systems, aware that insurers are working to contain extensive and possibly unnecessary hospitalizations, have begun

developing continuum of care services for youngsters that include inpatient, outpatient, partial hospitalization and residential programs. (20)

Psychiatric treatment for youth can be profitable. The president of an independent McLean, Va., mental health management firm estimated that psychiatric programs for children and adolescents can yield margins of up to 30 percent, compared to 20 percent margins for adult programs, due to higher occupancy levels and lengths of stay. Also, reimbursement may be less of an issue with youngsters, since many parents pay their children's treatment costs out of pocket. (21)

What Are the Alternatives?

No general consensus exists in the psychiatric community that longer lengths of inpatient stay produce better results. In fact, since the "deinstitutionalization" thrust of the '70s, when state mental health agencies began mass discharging of patients from state hospitals into community services, the trend in mental health care has been toward using the "least restrictive environment" suitable for a patient's needs.

Unlike the medical/surgical arena, where procedures are performed either inpatient or outpatient, the mental health arena offers more options for less restrictive settings.

Partial hospitalization programs that provide day care or evening care can be effective therapeutic environments for youngsters who need acute care but not 24-hour hospitalization. In many cases, residential treatment centers offer adolescents a 24-hour care environment but in a setting less restrictive than a psychiatric hospital. Group homes and halfway houses are two other residential alternatives to hospital settings. Extensive outpatient treatment, possibly including individual, group and family therapy, can also be arranged for youth who need mental health attention.

While youngsters' behavioral and family problems should be addressed and resolved, many do not require 30-day or 40-day hospital confinements. Increasingly, insurers are working with psychiatric practitioners to identify and use non-hospital settings for these youngsters when appropriate. This makes efficient use of employers' mental health dollars, which often carry annual maximums, stretching them farther and, in effect, getting more care for the dollar. It also promotes using the most appropriate level of care and mental health specialty for each patient instead of across-the-board hospitalization for all. In some cases, insurers use programs like Aetna's Individual Case Management to arrange coverage for treatment alternatives that wouldn't be included under the employer's existing benefit plan.

Many employers also use employee assistance programs (EAPs) to address the emotional or substance abuse problems of employees and their families. There are more than 10,000 existing EAPs today and the number is rising, according to the Association of Labor-Management Administrators and Consultants on Alcoholism. Many EAPS provide initial assessment and evaluation, as well as short-term professional counseling, thus avoiding use of mental health benefits altogether. When referral beyond the EAP is needed, company health benefit plans usually cover the services. But evidence suggests that up to 80 percent of problems can be resolved directly by an EAP when it offers professional counseling. (22)

Whether employers will continue to pay for psychiatric treatment for youngsters' behavioral and family problems remains to be seen. Aetna's claim experience with the under-19 age group shows that employers should be concerned about costs and about the services their dollars buy. Some employers have applied annual limits, higher copayments and lower coverage levels to their mental health benefits, and others have reduced psychiatric benefits where they are not mandated by state legislatures.

To protect and restore youngsters who require mental health care, psychiatric benefits in employer-sponsored plans must be preserved. To preserve them, employers' costs must be kept manageable. To do this, insurers, employers and practitioners must work together to identify and use the most efficient treatment for the individual patient.

REFERENCES

1. Employee Benefit Plan Review, November 1988
2. Ibid.
3. Employee Benefits News, August 1988
4. Business Month, September 1987
5. The New York Times, Oct. 7, 1986
6. Health Cost Management, Vol. 4, No. 2, March/April 1987
7. Ibid.
8. Benefits News Analysis, Vol. 9, No. 5
9. Journal of Occupational Medicine, Oct. 1987, reported in Medical Benefits, Nov. 15, 1987
10. Health Cost Management, op. cit.
11. Hospitals, Sept. 20, 1986
12. The New York Times, op. cit.
13. Hospitals, op. cit.
14. Business Insurance, Sept. 29, 1986
15. Modern Healthcare, June 6, 1986
16. Business and Health, February 1987
17. Kansas City Business Journal, July 4, 1988
18. Business Insurance, May 23, 1988
19. American Demographics, November 1987
20. Hospitals, op. cit.
21. Ibid.
22. American Demographics, op. cit.

Claim Data from Aetna Life Insurance Company
Employee Benefits Division, 1988

1987 Psychiatric and Substance Abuse Confinements
Total Population (males, females/employees, dependents)
Complete and Incomplete Confinements

Ages	# lives	% adms	Days/1,000	ALOS	% days	% Exp.
00-18	2,124,158	24.7	225.1	40.2	39.9	41.8
19-34	2,139,537	31.7	158.3	22.1	28.3	27.1
35-49	1,880,649	25.3	119.6	18.4	18.3	18.7
50-64	1,305,013	13.8	91.6	17.9	10.0	9.9
65+	723,418	4.5	50.4	16.7	3.0	2.5
Total	8,172,775	100.0	146.6	24.8	100.0	100.0

5/89

Aetna LIFE & CASUALTY

NEWS

For Release:
Immediate

Contact: Judith Hyfield-Starr
(203) 636-2259

FACTS: EXAMINING HEALTH CARE COSTS

Health care costs are skyrocketing. People are living longer. They have access to more -- and costlier -- medical procedures than ever before. Their doctors, afraid of being sued, prescribe more tests and procedures. Diseases such as AIDS take their toll.

What's being done about the resulting cost spiral? One answer is a concept called managed care -- a partnership of the patient, doctor, employer and insurer working together to guide the use of health care resources.

***

WHAT'S HAPPENING?

• Americans now spend $500 billion a year on health care. That's 11.4 percent of the GNP, and nearly twice what the U.S. military spends.

• Last year, the annual medical inflation rate hit 7.3 percent, while general inflation was only 4.6 percent.

• Per capita health care costs were $2,135 in 1988, up from $822 in 1978.

WHY IS IT HAPPENING?

Scientific breakthroughs and technological advances. They've improved the quality of life but carry a steep price tag. Just one premature birth treatment or liver transplant is $150,000; a heart bypass - $40,000.

Governmental limits on Medicare and Medicaid health benefits. Providers make up the difference caused by such cost-shifting by charging higher fees to non-Medicare/Medicaid patients.

A recent surge in use of outpatient services. Outpatient care is encouraged, when possible, to decrease inpatient care costs. As a result, outpatient costs have jumped 25 percent.

Increased psychiatric admissions. As hospitals experienced a reduction in patients, they increased the number of psychiatric beds to accommodate growing mental health utilization.

AIDS. The average medical claim for AIDS is about $50,000 per person. By 1991, the number of new AIDS cases will be five times as great as in 1986, according to the Health Insurance Association of America.

WHAT ELSE IS CONTRIBUTING?

Health care fraud adds at least $50 billion to our nation's health care bill every year, according to the National Health Care Anti-Fraud Association.

A rapidly aging population means more people than ever will require medical care.

Increased diagnostic testing has resulted from the increases in malpractice judgments.

A nursing shortage has forced hospitals to raise salaries to attract and retain staff.

HOW DO WE SOLVE IT?

Managed care -- programs that bring together the doctor, patient, employer and insurer to guide the use of health care resources -- helps keep costs under control while maintaining quality care.

These programs encourage employees, providers, employers and insurers to work as partners in care, help employees become more educated health-care consumers and eliminate unnecessary treatment and hospitalization.

Aetna's managed care effort focuses on health care networks, primarily a partnership with Voluntary Hospitals of America, the nation's largest not-for-profit hospital system. It also includes various utilization review, case management and precertification programs, as well as a HEALTHLINE, a toll-free line that assists employees in making health care decisions.

Aetna LIFE & CASUALTY

NEWS

For Release:

Immediate

Contact: Judith Hyfield-Starr
(203) 636-2259

HARTFORD, Conn. -- Aetna Life & Casualty has introduced an outpatient precertification program designed to reduce health benefits costs for employers while improving the quality of patient care.

Similar to the standard inpatient hospital precertification, the program reviews the need for 18 expensive and frequently performed outpatient tests and procedures. It also offers financial incentives to employees to seek review of the procedures.

The program aims to reduce costs and decrease the number of unnecessary medical procedures by providing patients and their doctors with timely, expert information, according to Constance M. Winslow, M.D., medical director of Aetna's Employee Benefits Division. The program is expected to reduce use of the outpatient procedures 10 percent, resulting in benefits cost-savings for employers, she said.

"Outpatient costs are increasing dramatically," Winslow said. "Utilization management in the outpatient setting is problematic, but we believe this is a great first step."

Equally important, she said, is the wealth of medical information and expertise the program places at the doctor's fingertips.

(MORE)

2-2-2 Outpatient Precert

"There are many medical procedures available today and in far too many cases, a procedure is not appropriate for the situation," Winslow said. "A cross-checking system managed by nurses and doctors raises a patient's comfort level."

Under the program, employees call an Aetna nurse on the toll-free HEALTHLINE number if they are scheduled for one of the 18 outpatient procedures. The nurse obtains clinical information from the patient and attending physician, asking questions based on a computerized model of established medical standards. The system then either certifies the procedure or indicates that it may not be medically appropriate and warrants further review.

Cases requiring further review are discussed by the patient's doctor and an Aetna-designated physician, and most are resolved at this level. If agreement is not reached, however, the case is sent to an Aetna regional medical director for final review.

Review for each procedure is based on indications for use set forth in the medical literature and established by expert physicians or medical societies. Academically based consultants developed the review guidelines for each procedure.

The 18 procedures include: cataract removal, knee arthroscopy, inguinal hernia repair, septoplasty, tonsillectomy/adenoidectomy, hammertoe repair, colonoscopy, carpel tunnel, coronary angiography, laparoscopy, bunionectomy, upper GI endoscopy, tympanostomy, cystocopy, CT scan (lumbar), CT scan (head), D&C (dilation and curettage) and strabismus repair.

Aetna LIFE & CASUALTY

NEWS

For Release:

Immediate

Contact: Judith Hyfield-Starr
(203) 636-2259

HARTFORD, Conn. -- Aetna Life Insurance Co.'s health care cost-management programs saved its employee benefits customers $1.64 billion in 1988.

The savings -- representing 18.2 percent of medical and dental benefit payments -- are up nearly 12 percent over the 1987 total of $1.47 billion.

"We're pleased that our efforts to manage health care costs are paying off in so many areas and improving every year," said Burton E. Burton, president of Aetna's Employee Benefits Division.

The cost-management programs and their savings are as follows:

• Coordination of benefits, $1.15 billion in savings, up 3.5 percent. COB limits total benefit payments to no more than the total cost of health services when a patient is covered under more than one group benefit plan.

• Individual case management, $181 million in savings, up 49 percent. ICM seeks cost-effective alternatives to hospitalization, particularly for catastrophic cases requiring intense management.

(MORE)

2-2-2 Cost Savings

• Dental consultant review, $70 million in savings, up 20 percent. In this program, Aetna's dental consultants review cases before treatment or after claims are submitted to determine whether such treatment is necessary and whether less expensive alternate treatment is appropriate.

• Medical necessity retrospective review, $69 million in savings, up 68 percent. Under this program, claims are reviewed to ensure treatment was actually required, and was appropriate, for a specific condition. Coverage is denied for medically unnecessary treatment.

• Surgical profiles, $60 million in savings, up 28 percent. Reimbursement is limited to reasonable charges for surgery, based on prevailing fees for various procedures in 250 geographical areas around the country.

• Medical profiles, $49 million in savings, up 26 percent. This program is similar to surgical profiles, but covers certain medical treatment.

• Dental profiles, $28 million in savings, up 13 percent. Reimbursement is limited to reasonable charges based on prevailing fees for various dental procedures in 250 geographical areas around the country.

• Fraud investigations, $19 million in savings, up 68 percent. Aetna's fraud investigation unit targets potential cases of health care fraud and, when appropriate, refers them to law enforcement agencies for prosecution.

(MORE)

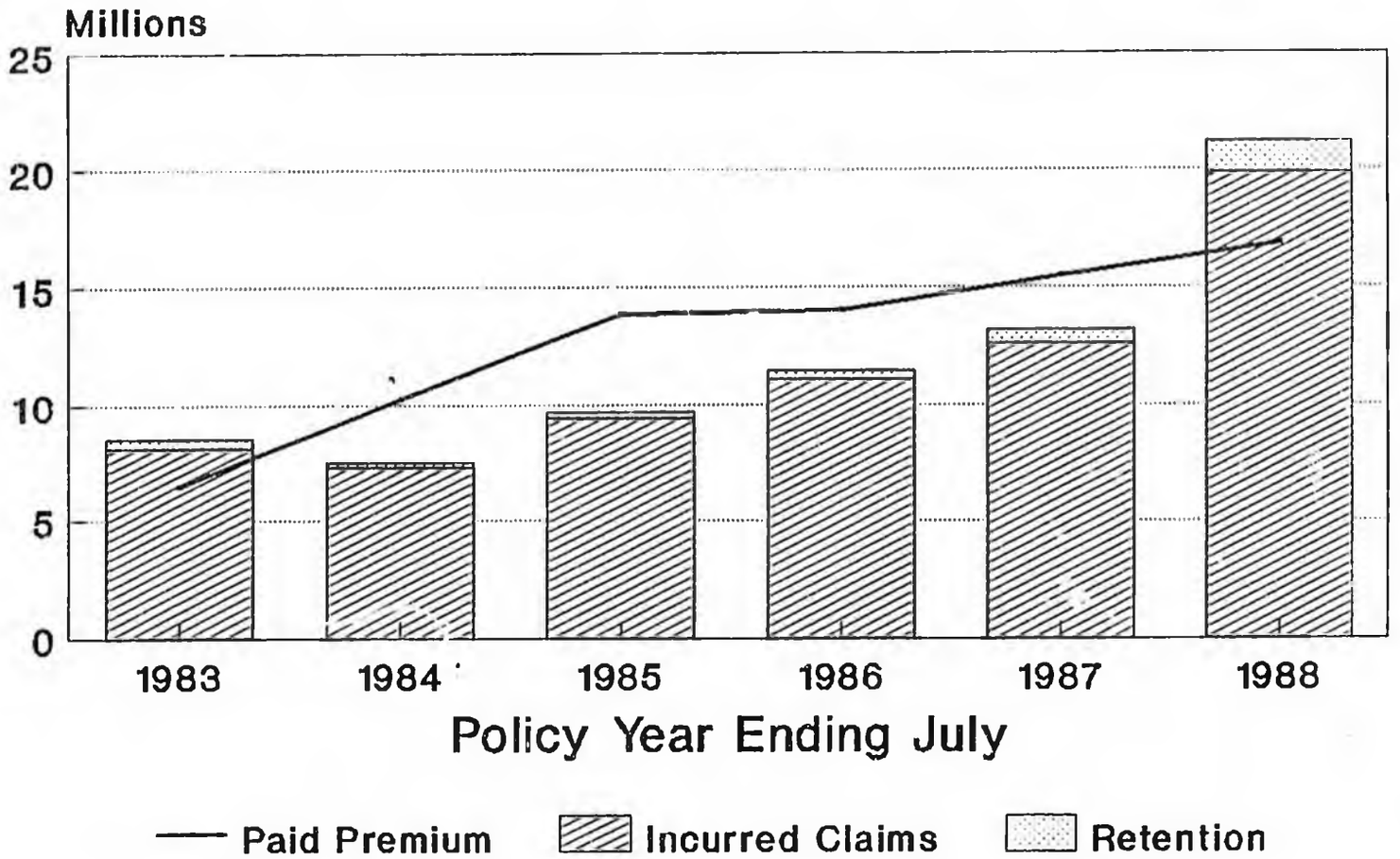
• Fast track, $9 million in savings, up 10 percent. In exchange for expedited claim handling, health care providers give Aetna a discount on payments.

• Hospital audits, $3 million in savings, up 29 percent. Using independent specialists, Aetna audits hospital bills to see that services on the statements were actually ordered by the physician, delivered by the hospital and used by the patient.

# # #

STATE OF ALASKA

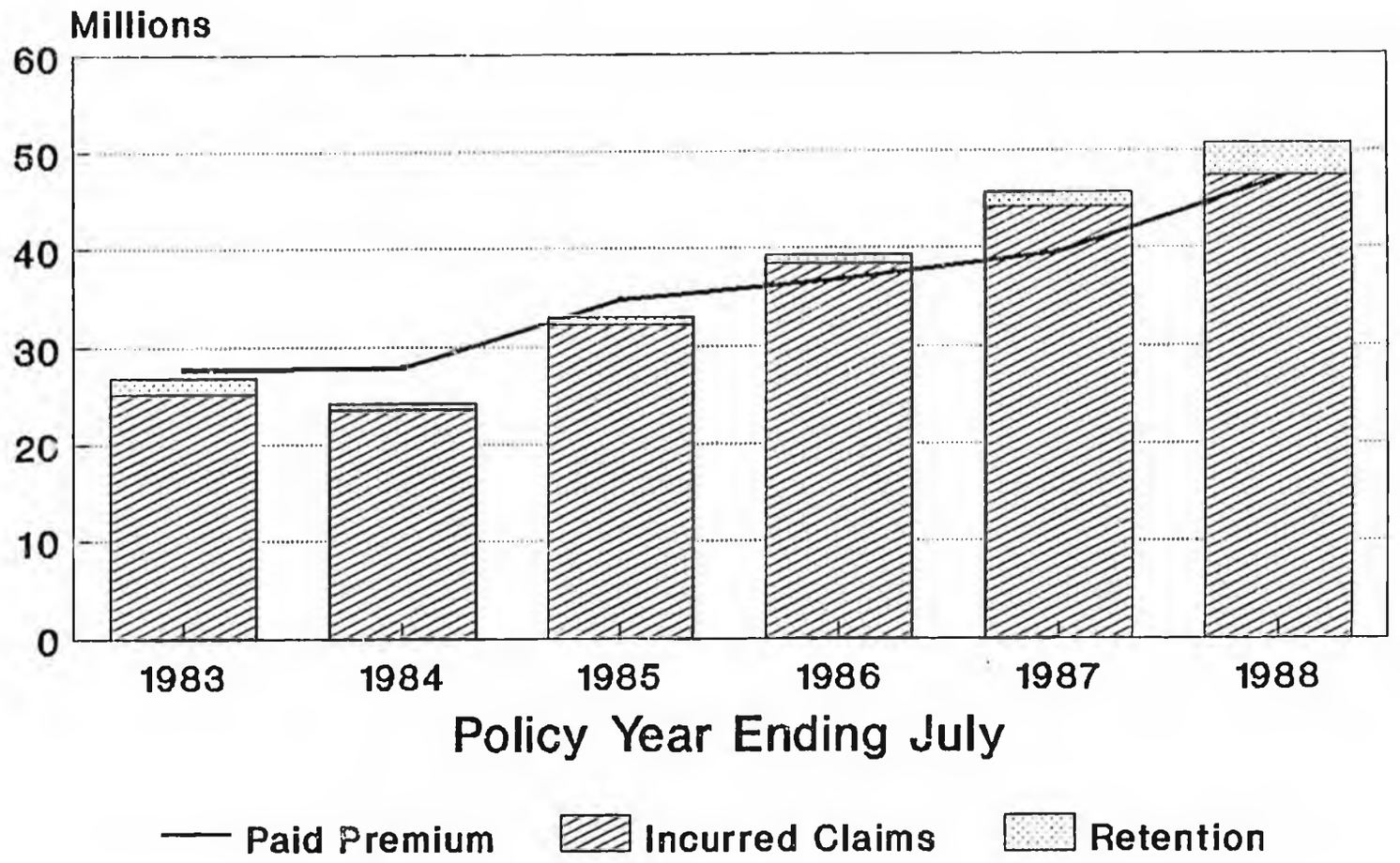
PREMIUM VS. INCURRED CLAIMS + RETENTION



RETIREES

STATE OF ALASKA

PREMIUM VS. INCURRED CLAIMS + RETENTION



ACTIVES

SB

78

FISCAL NOTE

STATE OF ALASKA
1991 LEGISLATIVE SESSION

BILL NO. SB 78

Revision Date: _____ Department Affected: Commerce & Economic Dev.

Title: An Act relating to capital and surplus requirements of domestic insurers and providing for an effective date

BRU: Insurance

Component: OPERATIONS /

Sponsor: Senator Adams

Requestor: Senator Adams

COMPONENT SERIAL NO. | | | | |

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY 92	FY 93	FY 94	FY 95	FY 96	FY 97
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	0	0	0	0	0	0
CAPITAL	0	0	0	0	0	0
REVENUE	0	0	0	0	0	0

FUNDING: (Thousands of Dollars)

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

POSITIONS:

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

Estimate of current year impact: _____

ANALYSIS: (Attach a separate page if necessary.)

No fiscal impact.

Prepared By: Donald P. Koch, Chief of Market Surveillance Phone: 465-2515

Division: Insurance Date: 2/7/91

Approved by Commissioner: Glenn A. Olds

Agency: Department of Commerce & Economic Development Date: 2/7/91

Distribution (by preparer): Legislative Finance, Legislative Sponsor, Requestor, OMB, & Impacted Agency(ies).

Rev 10/90
DK/dg18868D-1/020791a

Alaska State Legislature

Al Adams
District L

WHILE IN SESSION
P.O. Box V
State Capitol
Juneau, Alaska 99811
(907) 465-3707

OUT OF SESSION
P.O. Box 333
Kotzebue, Alaska 99752
(907) 442-3245

3111 C Street
Anchorage, Alaska 99503
(907) 561-7622

Official Business

TO: Senator Pearce, Chair
and members of the
Senate Labor and Commerce Committee

FROM: Senator Al Adams AA

RE: Senate Bill 78

DATE: February 8, 1991

This is to request a hearing on Senate Bill 78, " An Act relating to capital and surplus requirements of domestic insurers; and providing for an effective date."

This bill responds to an inadvertent problem created as a result of Senate Bill 212 (Chapter 50 SLA 1990) passed in the Sixteenth Legislature. In that legislation an elevation of the capital and surplus requirements for insurers admitted in Alaska was set too high for some insurers in the state. This bill stages the elevation of the working and surplus requirements so that those companies are relieved of the burden of immediate elevation.

The bill is supported by the division of Insurance and the Commissioner of Commerce and there are no fiscal impacts.

Following filing of this bill, an error was noted by our legal department. A committee substitute is included for your committee's consideration.

Included in your packet are:

- Committee substitute for SB 78
- Letter of support from the Department of Commerce
- Fiscal note
- Summary of Ch 50 SLA 1990 (Senate Bill 212)
- Letters of request and description of Umialik Insurance Company

POSITION PAPER

Department of Commerce
& Economic Development

CSSB 78(L&C) "An Act relating to capital and surplus requirements of domestic insurers; and providing for an effective date."

This Department is in favor of this legislation. Ch 50 SLA 1990 (SB 212) provided for a schedule of increases in the capital and surplus requirements for insurers admitted to write insurance in Alaska. This is to provide a larger financial cushion for a troubled insurer. Current levels at the time were insufficient. Unfortunately, that legislation is posing a considerable challenge for some insurers as they have a limited ability to come up with additional funds. This proposal offers some relief to those insurers by stretching the schedule out for an additional five years.

We recommend passage of this legislation

Spec. Asst.

Glenn A. Olds
Commissioner

February 7, 1991

Ukpeaġvik Iñupiat Corporation

January 14, 1991

Senator Adams
Box V
Juneau, Alaska 99811

Dear Senator Adams;

During the last Legislative Session Senate Bill 212 was passed. This Bill requires a domestic insurer such as Umialik Insurance Company to increase its additional working surplus to 5.25 million by January 1, 1992.

In our review of the insurance industry in Alaska, Umialik Insurance Company is the only domestic company affected by Senate Bill 212.

Last December Umialik Insurance Company had completed the working surplus requirement to 3 million.

I am requesting your assistance to relief this situation by way of a revisor bill.

Please find enclosed a copy of a letter from Tom Andritsch to our counsel David Case explaining the matter along with some recommended language on the same.

I would greatly appreciate your assistance on this matter.

Sincerely,

Ronald H. Brower Sr.
Ronald H. Brower Sr.
President

P.O. Box 427, Barrow, Alaska 99723 • (907) 852-4460 • Telefax (907) 852-4459

UMIALIK INSURANCE COMPANY

5300 "A" Street • Anchorage, Alaska 99518
(907) 563-3913 • FAX (907) 561-2292

JAN 1 1 1991

Mr. David Case P.C.
c/o Copeland, Landye,
Bennett and Wolf
550 West Seventh Ave.
Suite 1350
Anchorage, Alaska 99501

1/10/91

Re: Surplus Funding.

Dear David:

We had previously discussed the Senate Bill 212 passed in the last legislative session. This bill increased the amount we need for Additional Maintained Surplus By $2,250,000. The Bill also under section 84 & 86 gave us until January 1,1992 to get the funding.

I have had some correspondence with the Attorney General's Office and basically they stated the relief we are seeking should come by way of a revisor bill. I have also met with Mr. Dave Walsh our State Insurance Director who preferred to handle this matter administratively rather than change the bill to apply to everyone. You raised the question of where they get the authority to do this and apparently there is none.

This matter has now been referred to Mr Stan Garlington in the Insurance Department to work on. I have talked to Stan and the enclosed amendment to the bill will be introduced by the Department. If this matter is included with other Insurance legislation it may get lost in the shuffle. Stan also indicated that the status of Mr. Walsh is still not resolved under the new administration and the support from the Department may not be as strong as need be.

I would like to see our legislators back this bill or even file their own if need be. If the Insurance Department Bill contains other things that can not be supported we do not want this matter to die in a Committee or even loose. I am giving a copy of this letter to Mr. Ronald Brower today since he will be traveling to Juneau next week to meet with our legislators. I would appreciate your advice on this matter.

Sincerely,

Thomas A. Andritsch
President

cc. Mr Ronald Brower

For an Act entitled: An Act relating to examinations, fees, licenses, certificates, assets and liabilities, investments, and insolvency proceedings of insurers; immunity for persons performing activities related to insurance and for persons who report insurance fraud; changing Alaska Rules of Civil Procedure 19, 41, 62(a), and 65(c); changing Alaska Rules of Appellate Procedure 205,405, 511, 603, 606, and 611(d); and providing for an effective date.

OVERVIEW

The business of insurance is a dynamic, constantly changing business. The business of insurance is interstate commerce, however, unlike other forms of interstate commerce, it is regulated by the individual states. The most important concern of the individual states is that the consumer, both individual and business, be protected from an insolvency or impairment of an insurer. The concern with solvency is critical because insurance is an intangible product. It is concerned with whether the insurance company will be able to meet its obligations.

The statutes in the Alaska Insurance Code that provide this public protection mechanism were adopted in 1966 and are basically unchanged since that time. Events have occurred in this state and others which highlight the need to update, to upgrade and to clarify those laws. SB 212 is intended to accomplish that aim. The proposed changes have been substantially developed and adopted by the National Association of Insurance Commissioners.

In the Governor's transmittal letter for SB 212, six main points were listed. These were:

1. The minimum amount of capital and surplus required of an insurer wishing to do business has been increased. Capital and surplus provide the minimum amount of capitalization required to be an insurance company. This appears in several places throughout the bill and applies to admitted as well as non-admitted insurers. Minimum capital and surplus provides a tangible minimum floor on which to base solvency. When that floor is too low, it is considerably more difficult to detect problems in time to avoid loss to the public.

2. Reserving and reinsurance manipulations are a serious concern. The proposed changes strengthen our ability to determine whether adequate reinsurance or some other financial arrangement exists.

3. The investment chapter has been modernized to assure that the insurer's capital is not placed in weak or fraudulent investments.

SEE ALSO PGS 4 & 5

4. Reporting requirements are strengthened. Quarterly reports and electronic media reporting is enabled. The examination expense recovery provisions have been clarified, which will make it possible to examine more companies and more often.

5. Some insurers and licensee have used civil lawsuits as a means to deter insurance regulators from carrying out their duties. The bill extends immunity for civil liability to division of insurance personnel for carrying out their duties.

6. During a recent insurer insolvency, Alaska's delinquency proceeding statutes proved inadequate. This has been remedied in SB 212.

SB 212 is very lengthy and in some areas it is complex. It is very important that our regulatory mechanism be kept as up to date as possible. SB 212 does that.

DIRECTOR OF INSURANCE. **(Sections 1-7)**

Sections 1-7 pertain primarily to the director's ability to examine insurers and surplus lines brokers. The director may contract with independent examiners and may order the insurer or surplus lines broker to make direct payment to the contract examiner for the cost of examination. Formerly licensed insurers and surplus lines brokers may also be examined.

Participation is allowed by Alaska examiners in NAIC association examination of insurers that conduct the business of insurance in Alaska and other states. Civil immunity is provided to division personnel, agents of the division, regulators of other states, and NAIC staff in regard to the publication of and documentation of reports and in the exchange of regulatory information.

Section 1. AS 21.06.120(a). Examination of Insurers
Page 1, lines 17-27.

This section clarifies the director's ability to examine formerly licensed insurers and surplus lines brokers. Insurance contracts issued while the person was licensed many times continue to be in force after the person's license has terminated.

Section 2. AS 21.06.120. Examination of Insurers
Page 1, line 28 to page 2, line 5.

These new subsections specifically allow the division to participate along with insurance regulators from other states in the examination of an insurer located outside of Alaska. The director is also permitted to utilize contract examiners. Both of these functions have been assumed to exist under current statute but the clarification will avoid conflict with a differing opinion.

Section 3. AS 21.06.140(b). Conduct of Examination
Page 2, lines 6-14.

This section clarifies the director's ability to require that photocopies of documents requested during an examination be produced.

Section 4. AS 21.06.150(e). Examination Reports
Page 2, lines 15-21.

Changes in this section are primarily editorial in nature and provide that the director may withhold from public inspection any materials gathered as part of an examination if necessary for the protection of any person from unwarranted injury or if it is in the public's best interest.

Section 5. AS 21.06.160. Examination Expense
Page 2, line 22 to page 3 line 24.

Changes in this section make it clear that insurers are required to bear all costs of examinations and that the director can order an insurer to pay a contract examiner directly for its examination charges.

Section 6. AS 21.06.165. Immunity for Director and Others
Page 3, line 26 to page 4, line 7.

This is a new subsection that provides civil immunity for all division staff and insurance regulators in other states in regards to information and reports which are shared. However, immunity is not provided if there is reckless, willful, or intentional misconduct. This new section follows a National Association of Insurance Commissioners Model Immunity Act.

Section 7. AS 21.06.250. Fees and Licenses
Page 4, lines 8-17.

This change is editorial in nature. It is intended to avoid conflict with AS 21.06.160 which has been modified in Section 5.

AUTHORIZATION OF INSURERS. (Sections 8-19)

The format for insurer's financial statements is established to conform with the format adopted by the National Association of Insurance Commissioners (NAIC). The director may require that an insurer, in addition to the required annual financial reporting, file quarterly financial statements.

Foreign and alien admitted insurers are required to maintain the same financial requirements (capital and surplus) as Alaska domestic insurers. Minimum financial requirements (capital and surplus) for Alaska incorporated insurers are established if they wish to assume reinsurance ($10,000,000 at 12/31/90, $15,000,000 at 12/31/91, and $20,000,000 at 12/31/92). Domestic property or casualty insurers are prohibited from issuing life insurance or annuity contracts.

Section 8. AS 21.09.020(3). Exception, Certificate of Authority Requirement
Page 4, line 18 to Page 5, line 4.

This change is editorial in nature. It is to provide the correct cross reference, AS 21.34.

Section 9. AS 21.09.060. Combinations of Insuring Power in One Insurer
Page 5, lines 5-19.

A life and annuity insurer is barred from transacting a property or casualty business. The changes in this section clarify the reverse situation, that a property or casualty insurer is precluded from transacting life insurance or from issuing annuities.

Section 10. AS 21.09.070(a). Capital Funds Required of Foreign Insurers and New Domestic Insurers
Page 5, line 20 to page 7, line 10.

The amendments to this section are intended to provide for more stringent financial criteria for an insurer to become and remain licensed. The

additional surplus required to be maintained when first licensed is required to be maintained beyond initial licensure. Under existing law, the additional surplus could be siphoned off the day after the original certificate of authority was issued. The minimum amounts of capital and surplus have been increased.

Section 11. AS 21.09.070(b).
Page 7, lines 11-21.

This section allows the director to issue an order following a hearing, requiring an insurer to maintain funds required in AS 21.09.070(a) (see Section 10). Failure to maintain the ordered funds would be grounds for suspension or revocation of the certificate of authority.

Section 12. AS 21.09.070 (c).
Page 7, lines 22-26.

The repeal and reenactment of this section requires foreign or alien admitted insurers to maintain the currently required capital and surplus amounts. Under existing law, a foreign or alien admitted insurer need only maintain the amount required when first licensed even if that insurer was first licensed 25 years ago when the amounts required were substantially lower. Alaska domestic insurers have been required to meet the higher standards as adopted over the years. So, in effect, this amendment provides for equitable treatment both domestic and foreign or alien insurers.

Section 13. AS 21.09.070(f)
Page 7, line 27 to page 8, line 9.

This is a new section that establishes that a domestic insurer must possess policyholder surplus in adequate amounts in order to assume reinsurance. Policyholder surplus required is $10,000,000 at 12/31/90, $15,000,000 at 12/31/91 and $20,000,000 at 12/31/92. This requirement does not apply to intracompany pooling arrangements between affiliated insurers. A stronger financial position is required for a domestic insurer to get into the reinsurance business.

Section 14. AS 21.09.080 (a).
Page 8 lines 10-14.

The repeal and reenactment of this section requires domestic insurers to maintain the currently required capital and surplus amounts.

Section 15. AS 21.09.110(3). Application for Certificate of Authority
Page 8, lines 15-20.

This section is amended to include the requirement that quarterly financial statements as required by the director be attested to by at least two officers of the insurer or certified by the regulatory official of the insurer's state of domicile.

Section 16. AS 21.09.140(a). Mandatory Revocation, Suspension of Certificate
Page 8, line 21 to page 9, line 1.

Amendment to this section is necessary due to the change in AS 21.09.070(c) (see Section 12) requiring foreign insurers to maintain the current levels of policyholder surplus. Also, the more correct terms of "impaired" and "insolvent" have been substituted for "deficiency of assets". This section generally pertains to mandatory revocation or suspension of an insurer's license.

Section 17. AS 21.09.200(a). Annual Statement
Page 9, lines 2-17.

This section pertains to the format of the annual financial statement required by each licensed insurer. Amendment to this section provides for the adoption of the National Association of Insurance Commissioners (NAIC) format, which has been utilized historically. This promotes consistency in financial reporting in all states. Additionally, this section has been amended to allow the director to require that the financial statement be filed via electronic media (e.g. on computer disc).

Section 18. AS 21.09.200(f)
Page 9, lines 18-26.

This section requires all domestic insurers to also file their annual financial statements with the NAIC and to pay the appropriate fee to the NAIC. The purpose of this is that the NAIC has developed a data base for all insurers and provides analytical services to the various states. (Each state is linked by computer to the NAIC data base.) Eventually, it is expected that only one filing of the financial statement via electronic media will be filed with the NAIC. This would eliminate the need of a "hard copy" annual financial statement being filed in each state in which an insurer is licensed. This will be an expense savings. Also, it will provide for a more timely analysis of each financial statement.

Section 19. AS 21.09.205. Quarterly Statement
Page 9, line 27 to page 10, line 9.

This new section allows the director to require that NAIC formatted quarterly financial statements be filed with the division. A means is provided for more closely monitoring the financial well being of an insurer. Quarterly statements, when required, are due to be filed within 60 days after the end of a calendar quarter and a penalty of $100 per day for late filing is imposed.

KINDS OF INSURANCE, LIMITS OF RISK, AND REINSURANCE. (Sections 20-21)

In order to limit risk to meet with statutory requirements and sound business practices, insurers transfer risk to other insurers via reinsurance contracts. These sections provide the guidelines and parameters for an Alaska domestic insurer reinsuring its insurance contracts with reinsurers. Credit (reduced liabilities) is allowed in the financial statement for reinsurance ceded if done in accordance with the guidelines. The term "reinsurance" is defined.

Section 20. AS 21.12.020. Reinsurance Credit Allowed a Domestic Ceding Insurer
Page 10, line 10 to page 15, line 25.

In order to help protect their financial integrity and to meet the requirements that no more risk be retained in any one subject than 10% of its policyholders surplus, most insurers reinsure the insurance contracts they have underwritten. By appropriately passing this risk to a reinsurer, an insurer is allowed to reduce the liabilities for claim payments it is required to exhibit in its financial statement by an amount commensurate with the risk reinsured.

If a reinsurer becomes insolvent, all of the risk previously transferred falls back to the insurer. For that reason, it is important that standards exist for reinsurers that domestic insurers may transfer risk to and receive credit for the risk transferred in the form of reduced claim liabilities. The repeal and reenactment of this section provides the criteria for the reinsurers that domestic insurers may use and receive credit for in their financial statements.

Generally credit is allowed for reinsurance ceded by a domestic insurer to a reinsurer if:

1. the reinsurer is licensed in this state as in insurer;

2. the reinsurer is an accredited reinsurer in the state;

3. the reinsurer is domiciled in a state that employs standards for reinsurance substantially the same as Alaska and submits to examination by the division;

4. the reinsurer is an alien reinsurer that trustees specified amounts of funds in the United States and the trustees provide an annual accounting of the funds trusteed, and provides certification of its solvency by a independent auditor and the domestic regulator; or

5. the reinsurer does not meet any of the criteria in 1. through 4. above, then credit is allowed only if funds are trusteed in a form (cash, approved securities, or acceptable letters of credit) and for amounts corresponding to only the amount of funds trusteed.

This section also maintains the existing laws requirement that no credit for reinsurance is allowed if the reinsurance contract does not contain the classic "insolvency provision". The "insolvency provision' essentially provides that reinsurance will continue to be paid if due even if the ceding insurer were to become insolvent.

The director is also given the discretionary authority to require an insurer to provide information in regards to any material change in its reinsurance transactions.

Section 21. AS 21.12.120. Reinsurance Defined
Page 15, line 26 to page 16, line 3.

The term "reinsurance" is defined in this new section. This term was not previously defined in Title 21. The definition is intended to convey that a transfer of risk directly flowing from the underlying insurance contract is required to meet with this definition. It is necessary to define this term as other contractual arrangements between insurers have been reported as reinsurance when in fact the transactions are other financial arrangements having nothing to do with the transfer of the risk of the underlying insurance contract. Many such arrangements have been utilized due to recent changes in the federal income tax schema for insurers.

ASSETS AND LIABILITIES. **(Sections 22-27)**

These sections pertain to the basics in determining an insurer's solvency. It includes amended rules for determining which assets may be included and those which are specifically excluded in determining the asset base for an insurer. Requirements for the establishment of liabilities for the contractual

obligations of an insurer are included. A material change requiring title insurers to establish an unearned premium reserve is included. Also, the director may require a surety insurer to establish a special reserve for bail bonds or other single premium bonds that do not have a definite expiration date.

Section 22. AS 21.18.010. Allowable Assets
Page 16, line 4 to page 22 line 10.

This section has a number of general changes in defining the types of assets allowed in the determination of the insurer's ability to pay its liabilities.

Paragraph (1) is essentially the same as the existing Paragraph (1). The allowance of deposits in solvent savings and loan associations has been added . This adds alternative financial institutions to those already listed in the current law, such as banks and trust companies.

Paragraphs (2)(A)-(C) remain the same as the current law.

Paragraph (2)(D) essentially the same as the existing Paragraph (2)(D). The allowance of interest due or accrued on deposits in solvent savings and loan associations to complete its inclusion as an allowed depository above has been added .

Paragraph (2)(E) further defines allowable interest due or accrued as that earned on real estate mortgage loans which are allowed in the investments section of this title. Also changed is the exception that, when the interest or any taxes are overdue more than three months, none of the interest due or accrued may be allowed on that loan. This changes the exception in the current law from interest overdue 18 months to interest overdue for three months and includes the exception when taxes are overdue for three months. These modifications ensure that interest on only mortgages acceptable per this chapter are allowed and the exception eliminates those interest amounts not yet paid that may not be forthcoming.

Paragraph (2)(F) has been changed. It adds the requirement that, when collateral is accepted to guarantee the payment of rent more than three months overdue, the collateral must have a current market value that is at least 75% of the amount of total rent due. With this addition, when the current market value is less than 75% of the total rent due, the due and accrued rent cannot be allowed as an asset. This applies only when rent is more than three months overdue. All other due and accrued rent less than three months overdue is allowed as an asset without collateral as defined in current law.

Paragraph (2)(G) remains the same as the current law.

Paragraph (3) remains the same as the current law.

Paragraph (4) has been added to allow as an asset bills receivable for premiums and installment premiums for other than life insurance policies when the total of the receivable is not more than the unearned premium held for the policy and only when the payments are current.

This allows the insurance company to record premium receivable only when past payments have been made thereby showing a good chance that future payment will be received. The receivable is limited in that it cannot be more than the unearned premium held on the individual policy which ensures this is an ongoing policy that has some premium in reserve for future policy periods.

Old Paragraph (4) has been renumbered (5) and remains the same as the current law..

Old Paragraph (5) has been renumbered (6) and reformatted to add Subparagraph (A). To Subparagraph (A) has been added two subparagraph. These are regarding exemption from the limitation of allowing as assets only three months of premium in course of collection (less commissions) per policy.

Paragraph (6)(B) exempts reinsurance premiums from reinsurers authorized to do business in this state from this three-month limitation.

Paragraph (6)(C) allows as an asset more than three months of reinsurance premiums receivable from reinsurers when a corresponding liability is recorded by the reinsurance company but not when the amount due more than 90 days is more than 10% of the total assets reported in the last financial statement filed with the director. This helps to ensure the receivables are recognized by the reinsurer and the reinsurer has the ability to pay.

Paragraph (7) deals with premiums receivable less commissions payable from a person controlled by or controlling the insurer. This control is through ownership or by contract and when the person owes more than 50% of the insurer's premium in course of collection as reported in the financial statement.

In (7)(A), the premiums collected by the controlled or controlling person must be held in a trust account at a bank approved by the division. These funds must be kept separate from all other funds and paid only to the insurer or the insured. The investment income from the account can be allocated as the parties wish. All premiums collected by the controlled or controlling person must be deposited in the trust account within 5 working days. This ensures the receipt of premiums receivable by the insurer and reinforces the person's fiduciary responsibilities.

In (7)(B), the controlled or controlling person must provide a clean, unexpired irrevocable and unconditional letter of credit payable to the insurer for a term of at least one year which meets or exceeds the amount of the premiums payable to the insurer at any time. The letter of credit must have an automatic extension for one year unless the insurer has received 30 days prior to expiration written notice that the letter will not be renewed. The letter of credit must be issued by a Federal Reserve Bank and satisfactory to the division. This subsection is meant to ensure that premiums collected by a person controlled by or controlling an insurer will be available and paid to the insurer when due and, therefore, can be reported as an asset.

In (7)(C), the controlled or controlling person must provide a financial guaranty bond payable to the insurer for a term of at least one year which meets or exceeds the amount of the premiums payable to the insurer at any time. The guarantee bond must be of a continuous term and cancelable only when the insurer receives a 30 day written notice of termination with the bond continuing to cover any acts committed prior to the termination. The financial guaranty bond must be issued by an insurer authorized to transact business in Alaska, who is not related to the insurer or the purchaser of the bond and be satisfactory to the division. This subsection is meant to ensure that premiums collected by a person controlled by or controlling an insurer will be available and paid to the insurer when due and, therefore, can be reported as an asset.

In (7)(D), the premiums receivable from a controlled or controlling person can be allowed as an asset when a financial evaluation shows the person is solvent and able to pay. This financial evaluation can be called by the director and would be based on a review of books and records of the person.

Paragraph (8) is the same as Paragraph (7) of the existing law.

Paragraph (9) is the same as Paragraph (8) of the existing law.

Current law allows as an asset, amounts receivable by an assuming insurer when a solvent ceding insurer withholds funds under a reinsurance treaty. Paragraph (10), which is similar to Paragraph (9) of the existing law, has been amended to require the amount allowed as an asset not to exceed the amounts recorded as a liability by the assuming insurer for unpaid losses and reserves under the reinsurance treaty. This subsection requires that, when a ceding insurer withholds funds under a reinsurance treaty to guarantee the payment of amounts due, the assuming reinsurer may report these amounts withheld as an asset when they also have reported the payable as a liability. Any excess withheld over the liability may not be reported as an asset by the assuming insurer.

Paragraph (11) is the same as Paragraph (10) of the existing law.

Paragraph (12) defines the EDP equipment that is allowable as an asset. The asset can only be electronic data processing and related equipment and operating software that is a data processing, record keeping, or accounting system. The system must cost $50,000 or more and the cost must be depreciated fully (periodically charged to expense) over ten calendar years or less. The current law allows a system of $25,000 or more in cost, but the proposed law has increased this to $50,000 to ensure only true data processing systems are allowed as assets. The ten-year period for depreciation has not changed.

Paragraph (13) has been added to allow as an asset, receivables which arise from income tax allocations between organizations. These assets must stem from a tax allocation agreement which meets IRS regulations, describes the method of allocation, and sets a reasonable time for settling the balances receivable after filing of the tax return. The receivable must be due from a solvent organization that is not in default on its obligations and must meet all other requirements for admitted assets. The receivable must also have a related liability established by other organizations participating in the agreement. This Paragraph defines the requirements which must be met before a receivable based on a tax allocation can be allowed as an asset.

Paragraph (14) has been added to allow as an asset the effect of the excess of assets over liabilities on conversion to U.S. currency when the items are reported in foreign currencies. By way of explanation, if each of the asset and liability items is reported in foreign currency, this entry would convert the net total to U.S. dollars. If each individual line item is converted to U.S. dollars, the resultant gain or loss in foreign exchange rates is recorded on the statement of operations.

Paragraph (15) is added to allow as an asset only the unsecured receivable from a solvent affiliate that is not more than six months past due and where a related liability has been reported by the affiliates. This ensures that the receivable is recognized as a payable by the affiliate and payment will be made within six months.

Paragraph (16) allows as an asset, a receivable from a wholly or partially uninsured accident and health plan. This would arise from a self-insurance plan of the insurer.

Paragraph (17) is substantially similar to Paragraph (12) of the existing law. but revises the process that requires the approval of the director as necessary for the reporting of assets not specifically listed in this chapter of statutes. It is replaced with an allowance for those assets included in the annual statement form and consistent with instructions published by the NAIC (as approved by the director).

Paragraph (18) is the same as Paragraph (13) of the existing law.

Section 23. AS 21.18.030. Assets Not Allowed
Page 22, line 11 to page 23, line 25.

Subsections (a)(1)-(3) remain the same as the current law.

Subsection (a)(4) is amended to specifically exclude from assets tangible personal property, including but not limited to that listed in the current law. It is also amended to remove the broad exception that allows property permitted under AS 21.21 (Investments) but retains the exemption in 21.21.270 regarding acquisitions of property through the foreclosure of chattel mortgages. These amendments add a broad definition of the types of property that cannot be held and limits the exceptions included in AS 21.21.

Subsection (a)(5) remains the same as the current law.

Subsection (a)(6) excludes bonds and notes which are secured by mortgages or deeds or trust which are in default.

Subsection (a)(7) is added to exclude the payments of Alternative Minimum Tax or other tax refunds receivable from U.S. or state taxing authorities which are in dispute. This eliminates the recording as an asset of long-term tax receivables in dispute and noncollectible.

Subsection (a)(8) is added to exclude the amount of committed commissions where the present value of future commissions is paid in advance to agents.

Subsection (a)(9) is added to exclude as assets the forwarding of commissions and fees before the earning of these amounts by agents. These subsections exclude what would be a prepayment amount to agents that would be highly uncollectible for the payment of liabilities.

Subsection (a)(10) excludes unsecured loans from outside sources since these are unknown collection risks.

Subsection (b) requires that all assets which are not allowed because of doubtful value or character be deducted from the gross assets unless the director permits a reserve (liability) instead. This section requires a full reporting of assets held and deducting assets with questionable value to determine an insurer's ability to meet its contractual obligations.

Section 24. AS 21.18.060(a). Unearned Premium Reserve
Page 23, line 26 to page 24, line 1.

This subsection has been amended only to reflect editorial changes. No change in the existing law or intent has been undertaken.

Section 25. AS 21.18.060(b). Unearned Premium Reserve
Page 24, lines 2-28.

This subsection has been amended only to reflect editorial changes. No change in the existing law or intent has been undertaken.

Section 26. AS 21.18.073. Unearned Premium Reserve for Title Insurance
Page 24, line 29 to page 26, line 11.

This section is added to require reserves in addition to those required to pay losses for Title insurance. This is to take the form of a guaranty fund or unearned premium reserve and such funds cannot be used for general purposes. Investment of these funds is allowed and interest can be included in the insurer's general income. This reserve shall be calculated for: (1) policies issued after January 1, 1991 as 10% of premiums written in the calendar year which will be reduced by 5% for each of the next 20 years; and (2) policies issued before January 1, 1991 as $.30 per $1,000 face amount of all policies issued in the last ten years. No additional reserve of this type is required for policies issued more than ten years ago. This ensures sufficient assets to pay claims.

Section 26. AS 21.18.075. Bail Bond Reserve
Page 26, lines 12-19.

The director may require a reserve for bail bonds or other single premium bonds that are without an expiration date and furnished in judicial proceedings in the amount of 25% of total consideration charged for those bonds outstanding. This ensures sufficient reserves to pay claims and is in place of the unearned premium reserve required by AS 21.18.050.

Section 27. AS 21.18.120. Valuation of Bonds
Page 26, line 20 to page 27, line 10.

This section, in general, sets out the valuation of bonds that are allowed to be purchased and how they are to be recorded. It is amended to require the bonds be issued by a solvent entity and requires amortization of bond premium or discount.

Section 28. AS 21.18.900. Definitions
Page 27, line 11 to Page 28, line 5.

A new section has been added to define terms used in AS 21.18.

INVESTMENTS. **(Sections 29-50)**

The investment of an insurer's assets in appropriate and safe investments is important for continuing solvency. These sections extensively expand on the kind, quality, and amounts of investments allowed to be made by an insurer of its assets. The types of equities and investments have changed significantly in the last twenty years and the amendments bring recognition of these new investments and the rules for an insurer desiring to invest its assets in them.

Section 29. AS 21.21.020(c). Eligible Investments
Page 28, lines 6 - 9.

Changes simplify the language and delete the grandfathering necessary for the 1966 major redrafting of this chapter but which now, after 22 years, is not required.

Section 30. AS 21.21.030(c). General Qualifications
Page 28, lines 10 - 18.

Editorial changes in this Section accommodate changes made in Section 27.

Section 31. AS 21.21.030(d)-(e). General Qualifications
Page 28, line 19 - 29.

These modifications close a loophole in the law. Insurers can acquire otherwise ineligible assets by accepting these assets as payment under a contract of reinsurance. The new section requires the prior written approval of the director concerning a reinsurance contract being purchased substantially with ineligible assets. Should such a transaction have occurred without the prior approval of the director, the director is given a range of options for dealing with either the ineligible assets or the contract of reinsurance.

Section 32. AS 21.21.050. Diversification of Investments
Page 29, line 1 to page 31, line 11.

These changes exempt a new clan of securities from the general prohibition of lending based upon the credit of or investing in any one person or category of risk more than five percent of an insurer's assets. The new category is the general obligation of a state of the United States of America not insolvent and whose securities are not then in default. These securities are judged to be a

safe and prudent investments with the change allowing larger investments by Alaskan insurers in the securities of the State of Alaska.

An investment limitation designed to add to the safety and soundness of Alaska's domestic insurance industry is increased. Current law requires a dollar figure equal to a domestic insurer's minimum required capital to be invested in specified assets having a minimum of associated risk. The changes modify the minimum dollar amount to the higher of the previously specified minimum capital or one-half of the insurer's reported capital as shown on its most recent statement of financial condition filed with the director. The specified "minimum risk" assets are modified to require bank deposits to be fully insured or collateralized, and real estate mortgage loans are eliminated as a "minimum risk" asset.

Finally, the director is given the authority to consent to an insurer investing more than ten percent of its assets in common stocks which is the same authority granted the director in Subsections (5) and (7) which deal with corporate obligations and miscellaneous assets.

Section 33. AS 21.21.080. State, County, Municipal and School Obligations
Page 31, lines 12 - 24.

The amendments to this section require that more conservative investment choices be made by insurers in respect to investment in the obligations of the political subdivisions of a state or province. They eliminate, as an eligible investment, the obligations secured by a pledge or assignment of specific revenues of a political subdivision. This parallels the recent tightening done by the federal government with respect to tax exemption for the interest from industrial revenue bonds. Bonds which are payable only from a specific revenue source may carry the patina of safety associated with the political subdivision by whom they are issued but, in fact, are not required to be paid should the source of revenue fail, as would be the case, with a subdivision's general obligation bond. Revenue bonds of states and provinces and political subdivisions thereof continue as eligible investments under this chapter.

These changes further require that for obligations of states and political subdivisions to be eligible for investment, the associated state or province be:

(1) solvent;

(2) have the power to levy taxes for prompt payment; and

(3) not be in default on its obligations.

Section 34. AS 21.21.130. Inter-American Development Bank
Page 31, line 25 to Page 32, line 2.

This change adds the African and Asian Development Banks to the eligible list of development banks into which investments can be placed. Provisions regarding solvency and nondefault status are also added for eligibility. This section is contained in SB 353 by Senator Kelly which is in the House Labor and Commerce Committee.

Section 35. AS 21.21.140(a). Corporate Bond and Debentures
Page 32, lines 3 - 20.

Amendments to this section are to enhance the clarity of the language. The intent of the existing law is not altered.

Section 36. AS 21.21.140(b). Corporate Bond and Debentures
Page 32, line 21 to page 33, line 3.

Amendments to this section are to enhance the clarity of the language. The intent of the existing law is not altered.

Section 37. AS 21.21.140(c). Corporate Bond and Debentures
Page 33, lines 4 - 15.

Amendments to this section are to enhance the clarity of the language. The intent of the existing law is not altered.

Section 38. AS 21.21.140(d). Corporate Bond and Debentures
Page 33, lines 16 - 19.

Amendments to this section are to enhance the clarity of the language. The intent of the existing law is not altered.

Section 39. AS 21.21.150. Preferred or Guaranteed Stocks
Page 33, line 20 to page 34, line 12.

The changes to this section tighten up the eligible preferred or guaranteed stock investments by adding a nondefault requirement. Changes for the purpose of clarification are made with respect to the final year measurement of dividends during the immediate preceding two fiscal years.

Section 40. AS 21.21.160. Common Stocks
Page 34, lines 13 - 28.

This change tightens up the eligible common stock requirement by adding a nondefault requirement.

Section 41. AS 21.21.170(a). Insurance Stocks
Page 34, line 29 to page 35, line 4.

This change tightens up the eligible insurance stock requirement by adding a nondefault requirement.

Section 42. AS 21.21.190. Equipment Trust Certificates
Page 35, lines 5 - 12.

These changes are editorial only.

Section 43. AS 21.21.245. Pooled Investments
Page 35, lines 13 - 22.

Prior statute language was written before the advent of mutual funds, investment trusts, unit investment trusts and similar popular investment vehicles. This new section provides a statutory method for allowing and controlling a domestic insurer's use of these investment mechanisms by establishing a category titled "Pooled Investments."

It may be argued that any "pooled investment" that contains eligible securities should also be eligible for investment by insurers. This, however, is an extremely dangerous assumption which is best illustrated by example.

U.S. Government Securities are generally held to be the standard for a safe and sound conservative investment. Most U.S. government mutual funds also allow use of options and interest rate future's contracts which can either be highly speculative or income protecting ledger depending on their use. Thus, depending on the ranking of priorities in the pooled investment's investment objectives, the experience of the fund manager and other intent language in the registration documents, a pooled investment can on the surface appear to be conservative while, in practice, it is managed in a manner which puts the pooled investment at the opposite end of the safety and soundness spectrum, a result which would frustrate the legislative intent of this title.

Insurers should be allowed the use of pooled investment techniques because they lower risk through diversification and provide another source of professional funds management. This section's approach provides that

opportunity with a mechanism to avoid the risk of speculation and which "piggybacks" on the work of other regulators. Other changes dealing with how insurers will be measured with reference to adherence to the investment diversification and concentration prohibitions of this chapter and a method for treating currently held pooled investments after adoption of this section are also included.

Section 44. AS 21.21.270(b). Chattel Mortgages
Page 35, lines 23 - 29.

The change provided in this section pertains to an insurer's chattel mortgages and requires that appraisers hired to value an insurer's interest in a property must be independent of the insurer.

Section 45. AS 21.21.270(c). Chattel Mortgages
Page 36, lines 1 - 8.

The changes provided in this section pertains to an insurer's chattel mortgages and enhances an insurer's ability to place liens on personal property for the improvement of that insurer's collection efforts even when that lien is a property interest in what otherwise may be an ineligible investment.

Section 46. AS 21.21.280. Real Estate
Page 36, line 9 to page 39, line 25.

The first change in this section dealing with insurer-owned real estate clarifies how the maximum allowable investment will be measured.

Other changes enhance and clarify an insurer's authority to own real estate in excess of that which was previously allowed. Ownership of excess space for rent to others is newly authorized if such space is reasonably anticipated to be required for future expansion or in order to have a building that will be an economic unit. A provision is also made for insurers, under certain conditions, to hold real estate for the production of income with the prior approval of the director and only up to a maximum limit of five percent of the insurer's assets.

Section 47. AS 21.21.290(b).
Page 39, lines 26 - 29.

This editorial change merely amends a cross reference to statutes revised elsewhere in this legislation.

Section 48. AS 21.21.310(a). Failure to Dispose of Real Estate, Property or Securities
Page 40, lines 1 - 6.

This change, made for the purposes of clarification, specifies that assets required to be disposed of may not be allowed as an "admitted" asset for the purpose of determining an insurer's financial solvency.

Section 49. AS 21.21.350. Investment Transactions with Affiliated or Controlling Persons
Page 40, line 7 to page 41, line 15.

This new section provides for prudent rules for insurers to deal with investment transactions with affiliated or controlling persons. Before purchasing or selling an otherwise permissible investment issued by, due from or through the use of a broker who is an affiliated or controlling person or purchasing or selling either to or from same, an insurer must first disclose the facts and circumstances of the relationship fully to its board of directors. Once the insurer's board has the facts, they then are required to specifically authorize the transaction. Investments or loans are required to be at current market transfer prices or at commercially reasonable rates with the board being required to make that determination. Exceptions are provided for the board to rely on independent third party experts and to ignore transactions where the financial interest is nominal.

Section 49. AS 21.21.355. Certain Deposits Not Prohibited
Page 41, lines 16 - 25.

This addition clarifies that nothing in this chapter prohibits an insurer from making a deposit of its securities for the purposes of protecting the interests of its policyholders, or where it is necessary to secure permission to transact business or as collateral for the securing of any bond for the business of the insurer. These purposes generally are designed to protect the interests of the insurance consuming public and this change is an attempt to avoid inadvertently frustrating that objective.

Section 49. AS 21.21.360. Options and Futures Contracts
Page 41, line 26 to page 45, line 14.

Over the last decade, the U.S. financial markets have developed organized options and future contract markets. Proper use of these financial instruments when undertaken under a policy of hedging, as approved by an insurer's board of directors and prudently executed, can be an important part of reducing an insurer's overall investment risk. Reduction of investment risk

increases the safety and soundness of insurers and, thus, protects Alaska's insurance consuming public. There currently exists no mechanism under Alaska's Insurance Law which provides our domestic insurers with the opportunity to utilize options and future contracts.

This new section specifies that options and future contracts may be entered into by a domestic insurer if done under a policy of hedging an insurer's risk from market fluctuations approved by both the insurer's board of directors and the director.

With regard to valuation and accounting on the insurer's financial statements, this new section closely follows the model rule adopted by the National Association of Insurance Commissioners, Securities Valuation Office. Put options, call options, other stock options, stock purchase warrants and financial future contracts are all treated in some detail. Conservative valuation requirements, specified accounting treatments and consistency requirements are intended to mandate prudence.

Section 50. AS 21.21.600. Definitions
Page 45, line 15 to page 47, line 22.

This definitional section is highly expanded to clarify the technical terms utilized in AS 21.21. When possible, we have specified that certain definitions are to be consistently applied between this and other chapters of this title. An attempt has been made to rely on regulatory structures supervised by the federal government or the National Association of Insurance Commissioners where those regulatory structures have become the standards for the insurance industry and closely parallel the regulatory intent of this title.

SURPLUS LINES INSURANCE. (Section 51)

This section recognizes mutual protection and indemnity associations as nonadmitted insurers that may be classified as eligible surplus lines insurers. The financial requirements for an insurer to be included on the "white list" of eligible surplus lines insurers have been increased. The capital and surplus requirements are increased as well as the amount of assets required to be trusteed in the United States by alien insurers.

Section 51. AS 21.34.040(c). Eligible Surplus Lines Insurers Required
Page 47, line 23 to page 49, line 21.

The changes in this section generally are for the purpose of strengthening the financial requirements for a nonadmitted insurer to be declared an eligible insurer for the purposes of the lawful underwriting of surplus lines insurance under AS21.34. The policyholder surplus requirement for foreign insurers is increased to $6,000,000 at 12/31/90, $10,000,000 at 12/31/91, $12,500,000 at 12/31.92, and $15,000,000 at 12/31/93. The policyholder surplus requirements for alien insurers is the same as those above for foreign insurers. The amount of trusteed assets required in the United States for an alien stock or mutual insurer has been increased from $1,500,000 to $2,500,000. Additionally, the policyholder surplus requirement for an "insurance exchange" domiciled in another state has been increased from $15,000,000 to $50,000,000.

TRADE PRACTICES AND FRAUDS. (Section 52)

This section provides for civil immunity for a person that provides information to law enforcement officials, the NAIC, the Division of Insurance, or other states' insurance regulators pertaining to fraudulent insurance acts.

Section 52. AS 21.36.430. Immunity for Reports on Fraud
Page 49, line 22 to page 50, line 4.

This new section provides for civil immunity for any person reporting information covering suggested, anticipated, or completed fraudulent acts as long as the reporting does not entail reckless, willful, or intentional misconduct.

TITLE INSURANCE COMPANIES. (Sections 53-57)

The amendments found in these sections are to provide for the same treatment of title insurers as for other types of insurers in financial reporting and examination by the director. (The amendments mirror those found in Sections 5, and 17-19 of this Act which pertains to insurers other than title insurers.)

Section 53. AS 21.66.080. Annual Statement
Page 50, lines 5 - 23.

Amendments to this section prescribe that title insurers file the required annual financial statement in the format consistent with that adopted by the NAIC. The director may require that the annual financial statement be filed via electronic media. These amendments place the title insurers on the same financial reporting basis as other types of insurers noted in Section 17 of this Act.

Section 54. AS 21.66.080(b). Annual Statement
Page 50, lines 24 - 26

This Section requires Title insurers to file their annual financial statements with NAIC. This amendment is the same required of other types of insurers in Section 18 of this Act.

Section 55. AS 21.66.085. Quarterly Statement
Page 50, line 27 to page 51, line 7.

This new subsection allows the director to require that title insurers file quarterly financial statements on the same basis as for other types of insurers noted in Section 19 of this Act.

Section 56. AS 21.66.090(b). Application for Certificate of Authority
Page 51, lines 8 - 14 .

Amendment to this subsection clarifies that title insurers are responsible to pay the examination costs associated with the director's examination of any title plant associated with a title insurer.

Section 57. AS 21.66.130. Expenses of Examination
Page 51, lines 15 - 18.

The repeal and reenactment of this section provides for the payment of examination expenses associated with the director's examination of any title insurer on the same basis as that used for other types of insurers as revised in Section 5 of this Act.

ORGANIZATION AND CORPORATE PROCEDURES. (Section 58)

This amendment is editorial in nature. It replaces extensive verbiage relating to the description of financial impairment of an Alaska insurer with the term "impaired" which has now been defined by the Act in AS 21.90.900 (Section 81).

Section 58. AS 21.69.530 (a). Impairment of Capital or Assets
Page 51, lines 19 - 28.

Amendment to this section is editorial in nature. The full description for what impairment of an insurer means is removed and replaced by the term "impaired" which is defined in AS 21.90.900 (see Section 82) but also applies to this chapter.

REHABILITATION AND LIQUIDATION. (Sections 59-80)

Although extensive amendment is proposed, the basic intent of the existing law (AS 21.78) in regard to conducting the affairs of a financially impaired or insolvent insurer is unchanged. The procedures, requirements, and guidelines have been expanded and clarified so that the affairs of a financially troubled insurer can be conducted in an orderly and equitable manner without undue litigation.

Section 59. AS 21.78.020. Commencement of Delinquency Proceedings
Page 51, line 29 to page 53, line 15.

Although substantial amendment to this section has been undertaken, the basic intent remains unchanged. This section is clarified to clearly indicate that the director is the only person that may commence what amounts to a bankruptcy proceeding (rehabilitation or liquidation) for a domestic insurer. Additionally, this section provides that the director be the court appointed receiver and describes the jurisdiction of the court in these proceedings.

Section 60. AS 21.78.030. Injunctions and Orders
Page 53, line 16 to page 54, line 17.

The intent of this amended section remains the same in allowing the director to seek, without bond, orders or injunctions to prevent hypothecation, waste, dissipation or other inappropriate transfer of assets of a bankrupt insurer.