ALASKA LEGISLATURE COMMITTEE FILES 1995-1996 8672

8856 SENATE HEALTH EDUCATION & SOCIAL SERVICES

The following is a summary of the responses to the specific requests in your letter dated January 30, 1996:

Request 1. A quarterly breakdown of enrollees from the plan's inception.

	1993	1994	1995
1st Qtr.	0	93	150
2nd Qtr.	14	113	163
3rd Qtr.	36	129	181
4th Qtr.	64	128	184

Attachment 1 contains additional enrollment detail.

Request 2. Losses for each fiscal year of operation (1993 through 1995) and a projection for losses through the next three to five-year period.

	1993	1994	1995
Actual Losses	(118,698)	(245,433)	(1,615,239)

	1996	1997	1998
Projected Losses	(1.6 mi) to (2.1 mi)	(1.9 mi) to (3.0 mi)	(2.1 mi) to (4.1 mi)
Most Likely	(1.9 mi)	(2.5 mi)	(3.0 mi)

Request 3. A description of the type and amount of claims experienced and expected for the CHIA pool, given its mission.

Given that the mission of the pool is to provide health insurance coverage for individuals who are unable to obtain health coverage in the insurance market, the participants are more unhealthy individuals by design.

Attachment 2 shows each participant enrolled in the plan in December 1995 by diagnosis. The participants' names have been removed from the report. The claim risk numbers represent the average lifetime cost for a particular diagnosis. Therefore, these numbers do not necessarily represent the expected claim cost for the particular participant, since they do not include an individual evaluation of the participant's condition, costs already incurred or the fact that participants may leave the plan for any number of reasons, including death. This list clearly shows the fact that participants in the plan are, as a group, chronically ill, i.e., high risk.

Request 4. A breakdown of the assessments borne by CHIA member insurance companies.

Attachment 3 provides a breakdown of the billed assessments as provided by Aetna, the administrator of the plan.

Request 5. Aetna's percentage of CHIA assessment that is attributable to coverage of the State of Alaska Health Plans.

According to Aetna, 83 percent of their portion of the CHIA plan assessments is attributable to the State of Alaska health plan. As shown in Attachment 3, Aetna's assessment to date was about $800,000. Of this, approximately $664,000 was due to the State of Alaska health plan.

Request 6. The impact on remaining carrier assessments if the state health plan premium was no longer included in the CHIA assessment base.

Removing the State of Alaska health plan from the assessment base would have increased the remaining carrier's assessments from about .5 percent of premium to about .8 percent of premium.

Request 7. The amount of premium taxes collected by the state in 1995 broken down by property/casualty and health insurance categories.

Premium tax numbers for 1995 are not yet available. Premium taxes are due and payable March 1 of each year. Also, premium tax numbers are not available exclusively for health insurance. The 1994 premium tax breakdown by category:

CATEGORY	TAX
Life/Health	$9.0 mi
P/C	$18.5 mi
Other	$1.4 mi

Health insurance premiums represent about 65 percent of the total life and health insurance premiums in the state. Using this approximation, about $5.9 mi of the $9 mi premium tax in 1994 would have been paid on health insurance premiums.

Request 8. Any information which is available on the relative losses of other states which have enacted high risk pools and on the size of those markets over which losses are spread.

Attachment 4 provides this information for 1994 (latest available).

Request 9. Information relating to any statute or regulation that addresses the possibility or likelihood of health insurance carrier of standard risk coverage from narrowing the scope of eligibility or continuing coverage thereby encouraging those insured to pursue coverage through the high risk pool.

The only statutes or regulations that would address this issue would be Alaska Statute (AS) 21.55.300 which determines the eligibility requirements for enrollment in the plan and AS 21.56.150 which requires that an insurer provide coverage to all individuals in a small employer group.

Requests for recommendations:

Please note that these options may not result in any additional savings and some may just defer the costs. Plans, such as the CHIA plan, are not designed, in general, for premiums to cover the costs.

1. **Administrative action which would result in a reduction in the claim expense/loss ratio:**

   The Board of Directors of the CHIA has explored all administrative actions available under present statutes. The Board is negotiating with the administrator, Aetna, to provide a dedicated case manager and voluntary PPO.

ACTION	RESULT
Voluntary PPO	6% of claims
Dedicated Case Manager	7.5% of claims
Premium Increase at 175% of standard	4.5-6.0% of claims*
OR	
Premium Increase at 200% of standard	8-11% of claims*

*It is important to balance the rate increase with the potential loss of the healthier individuals. As premiums go up, healthier participants tend to leave plan, thus, decreasing premiums collected and driving cost per participant up.

2. **Legislative actions which would result in an improvement in claim experience through plan design changes and cost management strategies.**

ACTION	RESULT
Allow greater flexibility in selecting an administrator and negotiating the administrative contract.	See Attachment 5. Alaska's administrative cost per participant is the second highest in the nation or almost three times the national average. Potential savings of $200,000 to $300,000 per year.
Increase 6 month preexisting waiting period to 12 months	Although $640,000 in claims were paid in 1995 before a 12-month period elapsed and 6 additional months of premium collected before a claim is paid, claims may eventually be paid and in some cases an even higher amount would be paid due to potential increased severity.
Reduce lifetime maximum to $250,000	Potential unquantifiable long term savings, as of December 1995 would have saved $40,000. Additionally, the costs over the $250,000 will be incurred. In many cases, the payor will be the state through medical assistance.
Increase out of pocket maximum to 5 times deductible. Currently $2,000 for 200, 500 and 1500 deductible plans.	Would have resulted in $100,000 savings from inception
Minimum deductible of $1500	Would have resulted in a maximum $44,000 savings from inception
Lower coinsurance from 80% to 70%	Would have resulted in a maximum $45,000 savings from inception
Lower coinsurance from 80% to 70% and institute a mandatory PPO	Would allow greater savings from the voluntary PPO of an additional 6%, due to greater incentive to use the PPO.
Although the following actions would not result in cost savings, they would add clarity and greater efficiency:	
Change "writing carrier" to "administrator" and change 21.55.400 and 21.55.500 to be consistent with this change	Clarifies role of the administrator
Remove "actuarial soundness" requirement in AS 21.55.150(a)	Contradicts the 200% rate limit

Allow rates to be developed based on the standard rates for insurers with 80% of market share up to 5 insurers.

Since there are few insurers in the state who write individual health insurance, the requirement to base rates on 5 insurers results in the use of rates for insurers who do not actually write health coverage similar to the state plan.

3. **Please advise us if it is possible for the CHIA Board of the Division of Insurance to place a temporary moratorium on new enrollees in order to reduce the magnitude of losses during the time it takes to adopt a plan that will place the CHIA program on more solid footing. Given the current trend, what savings would likely result from a one year moratorium? In conjunction with other short-term changes, would a moratorium serve as an effective temporary means to insure the viability of CHIA?**

We have been advised by the Attorney General's office that AS 21.55.300 does not allow the board or the division to impose a moratorium.

Only 3 percent ($60,000) of claims paid in 1995 were from participants who enrolled in 1995. This is probably due to the six-month waiting period. Therefore, in the short-term, few savings would probably result from one year moratorium and, in the long-term, the savings are negated or costs are increased.

Assuming a policy decision to provide health coverage to individuals who are not otherwise insurable on a premium for coverage basis, there are few options for funding available. Alaska presently spreads the cost to people who have coverage through insurance. Cost containment options are limited at best as the board and other states have found out.

As indicated in Attachment 6, the Alaska CHIA losses are at a level consistent with other states who have enacted similar legislation. The design of these plans, in general, result in premium rates insufficient to cover the losses. We welcome any opportunity to discuss the challenges further.

Very truly yours,

Marianne K. Burke
Director
Division of Insurance

MKB/KC/pb146.ins
0212296c
Enclosures

ATTACHMENT 1

Comprehensive Health Insurance Association
Enrollment Listing

1993		1994		1995		1996	
Date	Number of Members	Date	Number of Members	Date	Number of Members	Date	Number of Members
Jan-93	0	Jan-94	70	Jan-95	139	Jan-96	192
Feb-93	0	Feb-94	82	Feb-95	143		
Mar-93	0	Mar-94	93	Mar-95	150		
Apr-93	5	Apr-94	96	Apr-95	155		
May-93	10	May-94	108	May-95	159		
Jun-93	14	Jun-94	113	Jun-95	163		
Jul-93	19	Jul-94	116	Jul-95	172		
Aug-93	25	Aug-94	123	Aug-95	183		
Sep-93	36	Sep-94	129	Sep-95	181		
Oct-93	44	Oct-94	131	Oct-95	185		
Nov-93	60	Nov-94	135	Nov-95	191		
Dec-93	64	Dec-94	128	Dec-95	184		
Average	23	Average	110	Average	167	Average	192

ATTACHMENT 2

CHIA RESERVE ESTIMATES DECEMBER 1995	
DIAGNOSIS	CLAIM RISK
KIDNEY FAILURE	100,000
CHRONIC GLOMERULONEPHRI .IS	50,000
BIRTH DEFECT/BREAST DISEASE	3,000
DIABETES	25,000
NERVOUS/EMOTIONAL COND.	25,000
DIABETES	25,000
PITUITARY TUMOR	5,000
CYSTIC FIBROSIS	50,000
MITRAL VALVE PROLAPSE	5,000
QUADRIPLEGIA	50,000
PSORIASIS	1,000
BY PASS HEART SURGERY	10,000
MULTIPLE SCLEROSIS	25,000
ARTERIAL VENOUS MALFORMATION	30,000
RHEUMATOID ARTHRITIS	40,000
CEREBRAL PALSY	10,000
GROWTH HORMONE DEFICIENCY	TERMINATED
SARCOIDOSIS	TERMINATED
LEUKEMIA (ACUTE)	30,000
CHRONIC MYELOGENOUS LEUKEMIA	TERMINATED
HEART CONDITION	50,000
HEIGHT/WEIGHT RATIO	2,000
HEART VALVE TRANSPLANT	50,000
SPINA BIFIDA	5,000
WOLF-PARKINSON WHITE SYNDROME	TERMINATED
BACK PROBLEMS	TERMINATED
HODGKIN'S DISEASE	30,000
DIABETES	25,000
A.L.L. LEUKEMIA	300,000
GROWTH HORMONE DEFFICIENCY	20,000
CHRONIC RESPIRATORY CONDITION	20,000
HEART CONDITION	50,000
DIABETES/ULCERS/WEIGHT	50,000
BREAST CANCER	25,000
ATRIAL SEPTAL DEFECT	40,000
CROHN'S DISEASE	30,000
DIABETES	25,000

ATTACHMENT 2

WEIGHT/HIGH BLOOD PRESSURE	5,000
ABNORMAL PAP TEST	5,000
PREGNANCY	10,000
DIABETES/RETINOPATHY	50,000
PREGNANCY	10,000
LIVER TRANSPLANT	TERMINATED
CELIAC DISEASE	10,000
CEREBRAL HEMORRHAGE/KIDNEY STONE	30,000
CYSTIC FIBROSIS	150,000
DIABETES	25,000
CYSTIC FIBROSIS/ASTHMA	30,000
ELEVATED LIVER FUNCTION	0
KIDNEY STONES & GASTRITIS/CHRO	20,000
MYELOMA	100,000
PREGNANCY	TERMINATED
DIABETES	25,000
MARFAN SYNDROME	25,000
HEIGHT/WEIGHT RATIO	2,000
DIABETES	25,000
SEIZURE DISORDER	5,000
AVASCULAR NECROSIS	40,000
SEVERE ANXIETY/PANIC DISORDER	25,000
MARFAN SYNDROME	200,000
HEART ATTACK	TERMINATED
HYPEREXTENDED KNEE	15,000
DIABETES	25,000
ULCERATIVE COLITIS	30,000
HEIGHT/WEIGHT RATIO	2,000
DIABETES	25,000
ULCERATIVE COLITIS	30,000
ATTEMPTED SUICIDE	25,000
BYPASS SURGERY/COR. ART. DIS.	1,000
VALVE REPLACEMENT/MARFAN'S SYND.	50,000
DRUG/ ALCOHOL ABUSE	40,000
DIABETES	25,000
REFRACTORY ANEMIA/ULC. COLITIS	40,000
SYSTEMIC LUPUS ERYTHEMATOSIS	30,000
PITUITARY GLAND	50,000
KIDNEY STONES	25,000
HEART CONDITION	50,000
KIDNEY DISORDER/COLON SURGERY	100,000
ENDOGENOUS DEPRESSION	25,000
MENINGIOMAS	75,000
ANKYLOSING SPONDYLITIES	10,000

ATTACHMENT 2

HODGKIN'S DISEASE	50,000
MYOCARDIAL INFARCTION	10,000
DIABETES	25,000
PARKINSON'S DISEASE	10,000
CYSTIC FIBROSIS	30,000
CYSTIC FIBROSIS	30,000
ASTHMA	5,000
SARCOIDOSIS	30,000
RHEUMATOID ARTHRITIS	10,000
HEART ARRYTHMIAS	30,000
DIABETES	25,000
KIDNEY STONES/TRIPLE BYPASS	15,000
HIV POSITIVE	75,000
WEIGHT/NODULE ON PROSTATE	30,000
LUNG SURGERY / ANGINA	TERMINATED
OVERWEIGHT	2,000
MULTIPLE SCLEROSIS (MIDDLE THIRD)	25,000
DIABETES	25,000
ANGINA/HEART ATTACK/TRIP BY-PASS	20,000
ALVEOLAR BONE GRAFT	10,000
ANGIOPLASTY/HEART	10,000
ARTHRITIS/PROSTATE CANCER	35,000
HOLE IN HEART/EPSTEIN'S DISEASE	40,000
PRE-EXIST. HEART CONDITION	10,000
BORDERLINE DIABETES	20,000
FIBROID TUMOR	15,000
HYPERTENSION	5,000
BI-POLAR DISORDER/LITHIUM THERAPY	30,000
ULCERATIVE COLITIS	30,000
HEMOPHILIA	100,000
DIVERTICULITIS	25,000
HEART CONDITION	50,000
HEART MURMUR	25,000
HEART ATTACK	10,000
DIABETES/HEART BYPASS SURGERY	20,000
WEIGHT/ THYROID	5,000
ISLET CELL CANCER/DIABETES	25,000
AMITRIPTYLINE FOR SLEEP DISORDERS	5,000
DIABETES	25,000
BREAST CANCER	25,000
CROHN'S DISEASE	30,000
RHEUMATOID ARTHRITIS	40,000
MANIC DEPRESSION	30,000
ARTHRITIS OF THE HIPS	45,000

ATTACHMENT 2

DIABETES	25,000
CEREBRAL PALSY	10,000
EPILEPSY	5,000
HEIGHT/WEIGHT RATIO	2,000
HEIGHT/WEIGHT RATIO	2,000
BIPOLAR DISORDER/DIABETES	50,000
HEART CONDITION	50,000
ANKYLOSING SPONDYLITIS	20,000
HEIGHT/ WEIGHT RATIO	2,000
HEPATITIS C	15,000
HYPERTENSION	5,000
PREVIOUS HEART ATTACKS	50,000
ALCOHOL ABUSE	25,000
BONE MARROW CANCER	200,000
ALCOHOL TREATMENT	25,000
DIABETES	25,000
CROHN'S DISEASE	30,000
WEIGHT/HEIGHT RATIO HYPERTENSON	5,000
CEREBRAL PALSY	10,000
THYROID CANCER	10,000
MULTIPLE SCLEROSIS	25,000
DIABETES MELLITUS II/ KIDNEY DISEASE	150,000
HYPERTENSION/DIABETES	TERMINATED
PARKINSON'S DISEASE	10,000
MULTIPLE SCLEROSIS/ OBESITY	25,000
COLON CANCER	50,000
DIABETES	25,000
HEART CONDITION	50,000
HIGH BLOOD PRESSURE	5,000
HIGH BLOOD PRESSURE	5,000
DIABETES	25,000
END STAGE RENAL DISEASE	150,000
KIDNEY FAILURE	150,000
KIDNEY FAILURE	150,000
KIDNEY FAILURE/ON DIALYSIS	150,000
LUPUS & KIDNEY FAILURE	150,000
CONGESTIVE HEART FAILURE/KIDNEY	150,000
KIDNEY FAILURE	150,000
KIDNEY FAILURE	150,000
CANCER/SPINAL SURGERY TWICE	30,000
KIDNEY FAILURE	150,000
KIDNEY FAILURE/DIABETES	150,000
END STAGE RENAL DISEASE	150,000
KIDNEY FAILURE	150,000

ATTACHMENT 2

KIDNEY STONES/TRIPLE BYPASS	10,000
KIDNEY FAILURE	150,000
DEPRESSION	35,000
ASTHMA (USES OXYGEN)/HYPERTENSION	40,000
KIDNEY FAILURE	150,000
KIDNEY FAILURE/ DIABETES	150,000
MULTIPLE SCLEROSIS	25,000
BONE CANCER	150,000
MENTAL RETARDATION	5,000
KIDNEY FAILURE	150,000
ANGINA	50,000
MENINGIOMAS	20,000
DIABETES/STROKE	50,000
HEART DISORDER	50,000
PROSTATE CANCER	15,000
DIABETES/HEART DISEASE	50,000
DIABETES	25,000
HEART CONDITION	50,000
HEIGHT/WEIGHT RATIO	2,000
HEART DISORDERS	50,000
GLYCOGEN METABOLISM	100,000
DIVERTICULOSIS	10,000
HEART CONDITION	50,000
BI-POLAR ILLINESS	30,000
PREGNANCY	10,000
CROHN'S DISEASE	30,000
KIDNEY CANCER	40,000
PROSTATE CANCER	50,000
HEIGHT/WEIGHT RATIO	2,000
HYPERTENSION/BUILD	5,000
ULCERATIVE COLITIS	30,000
OVERWEIGHT	2,000
NEUROFIBROMATOSIS	25,000
SUBSTANCE ABUSE	25,000
HEART DISORDER	50,000

Total $8,235,000

195 cc's

ATTACHMENT 3

Comprehensive Health Insurance Association
Assessment Listing

COMPANY NAME	CURRENT DIRECT PREMIUMS WRITTEN	CURRENT MARKET SHARE	*12/29/95 Assessment Amount*	*Approximate 8/4/95 Assessment Amount*	*Approximate 11/1/93 Assessment Amount*	*Approximate 2/9/93 Assessment Amount*	*Approximate Total Assessments to Date*
AAA Life Ins Co.	16,000	.0042%	$51	$23	$10	$3	$87
Academy Life Ins Co.	14,000	.0037%	$45	$20	$9	$3	$76
Aetna Life Ins. Co.	147,193,000	39.0149%	$468,179	$214,582	$89,734	$27,310	$799,805
Alexander Hamilton Life Ins. Co.	8,000	.0021%	$25	$12	$5	$1	$43
All American Life Ins. Co.	10,000	.0027%	$32	$15	$6	$2	$54
Allianz Life Ins. Co. of North America	828,000	.2195%	$2,634	$1,207	$505	$154	$4,499
American Chambers Life Ins. Co.	608,000	.1612%	$1,934	$886	$371	$113	$3,304
American Fidelity ASR Co.	63,000	.0167%	$200	$92	$38	$12	$342
American Franklin Life Ins. Co.	2,000	.0005%	$6	$3	$1	$0	$11
American Heritage Life Ins. Co.	213,000	.0565%	$677	$311	$130	$40	$1,157
American Life Ins. Co. of New York	7,000	.0019%	$22	$10	$4	$1	$38
American National Ins. Co.	17,000	.0045%	$54	$25	$10	$3	$92
American National Life Ins. Co. of TX	6,000	.0016%	$19	$9	$4	$1	$33
American Republic Ins. Co.	9,000	.0024%	$29	$13	$5	$2	$49
American Service Life Ins. Co.	1,000	.0003%	$3	$1	$1	$0	$5
American United Life Ins. Co.	2,000	.0005%	$6	$3	$1	$0	$11
Ameritas Life Ins. Corp.	253,000	.0671%	$805	$369	$154	$47	$1,375
Amex Life Assurance Co.	272,000	.0721%	$865	$397	$166	$50	$1,478
Anthem Life Ins. Co.	13,000	.0034%	$41	$19	$8	$2	$71
Balboa Life Ins. Co.	20,000	.0053%	$64	$29	$12	$4	$109
Banker Life & Cas Co.	172,000	.0456%	$547	$251	$105	$32	$935
Bankers Security Life Ins. Society	19,000	.0050%	$60	$28	$12	$4	$103
Bankers United Life Assurance Co.	1,000	.0003%	$3	$1	$1	$0	$5
BCS Life Ins. Co.	9,000	.0024%	$29	$13	$5	$2	$49
Beneficial Standard Life Ins. Co.	15,000	.0040%	$48	$22	$9	$3	$82
Berkshire Life Ins. Co.	3,000	.0008%	$10	$4	$2	$1	$16
Best Life Assurance Co. of CA	541,000	.1434%	$1,721	$789	$330	$100	$2,940
Blue Cross of Washington and Alaska	134,401,000	35.6242%	$427,491	$195,933	$81,936	$24,937	$730,297
Boston Mutual Life Ins. Co.	40,000	.0106%	$127	$58	$24	$7	$217
Business Mens Assurance Co.	20,000	.0053%	$64	$29	$12	$4	$109

ATTACHMENT 3

COMPANY NAME	CURRENT DIRECT PREMIUMS WRITTEN	CURRENT MARKET SHARE	*12/29/95 Assessment Amount*	*Approximate 8/4/95 Assessment Amount*	*Approximate 11/1/93 Assessment Amount*	*Approximate 2/9/93 Assessment Amount*	*Approximate Total Assessments to Date*
Capitol American Life Ins. Co.	109,000	.0289%	$347	$159	$66	$20	$592
Celtic Life Ins. Co	134,000	.0355%	$426	$195	$82	$25	$728
Centennial Life Ins. Co.	13,000	.0034%	$41	$19	$8	$2	$71
Central Security Life Ins. Co.	1,000	.0003%	$3	$1	$1	$0	$5
Central States H & L Co. of Omaha	79,000	.0209%	$251	$115	$48	$15	$429
Certified Life Ins. Co.	28,000	.0074%	$89	$41	$17	$5	$152
Chrysler Life Ins. Co.	(1,000)	-.0003%	($3)	($1)	($1)	($0)	($5)
Chubb Life Ins. Co. of America	17,000	.0045%	$54	$25	$10	$3	$92
Citicorp Life Insurance Co.	42,000	.0111%	$134	$61	$26	$8	$228
Colonial Penn Life Ins. Co.	8,000	.0021%	$25	$12	$5	$1	$43
Combined Ins. Co. Of America	399,000	.1058%	$1,269	$582	$243	$74	$2,168
Commercial Life Ins. Co.	25,000	.0066%	$80	$36	$15	$5	$136
Commercial Travelers Mutual Ins. Co.	115,000	.0305%	$366	$168	$70	$21	$625
Congress Life Ins. Co.	38,000	.0101%	$121	$55	$23	$7	$206
Connecticut General Life Ins. Co.	890,000	.2359%	$2,831	$1,297	$543	$165	$4,836
Continental General Ins. Co.	38,000	.0101%	$121	$55	$23	$7	$206
Continental Life Ins. Co.	1,000	.0003%	$3	$1	$1	$0	$5
Country Life Ins. Co.	36,000	.0095%	$115	$52	$22	$7	$196
Cuna Mutual Ins. Society	1,655,000	.4387%	$5,264	$2,413	$1,009	$307	$8,993
Equitable Life & Casualty Ins. Co.	8,000	.0021%	$25	$12	$5	$1	$43
Equitable Life ASR Soc of the US	400,000	.1060%	$1,272	$583	$244	$74	$2,173
Federal Home Life Ins. Co.	65,000	.0172%	$207	$95	$40	$12	$353
Fidelity Security Life Ins. Co.	108,000	.0286%	$344	$157	$66	$20	$587
Ford Life Ins Co	259,000	.0687%	$824	$378	$158	$48	$1,407
Fortis Benefits Insurance Company	2,266,000	.6006%	$7,207	$3,303	$1,381	$420	$12,313
Franklin Life Ins Co	149,000	.0395%	$474	$217	$91	$28	$810
General American Life Ins Co	49,000	.0130%	$156	$71	$30	$9	$266
General Fidelity Life Ins Co	5,000	.0013%	$16	$7	$3	$1	$27
Gerber Life Ins Co	31,000	.0082%	$99	$45	$19	$6	$168
Globe Life & Accident Ins. Co	13,000	.0034%	$41	$19	$8	$2	$71
Globe Life Ins. Co.	312,000	.0827%	$992	$455	$190	$58	$1,695
Golden Rule Ins Co	2,224,000	.5895%	$7,074	$3,242	$1,356	$413	$12,085
Great American Reserve Ins. Co	1,000	.0003%	$3	$1	$1	$0	$5
Great Southern Life Ins Co	13,000	.0034%	$41	$19	$8	$2	$71
Great West Life & Annuity Ins Co	5,905,000	1.5652%	$18,782	$8,608	$3,600	$1,096	$32,086
Great West Life Assurance Co	298,000	.0790%	$948	$434	$182	$55	$1,619
Guarantee Mutual Life Co	75,000	.0199%	$239	$109	$46	$14	$408
Guarantee Reserve Life Ins Co	2,000	.0005%	$6	$3	$1	$0	$11

ATTACHMENT 3

COMPANY NAME:	CURRENT DIRECT PREMIUMS WRITTEN	CURRENT MARKET SHARE	*12/29/95 Assessment Amount*	*Approximate 8/4/95 Assessment Amount*	*Approximate 11/1/93 Assessment Amount*	*Approximate 2/9/93 Assessment Amount*	*Approximate Total Assessments to Date*
Guarantee Trust Life Ins Co	1,000	.0003%	$3	$1	$1	$0	$5
Guardian Life Ins Co of America	8,722,000	2.3118%	$27,742	$12,715	$5,317	$1,618	$47,393
Hartford Life & Accident Ins Co.	110,000	.0292%	$350	$160	$67	$20	$598
Heritage Life Inc Co	255,000	.0676%	$811	$372	$155	$47	$1,386
Home Life Financial Assurance Corp	800,000	.2120%	$2,545	$1,166	$488	$148	$4,347
Horace Mann Life Ins. Co.	9,000	.0024%	$29	$13	$5	$2	$49
IDS Life Ins Co	22,000	.0058%	$70	$32	$13	$4	$120
Individual ASR Co Life Health & Acc	1,000	.0003%	$3	$1	$1	$0	$5
Investors Life Ins Co North America	1,000	.0003%	$3	$1	$1	$0	$5
ITT Hartford Life & Annuity Ins Co	1,000	.0003%	$3	$1	$1	$0	$5
Jefferson-Pilot Life Ins Co	1,000	.0003%	$3	$1	$1	$0	$5
John Hancock Mutual Life Ins Co	1,801,000	.4774%	$5,728	$2,626	$1,098	$334	$9,786
Liberty Life Assurance Co of Boston	1,000	.0003%	$3	$1	$1	$0	$5
Liberty Life Ins Co	1,000	.0003%	$3	$1	$1	$0	$5
Liberty National Life Ins Co	5,000	.0013%	$16	$7	$3	$1	$27
Life Ins Co of North America	297,000	.0787%	$945	$433	$181	$55	$1,614
Life Ins Co of the Southwest	1,000	.0003%	$3	$1	$1	$0	$5
Life Investors Ins Co of America	224,000	.0594%	$712	$327	$137	$42	$1,217
Lincoln National Life Ins Co	4,816,000	1.2765%	$15,318	$7,021	$2,936	$894	$26,169
Lone Star Life Ins Co	84,000	.0223%	$267	$122	$51	$16	$456
Loyal American Life Ins Co	3,000	.0008%	$10	$4	$2	$1	$16
Massachusetts Casualty Ins Co	119,000	.0315%	$379	$173	$73	$22	$647
Massachusetts General Life Ins Co	1,000	.0003%	$3	$1	$1	$0	$5
Massachusetts Mutual Life Ins Co	77,000	.0204%	$245	$112	$47	$14	$418
Medico Life Ins Co	189,000	.0501%	$601	$276	$115	$35	$1,027
Mega Life & Health Ins Co	674,000	.1786%	$2,144	$983	$411	$125	$3,662
Metropolitan Life Ins Co	1,672,000	.4432%	$5,318	$2,437	$1,019	$310	$9,085
MIC Life Ins Corp	371,000	.0983%	$1,180	$541	$226	$69	$2,016
Minnesota Mutual Life Ins Co	703,000	.1863%	$2,236	$1,025	$429	$130	$3,820
Montgomery Ward Life Ins Co	79,000	.0209%	$251	$115	$48	$15	$429
Monumental Life Ins Co	1,416,000	.3753%	$4,504	$2,064	$863	$263	$7,694
Mutual Life Ins Co of New York	427,000	.1132%	$1,358	$622	$260	$79	$2,320
Mutual Of Omaha Ins Co	1,566,000	.4151%	$4,981	$2,283	$955	$291	$8,509
National Benefit Life Ins Co	7,000	.0019%	$22	$10	$4	$1	$38
National Foundation Life Ins Co	9,000	.0024%	$29	$13	$5	$2	$49
National Guardian Life Ins Co	1,000	.0003%	$3	$1	$1	$0	$5
National Health Ins Co	10,000	.0027%	$32	$15	$6	$2	$54
National Liberty Life Ins Co	1,000	.0003%	$3	$1	$1	$0	$5

ATTACHMENT 3

COMPANY NAME	CURRENT DIRECT PREMIUMS WRITTEN	CURRENT MARKET SHARE	*12/29/95 Assessment Amount*	*Approximate 8/4/95 Assessment Amount*	*Approximate 11/1/93 Assessment Amount*	*Approximate 2/9/93 Assessment Amount*	*Approximate Total Assessments to Date*
National Life Ins Co	18,000	.0048%	$57	$26	$11	$3	$98
National Travelers Life Co	1,000	.0003%	$3	$1	$1	$0	$5
Nationwide Life Ins Co	508,000	.1347%	$1,616	$741	$310	$94	$2,760
New England Mutual Life Ins Co	13,000	.0034%	$41	$19	$8	$2	$71
New York Life & Health Ins Co	133,000	.0353%	$423	$194	$81	$25	$723
New York Life Ins Co	5,922,000	1.5697%	$18,836	$8,633	$3,610	$1,099	$32,178
North American Co For Life & Health Ins	1,000	.0003%	$3	$1	$1	$0	$5
North Central Life Ins Co	(3,000)	-.0008%	($10)	($4)	($2)	($1)	($16)
Northern Life Ins Co	1,000	.0003%	$3	$1	$1	$0	$5
Northwestern National Life Ins Co	344,000	.0912%	$1,094	$501	$210	$64	$1,869
Occidental Life Ins Co of North Carolina	2,000	.0005%	$6	$3	$1	$0	$11
Old Republic Ins Co	1,000	.0003%	$3	$1	$1	$0	$5
Pacific Heritage Assurance Co	7,000	.0019%	$22	$10	$4	$1	$38
Paul Revere Life Ins Co	307,000	.0814%	$976	$448	$187	$57	$1,668
Penn Mutual Life Ins Co	14,000	.0037%	$45	$20	$9	$3	$76
Pennsylvania Life Ins Co	2,000	.0005%	$6	$3	$1	$0	$11
PFL Life Ins Co	1,791,000	.4747%	$5,697	$2,611	$1,092	$332	$9,732
Philadelphia American Life Ins Co	13,000	.0034%	$41	$19	$8	$2	$71
Phoenix American Life Ins Co	3,000	.0008%	$10	$4	$2	$1	$16
Phoenix Home Life Mutual Ins Co	163,000	.0432%	$518	$238	$99	$30	$886
Physicians Mutual Ins Co	767,000	.2033%	$2,440	$1,118	$468	$142	$4,168
Pioneer Life Ins Co of Illinois	704,000	.1866%	$2,239	$1,026	$429	$131	$3,825
PM Group Life Ins Co	469,000	.1243%	$1,492	$684	$286	$87	$2,548
Primerica Life Ins Co	13,000	.0034%	$41	$19	$8	$2	$71
Principal Mutual Life Ins Co	20,083,000	5.4232%	$63,878	$29,278	$12,243	$3,726	$109,125
Protective Life Ins Co	11,000	.0029%	$35	$16	$7	$2	$60
Provident Indemnity Life Ins Co	76,000	.0201%	$242	$111	$46	$14	$413
Provident Life & Accident Ins Co	951,000	.2521%	$3,025	$1,386	$580	$176	$5,167
Provident Mutual Life Ins Co of Philadel	10,000	.0027%	$32	$15	$6	$2	$54
Prudential Ins Co of America	4,396,000	1.1652%	$13,982	$6,409	$2,680	$816	$23,887
Reliance Standard Life Ins Co	28,000	.0074%	$89	$41	$17	$5	$152
Royal Maccabees Life Ins Co	45,000	.0119%	$143	$66	$27	$8	$245
Safeco Life Ins Co	521,000	.1381%	$1,657	$760	$318	$97	$2,831
Security Life Ins Co of America	111,000	.0294%	$353	$162	$68	$21	$603
Security Life of Denver Ins Co	58,000	.0154%	$184	$85	$35	$11	$315
Sentry Life Ins Co	204,000	.0541%	$649	$297	$124	$38	$1,108
SMA Life Assurance Co	4,000	.0011%	$13	$6	$2	$1	$22
Standard Ins Co	1,800,000	.4771%	$5,725	$2,624	$1,097	$334	$9,781

ATTACHMENT 3

COMPANY NAME	CURRENT DIRECT PREMIUMS WRITTEN	CURRENT MARKET SHARE	*12/29/95 Assessment Amount*	*Approximate 8/4/95 Assessment Amount*	*Approximate 11/1/93 Assessment Amount*	*Approximate 2/9/93 Assessment Amount*	*Approximate Total Assessments to Date*
Standard Security Life Ins Co of New Yor	6,000	.0016%	$19	$9	$4	$1	$33
State Mutual Life ASR Co of America	1,000	.0003%	$3	$1	$1	$0	$5
States West Life Ins Co	1,435,000	.3804%	$4,564	$2,092	$875	$266	$7,797
Sun Life ASR Co of Canada	105,000	.0278%	$334	$153	$64	$19	$571
Sunset Life Ins Co of America	1,000	.0003%	$3	$1	$1	$0	$5
TMG Life Insurance Company	768,000	.2036%	$2,443	$1,120	$468	$142	$4,173
TransAmerica Occidental Lic	79,000	.0209%	$251	$115	$48	$15	$429
Travelers Ins Co (Life Department)	3,920,000	1.0390%	$12,468	$5,715	$2,390	$727	$21,300
Trustmark Ins Co	81,000	.0215%	$258	$118	$49	$15	$440
Union Bankers Ins Co	41,000	.0109%	$130	$60	$25	$8	$223
Union Central Life Ins Co	11,000	.0029%	$35	$16	$7	$2	$60
Union Fidelity Life Ins Co	631,000	.1673%	$2,007	$920	$385	$117	$3,429
Union Labor Life Ins Co	129,000	.0342%	$410	$188	$79	$24	$701
United American Ins Co	16,000	.0042%	$51	$23	$10	$3	$87
United of Omaha Life Ins CO	4,827,000	1.2794%	$15,353	$7,037	$2,943	$896	$26,229
United States Life Ins Co In New York Ci	174,000	.0461%	$553	$254	$106	$32	$945
United World Life Ins Co	48,000	.0127%	$153	$70	$29	$9	$261
Universe Life Ins Co	34,000	.0090%	$108	$50	$21	$6	$185
USAA Life Ins Co	135,000	.0358%	$429	$197	$82	$25	$734
USLife Credit Life Ins Co	11,000	.0029%	$35	$16	$7	$2	$60
Veterans Life Ins Co	47,000	.0125%	$149	$69	$29	$9	$255
Vista Life Ins Co	133,000	.0353%	$423	$194	$81	$25	$723
Wabash Life Ins Co	1,000	.0003%	$3	$1	$1	$0	$5
Washington National Ins Co	83,000	.0220%	$264	$121	$51	$15	$451
Western Fidelity Ins Co	1,000	.0003%	$3	$1	$1	$0	$5
	377,274,000	100.0000%	$1,200,000	$550,000	$230,000	$70,000	$2,050,000

* Please note that the assessment amounts for the assessments received 8/4/95, 11/1/93 & 2/9/93 are approximations based on the current market shares for the most recent assessment.

All, $10,000 [illegible] assessments in 1992

Risk Pool Operations

Compiled by Communicating for Agriculture, the following operational statistics of state risk pools are for end of 1994, unless otherwise noted.

State	Premiums Collected	Claims Paid	Assessments To Members	Administration Costs
Alaska	$348,744	$474,619	$600,000	$91,545
Arkansas	Not yet Operational — Passed in 1995			
California	39,778,553	55,465,253	NA*	3,500,000
Colorado	5,668,927	6,299,467	NA*	589,237
Connecticut	6,226,255	12,934,625	8,365,979	406,418
Florida	9,945,683	19,159,272	11,814,627	NA*
Illinois	18,883,753	27,246,801	NA*	2,303,270
Indiana	15,811,955*	23,530,818*	10,717,539	1,655,019
Iowa	6046,246	8,246,354	3,000,000	333,216
Kansas*	793,318	1,054,768	0	209,200
Louisiana	792,585	1,397,330	NA*	408,703
Maine**	456,894	1,344,695	NA*	72,947
Minnesota	54,213,705	92,521,137	44,424,903	6,370,804
Missouri	3,946,459	5,560,796	1,934,854	262,031
Montana	1,591,675	1,284,504	0	153,598
Nebraska	8,264,790	1,304,497	6,200,000	560,751
New Mexico	4,402,007	7,552,839	3,426,625	317,625
North Dakota	3,311,067	4,738,731	1,500,000	210,186
Oklahoma	Not yet operational — Passed in 1995			
Oregon*	8,633,692	11,834,185	3,956,818	880,552
South Carolina	3,867,554	6696557	NA*	446,235
Tennessee***	NA	NA	NA	NA
Utah	1,924,438	2865890	NA*	271,779
Washington	6,705,787	19261747	11,499,657	1,172,972
Wisconsin*	25,600,544	43804921	17,107,689	2,140,809
Wyoming	725,690	1082156	517,350	20,560

**Notes: California, Illinois, Maine and Utah are funded by state appropriation and therefore do not utilize assessments. Colorado funded by funds from unclaimed business association property; Illinois data uses premiums earned and claims incurred. Indiana reports premiums earned and claims incurred. Kansas data through March 1995. Louisiana additionally funded by mandated service charge, and state appropriations; administrative costs include both claims and administration, mandated service charge collections and other administrative charges; Maine figures are for FY 1994. Oregon figures are estimates through FY 1994/95 made in April 1995. Wisconsin data is based on fiscal year except for assessments to members, which are calendar year.*

***Note: Maine's pilot risk pool terminated all remaining policies as of December 31, 1994.*

****Note: Tennessee's program has been merged into the TennCare Medicaid Program. Transfer of coverage for insured participants completed by March 30, 1995.*

QUICK CHECK

ATTACHMENT 4

Waiting Period for Pre-existing Condition

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

Several states have expanded the pre-existing waiting period condition clause to cover other areas. One option being used by several states allows a waiver of this waiting period if the pre-existing condition exclusion has already been satisfied under any prior health insurance coverage that was involuntarily terminated, and application for pool coverage is made not later than 30 days following the involuntary termination.

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

STATE	WAITING PERIOD	CONDITION PERIOD
Alaska	6 months	3 Months
Arkansas	To be determined	To be determined
California	90 Days	6 Months
Colorado	6 Months	6 Months
Connecticut	12 Months	6 Months
Florida	12 Months	6 Months
Illinois	6 Months	6 Months
Indiana	6 Months	6 Months
Iowa	6 Months	6 Months
Kansas	90 Days (5/1/94)	6 Months
Louisiana	6 Months	6 Months
Minnesota	6 Months	90 Days
Mississippi	6 Months	6 Months
Missouri	12 Months	6 Months
Montana	12 Months	5 Years
Nebraska	6 Months	6 Months
New Mexico	6 Months	6 Months
North Dakota	180 Days (270 Maternity)	90 Days
Oklahoma	12 Months	6 Months
Oregon	6 Months	6 Months
South Carolina	6 Months	6 Months
Tennessee	None	None
Utah	6 Months	6 Months
Washington	6 Months	6 Months
Wisconsin	6 Months	6 Months
Wyoming	12 Months	6 Months

Deductibles

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

State	Deductibles Offered					
Alaska	$500	$1,000	$1,500	$2,500	$5,000	$10,000
Arkansas	$1,000	$5,000	$10,000			
California	$500 for PPOs - None for HMOs					
Colorado	$300	$750	$2,000			
Connecticut	see plan coverage options in state section					
Florida	$1,000	$1,500	$2,000	$5,000	$10,000	
Illinois	$500 $1,000	$1,000 $ 000	$2,500/Individual $5,000/Family			
Indiana	$500	$1,000	$1,500			
Iowa	$500	$1,000	$1,500	$2,000		
Kansas	$1,000	$5,000				
Louisiana	$1,000	$2,000				
Minnesota	$500	$1,000				
Mississippi	$500	$1,500				
Missouri	$500	$1,000				
Montana	$1,000					
Nebraska	$250 $250 PPO	$500 $2,000 PPO	$1,000	$2,000		
New Mexico	$500	$1,000	$2,000			
North Dakota	$500	$1,000				
Oklahoma	$500	$1,000	$1,500	$2,000	$5,000	$7,500
Oregon	$500					
South Carolina	$500					
Tennessee	$250/Individual, $500/Family (incomes of 101-199% of poverty) optional $1,000/Individual, $2,000/Family (incomes of 200% of poverty or higher)					
Utah	$500	$1,000				
Washington	$500	$1,000	$1,500			
Wisconsin	$1,000	$500 Medical Disability Supplement Plan				
Wyoming	$500 Type A, $2,000 Type B, $3,000 Type C — See Benefit Structure					

Benefits and Criteria

Maximum Lifetime Benefits Provided

State	Benefit
Alaska	$1 million Lifetime Benefit
Arkansas	500,000 Lifetime Benefit
California	$500,000 Lifetime Benefit - $50,000 Annual
Colorado	$500,000 Lifetime Benefit
Connecticut	$1 million Lifetime Benefit
Florida	$500,000 Lifetime Benefit
Illinois	$500,000 Lifetime Benefit
Indiana	No Maximum Lifetime Benefit
Iowa	$250,000 Lifetime Benefit
Kansas	$500,000 Lifetime Benefit
Louisiana	$500,000 Lifetime Benefit - $100,000 Annual
Minnesota	Regular Plan - $1.5 million Lifetime Benefit Medicare Plan - unlimited Lifetime Benefit
Mississippi	$250,000 Lifetime Benefit
Missouri	$1 million Lifetime Benefit
Montana	$250,000 Lifetime Benefit
Nebraska	$500,000 Lifetime Benefit
New Mexico	$750,000 Lifetime Benefit With Exceptions
North Dakota	$1 million Lifetime Benefit
Oklahoma	$500,000 Lifetime Benefit
Oregon	$1 million Lifetime Benefit
South Carolina	$250,000 Lifetime Benefit
Tennessee	None
Utah	$500,000 Lifetime Benefit - $150,000 Annual
Washington	$500,000 Lifetime Benefit
Wisconsin	$500,000 Lifetime Benefit
Wyoming	$250,000 Lifetime Benefit

Quick Check:

Risk Pool Participation and Operations

Risk Pool Participation

Compiled by Communicating for Agriculture, the following statistics are the number of participants with in-force policies in state risk pools. All statistics are for the end of 1994, unless otherwise noted.

State	Participants	Year Operational
Alaska	128	1993
Arkansas	0	1996
California*	19,353	1991
Colorado	1,921	1991
Connecticut*	1,364	1976
Florida	2,387	1983
Illinois	4,755	1989
Indiana	4,638	1982
Iowa	1,341	1987
Kansas*	619	1993
Louisiana	386	1992
Maine**	142	1988
Minnesota	33,477	1976
Mississippi	610	1992
Missouri	931	1992
Montana	268	1987
Nebraska	3,331	1986
New Mexico	1,124	1988
North Dakota	1,422	1982
Oklahoma	0	1996
Oregon*	4,313	1990
South Carolina	1,264	1990
Tennessee***	1,782	1987
Utah*	710	1991
Washington	1,307	1988
Wisconsin	10,864	1981
Wyoming	200	1991

**Notes: California data through April 1995. Connecticut data includes number of policies and not individuals. Kansas data is through March 15, 1995. Maine data through FY 1994. Oregon figures through June 1995. Utah through May 1995*

***Note: Maine's pilot risk pool terminated all remaining policies as of December 31, 1994*

****Note: Tennessee's risk pool has been merged into it TennCare Medicaid program, with transfer of coverage completed June 30, 1995*

ATTACHMENT 4

States With Programs For The Medically Uninsurable:

Open Enrollment or Comprehensive Health Insurance Plans For High-risk Individuals

NOTE: Comparisons of uninsureds between states with risk pool programs and those without should be made with caution. Many factors affect the uninsured population and do not always compare directly from state to state. Data is presented for informational purposes only. States identified as having open enrollment for the state Blue Cross and Blue Shield plan according to the Blue Cross and Blue Shield Association.

State	*Plan Status*	*Nonelderly uninsured*[1]	*Percent of population*[2]
Alabama	BCBS Open Enrollment	761,000	20.6
Alaska	Program in effect – 1992	97,470	17.1
Arizona	None	636,000	21.1
Arkansas	Program in effect – 1996	398,000	18.5
California	Program in effect – 1991	5,835,000	21.7
Colorado	Program in effect – 1991	346,000	11.8
Connecticut	Program in effect – 1976	259,000	8.8
Delaware	None	97,000	15.8
Florida	Program in effect – 1983	2,538,000	23.5
Georgia	Passed 1989. Not yet operational	912,000	16.9
Hawaii	None	86,000	9.0
Idaho	None	189,000	20.6
Illinois	Program in effect – 1989	1,395,000	13.5
Indiana	Program in effect – 1982	732,000	15.0
Iowa	Program in effect – 1987	255,000	10.5
Kansas	Program in effect – 1992	308,000	13.7
Kentucky	None	490,000	15.9
Louisiana	Program in effect – 1992	877,000	23.8
Maine	Program withdrawn – 1995	140,000	13.1
Maryland	BCBS Open Enrollment	642,000	15.5
Massachusetts	BCBS Open Enrollment	664,000	13.2

Michigan	BCBS Open Enrollment	865,000	10.5
Minnesota	Program in effect – 1976	429,000	11.2
Mississippi	Program in effect – 1992	518,000	22.1
Missouri	Program in effect – 1992	617,000	14.0
Montana	Program in effect – 1987	105,000	14.7
Nebraska	Program in effect – 1986	145,000	10.2
Nevada	None	235,000	21.8
New Hampshire	BCBS Open Enrollment	113,000	11.5
New Jersey	BCBS Open Enrollment	857,000	12.7
New Mexico	Program in effect – 1988	333,000	24.5
New York	Open Enrollment	2,288,000	14.7
North Carolina	None	1,014,000	17.8
North Dakota	Program in effect – 1982	50,000	9.2
Ohio	None	1,188,000	12.2
Oklahoma	Program in effect – 1996	604,000	22.1
Oregon	Program in effect – 1990	432,000	16.8
Pennsylvania	BCBS Open Enrollment	975,000	9.4
Rhode Island	BCBS Open Enrollment	98,000	12.3
South Carolina	Program in effect – 1990	491,000	15.5
South Dakota	None. Enacting legislation repealed – 1995	73,000	12.6
Tennessee	TennCare – 1995. Risk Pool 1987-1994	659,000	16.0
Texas	Passed 1989 – Not yet operational	3,786,000	25.3
Utah	Program in effect – 1991	242,000	15.8
Vermont	BCBS Open Enrollment	75,000	14.8
Virginia	BCBS Open Enrollment	1,050,000	19.6
Washington	Program in effect – 1988	535,000	12.4
West Virginia	None	291,000	18.5
Wisconsin	Program in effect – 1981	413,000	9.6
Wyoming	Program in effect – 1991	57,000	13.8
District of Columbia	BCBS Open Enrollment	141,000	30.3

1. Number of nonelderly uninsured, March 1992 Current Population Survey. Employee Benefits Research Institute (Washington, D.C.) Issue Brief Number 133.

2. Number of nonelderly uninsured as percent of state population.

Attachment 5

Administration Costs by State
1994

State	Average # Participants	Admin Cost	Per Participant per Month
WY	203	20,560	8.44
ND	1,480	210,186	11.33
NE	3,307	560,751	14.13
MN	34,387	5,926,931	14.36
WI	11,455	2,140,809	15.57
CA	18,069	3,500,000	16.14
OR	4,143	880,552	17.71
IA	1,547	333,216	17.95
NM	1,209	317,625	21.89
MO	959	262,031	22.77
CT	1,487	406,418	22.78
CO	1,984	589,237	24.76
MS	488	159,395	27.25
SC	1,351	446,235	27.54
IN	4,781	1,655,019	28.85
FL	3,901	1,449,351	30.96
WA	2,847	1,172,972	34.33
UT	650	271,779	34.84
IL	4,724	2,303,270	40.63
KS	401	209,200	43.47
MT	279	153,598	45.96
Alaska	**167**	**167,688**	**83.68**
LA	307	408,703	110.94

Highest cost per participant per month: **110.94**
Lowest cost per participant per month: **8.44**

Average cost per participant per month: **27.54**

Assessments by state
1994 or 1995

States where the Assessment Is Based on Premium Writings

State	Assessment	Premium	% Prem	Premium Tax Offset	Other
SC	1,490,700	1,005,381,615	0.15%	YES	up to $5mil for the state
IA	3,000,000	1,786,635,802	0.17%	NO	
WA	11,499,657	4,100,000,000	0.28%	YES	
WI	17,107,689	3,421,537,800	0.50%	NO	
NM	3,426,625	673,688,000	0.51%	YES	30% offset after $75,000
Alaska*	**2,050,000**	**377,274,000**	**0.54%**	**NO**	
IN	17,500,000	2,811,780,372	0.62%	NO	
CT	8,365,979	1,001,631,744	0.84%	NO	Will start to assess HMOs for 1995 assessment
NE	6,200,000	620,000,000	1.00%	YES	
MN	44,424,903	2,800,000,000	1.59%	NO	
WY	997,000	56,115,417	1.78%	YES	up to $1mil for the state
FL	11,814,627	72,000,000	16.41%	YES	up to 1% of premium in state

States where the Assessment Is Funded by Other Means

CA			Cigarette and tobacco tax
CO			State income tax surcharge
IL			General fund
KS		YES	80% of premium tax is offset
LA			General fund
MS			$1/mo/policy
MO	1,934,854	YES	
MT	200,000	YES	
ND	1,500,000	YES	
OR	3,956,818	NO	
UT			State appropriation

* includes total assessments since inception

HCS CSSB 74(FIN)
5/10/92
Referred: Rules
Sponsor(s): SENATORS KERTTULA, Cotten, Menard, Rodey, Eliason, Uehling, Sturgulewski, Craft, Shultz, Collins, Halford, Pearce REPRESENTATIVES Ellis, Bruckman, Donley
BY THE HOUSE FINANCE COMMITTEE

"An Act relating to pooled health insurance for individuals who are uninsured or denied adequate coverage; and providing for an effective date."
BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

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

* Sec. 2. AS 21 is amended by adding a new chapter to read:
CHAPTER 55. STATE HEALTH INSURANCE.
ARTICLE 1. COMPREHENSIVE HEALTH INSURANCE ASSOCIATION.
Sec. 21.55.010. CREATION; MEMBERSHIP. There is established a nonprofit incorporated legal entity to be known as the Comprehensive Health Insurance Association. Membership consists of all licensed hospital or medical service corporations in the state that offer subscriber contracts for major medical coverage and all insurers licensed to transact health insurance in the state that offer policies for major medical coverage on an expense incurred basis. All members shall maintain membership in the association as a condition of doing health insurance business, or being able to offer subscriber contracts, in
the state.
Sec. 21.55.020. BOARD OF DIRECTORS; ORGANIZATION. (a) The board of directors of the association shall be made up of seven individuals. Five board members shall be selected by participating members, subject to approval by the director of the division of insurance, and two board members shall be consumers selected by the director of the division of insurance. The director or the director's designee shall serve as a nonvoting ex officio member of the board. In determining voting rights at members' meetings, a member is entitled to vote in person or proxy. The vote shall be a weighted vote based upon the member's premiums for health insurance for major medical coverage on an expense incurred basis, or the member's subscriber fees, derived from or on behalf of state residents in the previous calendar year, as determined by the director. In approving members of the board, the director shall consider, among other things, whether all types of participating members are fairly represented. Members of the board may be reimbursed from the association for expenses incurred by them as members, but may not otherwise be compensated by the association for their services. The costs of conducting meetings of the association and its board of directors shall be borne by members of the association.
(b) The board shall study and report to the legislature at least once every three years on the effectiveness of this chapter. The report must include an analysis of the effectiveness of this chapter in promoting rate stability, product availability, and affordability of coverage. The report may contain recommendations for legislative or other regulatory
action.
Sec. 21.55.030. GENERAL POWERS. The association may
(1) exercise the powers granted to insurers under the laws of
the state;
(2) sue or be sued;
(3) enter into contracts with insurers, similar associations in other states, or with other persons for the performance of administrative functions;
(4) establish administrative and accounting procedures for the operation of the association; and

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

Sec. 21.55.040. PLAN OF OPERATION. (a) The association shall submit to the director a plan of operation and amendments necessary or suitable to assure the fair, reasonable, and equitable administration of the association. The plan of operation and amendments become effective upon approval in writing by the director. If the association fails to submit a suitable plan of operation by a date that is 180 days after the effective date of this Act, or if at subsequent time the association fails to submit suitable amendments to the plan, the director may, after notice and hearing, adopt reasonable regulations necessary or advisable to effectuate the provisions of this chapter. These regulations shall continue in force until modified by the director or superseded by a plan submitted by the association and approved by the director. (b) All members of the association shall comply with the plan of
operation. (c) The plan of operation shall

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

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

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

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

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

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

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

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

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

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

ARTICLE 2. STATE HEALTH INSURANCE PLANS.

Sec. 21.55.100. TYPES OF INSURANCE PLANS. (a) The association shall make available to residents who are high risks an individual state plan of health insurance. The association shall offer three alternatives related to deductibles as described in AS 21.55.120 and may offer additional deductible alternatives.

(b) The association shall make available to residents who are high risks, eligible for and covered by Medicare, 65 years of age or older, and eligible under this chapter at least one Medicare supplement plan that meets the minimum policy standards and minimum benefit standards established by regulations adopted by the director under AS 21.89.060. (c) The association may not refuse to offer coverage under a state plan to residents who are high risks and who are eligible under this chapter. The association may not refuse coverage under a state plan to residents who are high risks, are eligible under this chapter, apply for coverage, and pay the required premium.

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

(1) hospital services;

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

dental conditions;

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

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

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

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

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

(8) use of radium or other radioactive materials;

(9) outpatient chemotherapy;

(10) oxygen;

(11) anesthetics;

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

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

(14) diagnostic x-rays and laboratory tests;

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

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

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

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

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

(20) second surgical opinions;

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

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

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

services described in AS 21.55.110(3) in excess of the deductible. (c) The sum of the deductible and copayments required in any calendar year under a plan may not exceed a maximum limit of $2,000 per covered individual. Covered expenses incurred after the applicable maximum limit has been reached shall be paid at the rate of 100 percent of usual, customary, reasonable, or prevailing charges, except that expenses incurred for treatment of mental and nervous conditions shall be paid at the rate of 50 percent. The $2,000 maximum shall be adjusted yearly to correspond with the change in the medical care component of the Consumer Price Index as adjusted by the director.

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

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

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

(2) medical advice or treatment was recommended or received within the period of three months immediately before the effective date of coverage.

(b) A policy may not exclude coverage for a loss due to preexisting conditions for a period greater than six months following the effective date of
coverage. (c) A state plan issued to a person whose previous subscriber contract, health policy, or Medicare supplement policy was involuntarily terminated shall credit the time covered under the previous contract or policy toward an exclusion for preexisting conditions under the state plan if the previous contract or policy had a similar preexisting condition exclusion and the person applies for a state plan within 31 days after termination of the previous contract or policy. If a person covered by this subsection is accepted by the writing carrier and pays a specified premium for retroactive coverage, the state plan is effective retroactively to the date that the person's previous contract or policy terminated.

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

(1) care for an injury or disease either

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(14) experimental procedures; and

(15) services and supplies for which the patient was not charged. (b) A state plan may not provide coverage for a person eligible for major medical coverage under

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

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

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

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

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

ARTICLE 3. ADMINISTRATION OF PLANS.

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

Sec. 21.55.210. DUTIES OF WRITING CARRIERS. (a) The writing carrier shall perform the administrative and claims payment functions required by this section. The writing carrier shall provide these services for a period of three years, unless a request to terminate is approved by the director. The director shall approve or deny a request to terminate within 90 days of its receipt. A failure to make a final decision on a request to terminate within the specified period shall be considered an approval. Six months before the expiration of each three-year period, the association shall invite submissions of policy forms from members of the association, including the writing carrier. The association shall follow the provisions of AS 21.55.210 in selecting a writing carrier for the subsequent three-year period. (b) The writing carrier shall provide to all eligible persons enrolled in a state plan an individual policy or certificate, setting out a statement of the insurance protection to which the person is entitled, with whom claims are to be filed, and to whom benefits are payable. The policy or certificate must indicate that coverage was obtained through the association. (c) The writing carrier shall submit to the association and the director on a quarterly basis a report on the operation of the state plans. Specific information to be contained in the report shall be determined by the association.

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

(e) The writing carrier shall be reimbursed from the state plan premiums received for its direct and indirect expenses for administering the plan. Direct and indirect expenses shall include a pro rata reimbursement for that portion of the writing carrier's administrative, printing, claims administration, management and building overhead expenses that are assignable to the maintenance and administration of the state plans. The association shall approve cost accounting methods to substantiate the writing carrier's cost reports consistent with generally accepted accounting principles. Direct and indirect expenses may not include costs directly related to the original

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

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

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

(d) The association shall make an annual determination of each member's liability, if any, and may make an annual fiscal year end assessment if necessary. The association may also, subject to the approval of the director, provide for interim assessments against the members as may be necessary to assure the financial capability of the association in meeting the incurred or estimated claims expenses of the state plans and operating and administrative expenses of the association until the association's next annual fiscal year end assessment. Payment of an assessment is due within 30 days of receipt by a member of written notice of a fiscal year end or interim assessment. Failure by a member to tender to the association the assessment within 30 days shall be grounds for revocation of a member's certificate of authority. A member that ceases to do health insurance business in the state, or ceases to offer subscriber contracts in the state, due to revocation, suspension, or voluntary surrender of its certificate of authority remains liable for assessments through the calendar year that the health insurance business ceased. The association may decline to levy an assessment against a member if the assessment would not exceed $10. Assessments paid by a member are a general expense of the member. (e) Net gains, if any, from the operation of the state plans shall be held at interest and used by the association to offset future losses due to claims expenses of a state plan or allocated to reduce state plan premiums.

ARTICLE 4. ENROLLMENT IN THE STATE HEALTH INSURANCE PLAN.

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

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

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

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

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

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

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

Sec. 21.55.320. WRITING CARRIER'S RESPONSE. Within 30 days after receiving the certificate described in AS 21.55.310, the writing carrier shall either reject the application for failing

to comply with the requirements of AS 21.55.300 and 21.55.310 or forward the eligible person a notice of acceptance and billing information.

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

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

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

(2) is accepted by the writing carrier; and

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

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

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

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

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

ARTICLE 5. GENERAL PROVISIONS.

Sec. 21.55.400. DUTIES OF DIRECTOR. The director may

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

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

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

(4) adopt regulations necessary to administer this chapter.

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

Sec. 21.55.500. DEFINITIONS. In this chapter

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

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

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

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

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

plan:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ANNUAL REPORT
OF
ALASKA COMPREHENSIVE
HEALTH INSURANCE ASSOCIATION

JANUARY 1, 1994 - DECEMBER 31, 1994

ACHIA ANNUAL REPORT

Introduction

The Alaska Comprehensive Health Insurance Association (ACHIA) was established by the Alaska Legislature to provide access to health insurance to all residents of the state who are denied adequate health insurance or who are considered uninsurable.

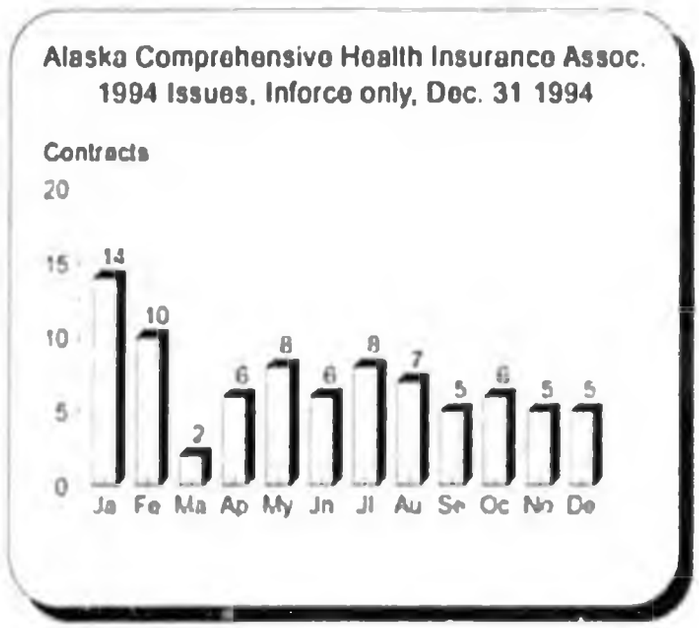
ACHIA is a nonprofit incorporated legal entity established under the provisions of Alaska Statute Title 21, Chapter 55, and is exempt from the payment of fees and taxes levied by the state or any of its political subdivisions except taxes levied on real or personal property. The Plan is governed by a Board of Directors composed of seven individuals. Five directors are participating members of the association approved by the director of the Division of Insurance and two are consumers selected by the director of the Division of Insurance. The director of insurance or the director's designee serves as a nonvoting ex officio member of the Board.

Since the implementation date of the Plan, January 1, 1993, Aetna Insurance Company has served as the administrator of the Plan. As such Aetna determines the eligibility of the applicants, collects premiums, pays claims on behalf of the Plan and provides reports requested by the Board of Directors.

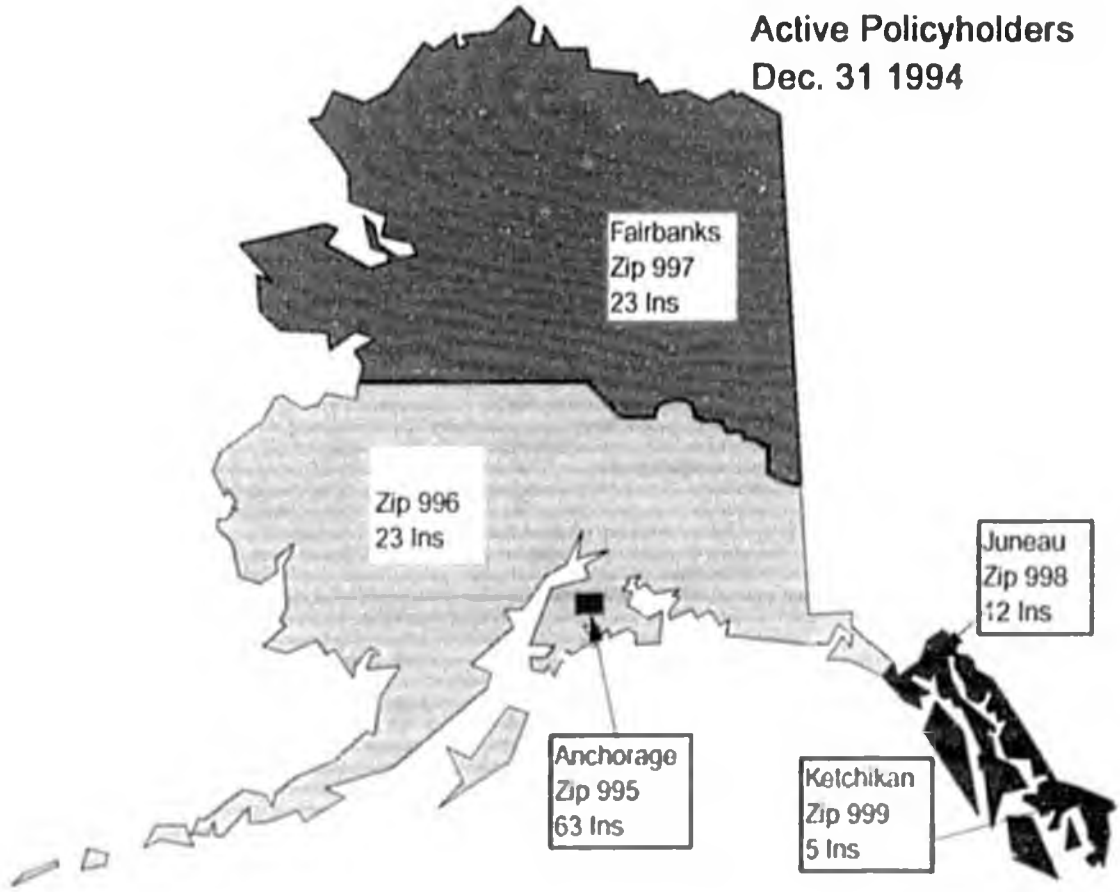
The Plan is funded through premiums collected from Insureds and assessments received from disability insurers doing business in Alaska.

At the beginning of 1994, there were 57 insureds on the plan. As of December 31, 1994, there were 128 insured. During the year, there were 30 terminations, for various reasons, generally due to the enactment of Small Group Reform or the insured leaving the state.

In 1994, 101 policies were issued. 82 of these policies were still inforce and active on December 31, 1994.

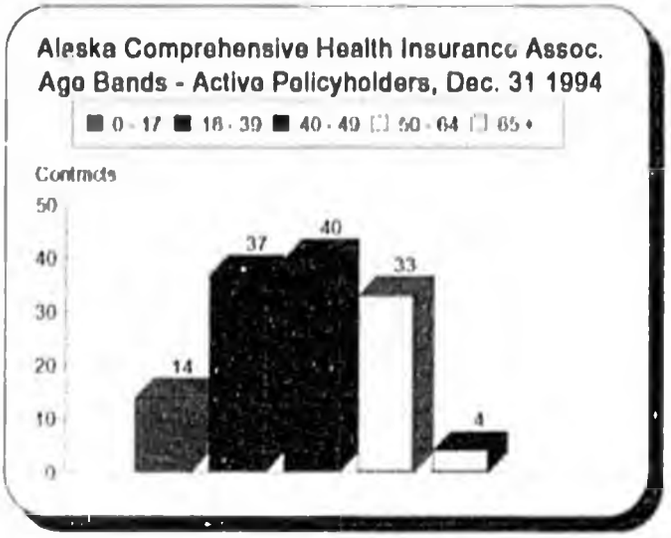


ACTIVE POLICYHOLDERS BY GEOGRAPHIC AREA



Note: Two billing addresses are outside Alaska but the insureds reside in Alaska or are only temporarily away going to school.

As of December 31, 1994, fourteen (14) of the insureds were under age 18, thirty-seven (37) were from age 18 through 39, forty (40) were from 40 through 49, thirty-three (33) were from 50 through 64, and four (4) were age 65 or over.



What are the Benefits?

The lifetime maximum benefit is $1,000,000 for all injuries and sickness combined. The Plan provides benefits which includes inpatient and outpatient hospital care, office visits, surgery and anesthesia, x-ray and lab, radiation and chemotherapy, ambulance, oxygen, durable medical equipment, prosthetics, home health care, mammography, hospice services, prescription drugs, phenylketonuria treatment, treatment for complications of pregnancy, mental or nervous, alcoholism and drug abuse.

What Is Not Covered?

The following is a brief list of expenses not covered under the Plan and may not reflect the full extent of the policy limitations: services that are not medically necessary, well baby care, eyeglasses, contact lenses, hearing aids, dental care, acupuncture therapy, routine physical or preventive exams, pregnancy, TMJ, experimental procedures (including related services, drugs and other supplies), and reconstructive or cosmetic surgery.

Does a Waiting Period Apply?

The Plan will not cover expenses incurred during the first six months after the policy date for a preexisting condition. Payments will be in accordance with the provisions of the policy, however, if the person had coverage under another medical plan which was involuntarily terminated and coverage is applied for under ACHIA within 31 days after such involuntary termination, the preexisting condition waiting period will apply only to the excess, if any, of six months over the time coverage was in force under the prior plan.

Who Is Eligible?

Even though Medicare is provided, a person may still be eligible for coverage under this plan. Any person is eligible for the ACHIA plan if he or she:

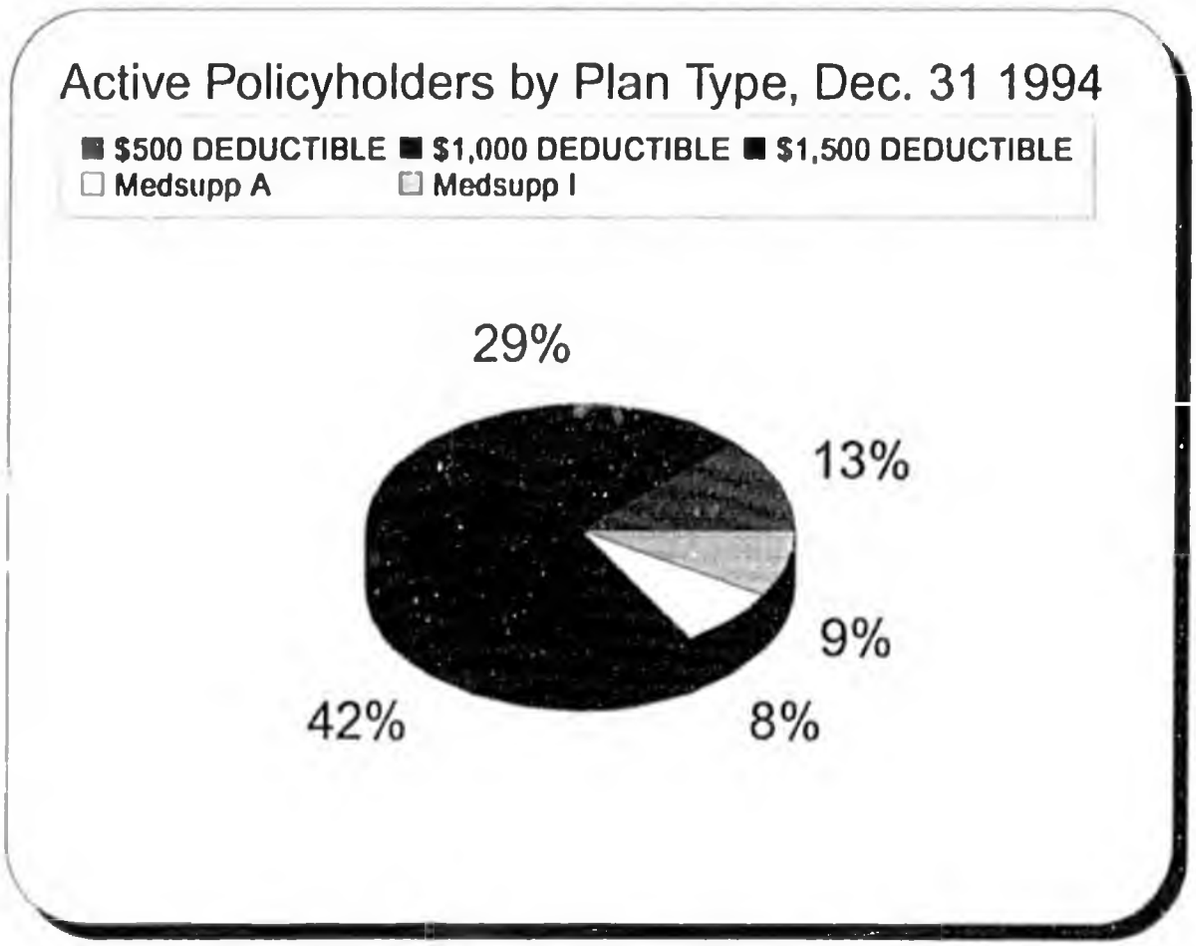
- is not covered by any other form of health insurance that is similar to this plan;
- is not eligible for coverage under AS 21.56;
- has been a resident for the past 12 months and continues to be a resident of Alaska; and
- at least one of the following:

1) has received from two health insurers notice of rejection for health insurance dated within the last six months;
2) has received restrictive riders that substantially reduce coverages;
3) is currently insured under similar insurance and the current premium exceeds the CHIA plan premium;
4) has been offered coverage at a rate higher than the CHIA plan premium, based upon comparable deductibles, coinsurance and benefits; or
5) has any of the conditions listed below:

Acquired Immune Deficiency Syndrome (AIDS)
Alzheimers
Angina Pectoris
Anorexia Nervosa
Arteriosclerosis Obliteran
Articial Heart Valve
Ascites
Brain Tumors
Cardiomyopathy
Cerebral Palsy
Chronic Pancreatitis
Cirrhosis of the Liver
Coronary Insufficiency
Coronary Occlusion
Crohn's Disease
Cystic Fibrosis
Dermatomyositis
Diabetes
Epilepsy
Friederich's Disease
Heart Disorders
Hemophilia
HIV+
Hodgkin's Disease
Huntington's Chorea
Hydrocephalus
Intermittent Claudication
Kidney Failure
Lead Poisoning with Cerebral Involvement
Leukemia
Lupus Erythematosus Disseminate
Malignant Tumor (if treated or has occurred within last 4 yrs)
Mental Retardation
Metastatic Cancer
Motor or Sensory Aphasia
Multiple or Disseminated Sclerosis
Muscular Atrophy or Dystrophy
Myasthenia Gravis
Myotomy
Obesity - Surgical Treatment
Open Heart Surgery
Paraplegia or Quadriplegia
Parkinson's Disease
Peripheral Arteriosclerosis (if treatment within last 3 yrs)
Poliomyelitis
Polyarteritis (Periarteritis Nodosa)
Postero-lateral Sclerosis
Psychotic Disorders
Rheumatoid Arthritis
Sickle Cell Anemia
Silicosis
Splenic Anemia (True Banti's Syndrome)
Still's Disease
Stroke (CVA)
Syringomyelia
Tabes Dorsalis (locomotor Ataxia)
Thalassemia (Cooley's or Mediterranean Anemia)
Topectomy and Lobotomy
Ulcerative Colitis
Wilson's Disease

What Deductible Options are Available?

Three deductible options were available during 1994, $500, $1,000, and $1,500. As of December 31, 1994, the plan insured 16 in the $500 deductible, 38 in the $1,000 deductible, 53 in the $1,500 deductible, 10 in Medicare Supplement A and 11 in Medicare Supplement I. The three additional deductible options, $2,500, $5,000 and $10,000, were made available beginning January 1, 1995.



What are the Rates?

Major Medical Rates/1993-1995

Deductible	$500		$1,000		$1,500	
Out of Pocket Maximum	$2,000		$2,000		$2,000	
Adult Age	**Monthly**	**Quarterly**	**Monthly**	**Quarterly**	**Monthly**	**Quarterly**
<18	$135	$405	$ 98	$294	$ 89	$267
19-24	$240	$720	$175	$525	$159	$477
25-29	$243	$729	$180	$540	$163	$489
30-34	$289	$867	$212	$636	$193	$579
35-39	$306	$918	$225	$675	$204	$612
40-44	$363	$1089	$268	$804	$243	$729
45-49	$418	$1443	$308	$1924	$279	$837
50-54	$510	$1530	$380	$1140	$344	$1032
55-59	$586	$1758	$438	$1314	$397	$1191
60-64	$694	$2082	$520	$1560	$471	$1413

Deductible	$2,500		$5,000		$10,000	
Out of Pocket Maximum	$3,500		$7,500		$10,000	
Adult Age	**Monthly**	**Quarterly**	**Monthly**	**Quarterly**	**Monthly**	**Quarterly**
<18	$74	$222	$52	$156	$38	$114
19-24	$131	$393	$92	$276	$67	$201
25-29	$135	$405	$94	$282	$68	$204
30-34	$159	$477	$112	$336	$81	$243
35-39	$169	$507	$118	$354	$86	$258
40-44	$201	$603	$141	$423	$102	$306
45-49	$230	$690	$162	$486	$118	$354
50-54	$284	$852	$199	$597	$145	$435
55-59	$328	$984	$230	$690	$167	$501
60-64	$389	$1167	$273	$819	$193	$594

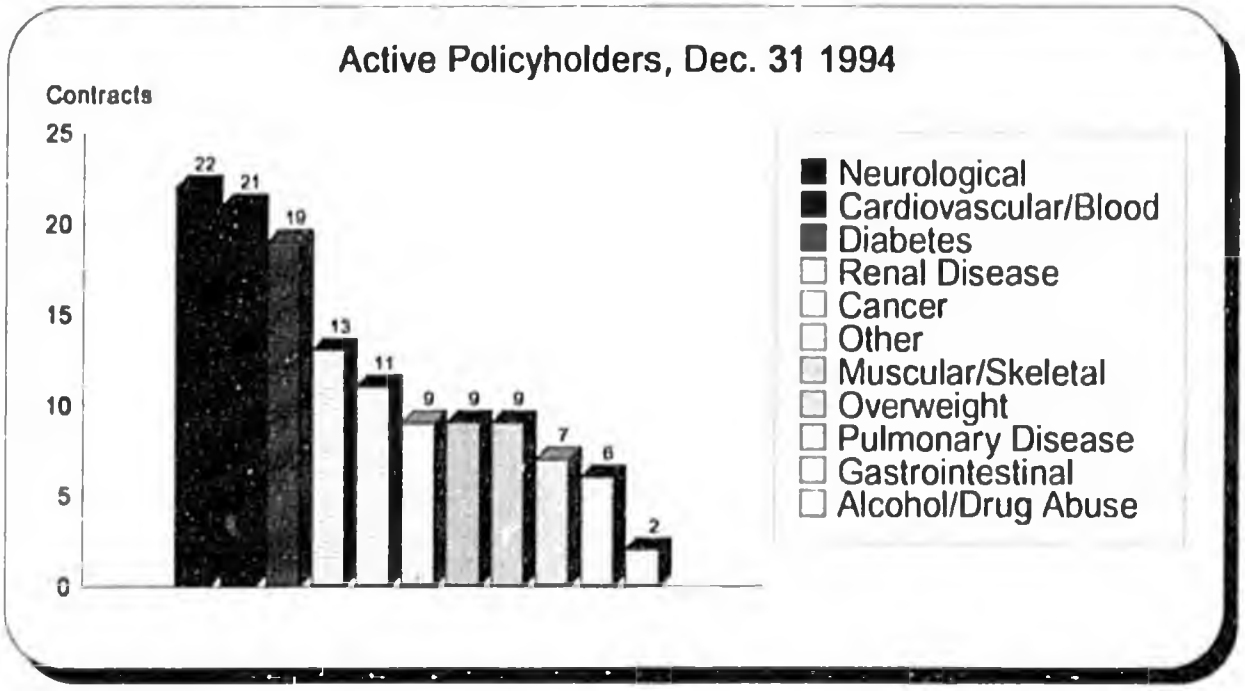
Medicare Supplement Rates/1993-1995

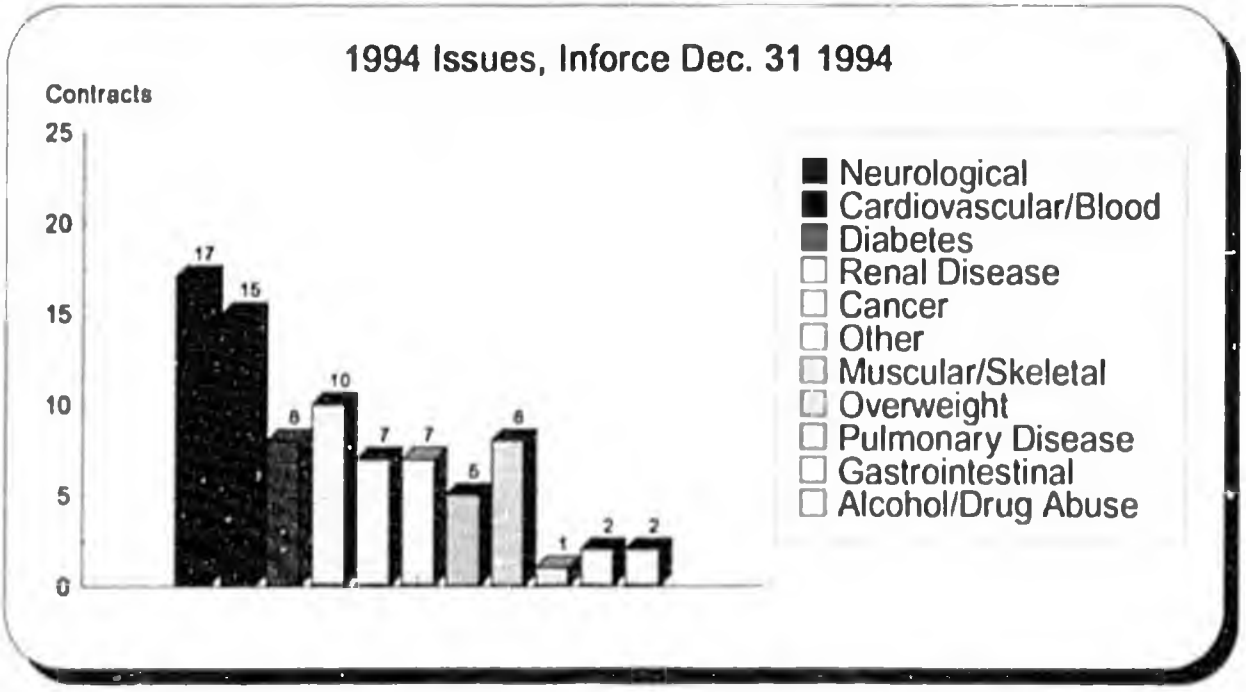
	Plan A		Plan I	
Adult Age	**Monthly**	**Quarterly**	**Monthly**	**Quarterly**
69 & under	$79	$237	$182	$546
70-74	$90	$270	$205	$615
75-79	$96	$288	$222	$666
80+	$102	$306	$236	$708

Note: All premiums are payable quarterly. Monthly rates are shown for comparison purposes only. Rates have not changed since inception of Plan

Primary Medical Condition

Applicants for ACHIA coverage are asked to identify their primary medical condition. The most frequently listed category includes conditions related to a history of diabetes. The next most listed categories include people with musculoskeletal problems, followed by individuals with a history of cardiovascular, pulmonary or gastrointestinal conditions. These conditions, as well as experience from member companies, make up a list of specified conditions for eligibility in the program in addition to the rejections formerly requested.





Financial

This section details the policy year financial experience for the Plan coverages. Exhibits 1-5 cover Aetna's financial reporting. Exhibits 6 and 7 include all financial considerations of the pool.

Financial Summary - Exhibit 1 summarizes the status of the Plan account. It illustrates the current year ending balance, prior year balance, transfers to and from the Premium Stabilization Reserve (PSR) and the cumulative balance. The current policy period balance had a deficit balance of $548,443. A withdrawal of $107,707 was made from the PSR. The balance carry-forward is a deficit of $440,736.

Cash Balance Report - Exhibit 2 displays the credited premium, recorded claims, reserves, other claim charges and expenses for the policy period by line of coverage. The credited premiums are premium actually paid to Aetna by the enrollees. Recorded claims are claims paid by Aetna. As shown, claims, retention and other charges exceeded credited premium by $548,443. This left a net cash deficit of $19,865 on December 31, 1994, in the Aetna account.

Premium Stabilization Reserve - Exhibit 3 shows the Premium Stabilization Reserves (PSR). The PSR balance as of January 1, 1994 was $107,707. The full amount in the PSR was applied against the deficit balance that was generated during the policy period. Therefore, the PSR balance as of December 31, 1994 was $0. Interest was credited on the reserve balance at a rate of 5.0% during the accounting period.

Expense Comparison - Exhibit 4 displays Aetna's administrative charges and the customer specific charges for the current period and compares them to the original proposal. During the accounting period from January 1994 through December 31, 1994, a total of 101 members enrolled in the plan by remitting premium of which 82 remained inforce at year-end in addition to 46 individuals who were issued in 1993 and who were still inforce. Expense calculations were based on the average enrollment, number of accounts established, number of claims transactions (PCT's) and the amount of paid and incurred claims. A total of 30 enrollees terminated this coverage during 1994.

Reserve Comparison - Exhibit 5 compares the estimated liabilities with respect to claims incurred during a policy year but not recorded as paid until after the policy anniversary. "Runoff" claims are defined as claims which are incurred prior to termination but are not recorded as paid. The unrecorded claim reserve (UNR) is the estimate of the outstanding liability for claims incurred during the policy year but not recorded as paid until after the policy anniversary. The reserve calculation was set actuarially as agreed upon by the board of directors.

Analysis of Claims - The incurred claim amount of $805,642 represents the claims recorded during the policy period plus any change in reserves.

Statements of Revenues, Expenses and Changes in Fund Balance (Deficits) - Exhibit 6 shows these for 1993 and 1994.

Statements of Cash Flows - Exhibit 7 shows these for 1993 and 1994.

Observations & Recommendations

The Board of Directors of the Comprehensive Health Insurance Association recommended and the Legislature passed several changes to Chapter 55 regarding the Comprehensive Health Insurance Association as encompassed in senate Bill No. 538.

AS 21.55.010 was amended to include all health maintenance organizations or other managed care arrangements as approved by the Director. This change envisioned managed care arrangements which may be recognized and approved by the Director and the need to have these organizations included in the membership of the Comprehensive Health Insurance Association. It is also our hope that at some point in the future, the Association may establish a plan which includes managed care arrangements in order to provide better benefits to the participants and increase efficiencies within the Plan. This is further envisioned by the addition of a new subsection under AS 21.55.100(d) which allows the Association to make coverage available to residents under health maintenance organization or other managed care arrangement as approved by the Director.

AS 21.55.120 was amended to allow other deductible, copayment or other maximum limits to be established if approved by the Director. Under this provision, additional deductible ranges as now offered at lower premium levels for participants who are willing to pay higher deductible and out-of-pocket maximums. Deductible ranges now include $2,500, $5,000, and $10,000 levels.

In an additional cost saving effort, the Association may use separate scales of premium rates based on other factors, including use of tobacco as approved by the Director. This change is made in AS 21.55.150(b).

AS 21.55.300 was amended to clarify the eligibility requirements and reduce adverse selection into the Association plan. First, under (b), employees who are eligible to be covered under the small employer health reforms will not be eligible to enroll in the Association's plan. The effect is to prevent employers from refusing to cover certain high risk employees. In addition, additional eligibility requirements for enrollment may be imposed if approved by the Director under (d). An example of such an eligibility requirement may be that if a participant voluntarily discontinues coverage within the Association, they may not reapply for one year. This would prevent participants from enrolling, obtaining benefits for needed conditions,

discontinuing coverage and then reenrolling when additional benefits are needed. These additional eligibility requirements would only be imposed if, in the discretion of the Director, they are needed to enhance plan solvency, reduce premiums, or prevent gaming of the system.

Based on some administrative confusion by applicants, AS 21.55.310 was amended to require that the initial application include payment of the first quarter's premium. Premium information is available with the application. Therefore, all applicants know the specific premium which will be due. This will allow a smoother application process and for coverage to be put in place more quickly.

Along similar lines, if the payment of the first premium is submitted with the application, the administrator's response would not include billing information and such wording has been deleted in the amendment to AS 21.55.320.

AS 21.55.400 was amended to expand the duties of the Director to include formulating general policies that are reasonably necessary to administer the Chapter. The intent was to give the Director more discretion, not only to adopt regulations, but to form general policies that are consistent with the intent of the Chapter and the provision of coverage to high-risk residents under the Plan.

A new section was also added to give Board members civil and criminal immunity under AS 21.55.420. It is especially important to the community members of the Board that immunity exist as long as the Board member acts in good faith and within the scope of the duties under this Chapter. This same immunity is provided for board members under the Small Employer Health Reinsurance Association. Without this immunity, it would be difficult to involve citizens of the state in certain boards where their involvement is critical.

Finally, AS 21.55.500(10)(c) expands the definition of residents who are high risk in order to simplify the eligibility process for high risk residents who are clearly unable to obtain coverage elsewhere. This provision allows the Director to establish other requirements that are consistent with the Chapter and indicates that a person is unable to obtain coverage. For example, certain medical conditions now qualify automatic eligibility. The list can be changed as medical technology and information changes without the need for legislative intervention.

Alaska Comprehensive Health Insurance Association

Balance Sheet

December 31, 1994

Assets

Cash	$29,287
Funds held by writing carrier	$ --
	$29,287

Liabilities and Fund Balance

Reserve for claims and claim adjustment expenses	$420,871
Funds due to writing carrier	19,865
Accounts Payable	--
Unearned premiums	35,905
Assessments collected in advance	43,628
Fund balance	(490,982)
	$29,287

Board of Directors

The Board of Directors for 1994 are:

Elaine Hurley
540 West Intnl Airport Road
Anchorage, AK 99518
ph: (907) 561-5335
fax: (907) 564-7429
home: (907) 522-1097

Robert Niebrugge, Vice Chairman
Box 4187 - Lot 2
Campbell Road off Palmer Fishhook
Palmer, AK 99645
ph: (907) 746-3256
fax: (907) 745-3110

Ross Blaker, CEBS
Aetna Life & Casualty
4300 B Street, Suite 205
Anchorage, AK 99503
ph: (907) 563-0433
Fax: (907) 561-2362

Christina Palme-Krizak
Fortis, Inc.
500 Bellenberg Drive
Woodbury, MN 55125
P.O. Box 64271
St. Paul, MN 55164
ph: 800-800-2000, ext. 4009
(612) 738-4009
fax: (612) 738-4187

Cecil D. Bykerk, Chairman
Sr. Executive V.P. & Chief Actuary
4 Actuarial
Mutual of Omaha Insurance Company
Mutual of Omaha Plaza
Omaha, NE 68175
ph: (402) 351-2534
fax: (402) 351-2465

Thelma S. Walker, Deputy Director
State of Alaska Division of Insurance
3601 C Street, Suite 1324
Anchorage, AK 99503-5948
ph: (907) 269-7900
fax: (907) 269-7912
ex-officio member

Bill Dowden
Golden Rule Insurance Co.
7440 Woodland Drive
Indianapolis, IN 46278-1719
ph: (317) 297-4123
fax: (317) 297-0908

John Gabriel, Asst. Actuary
Blue Cross of Washington & Alaska
7001 220th Street S.W., Bldg 3
Mountlake Terrace, WA 98043-2124
ph: John (206) 670-5656
fax: (206) 670-4007

Exhibit 1
FINANCIAL SUMMARY

COMPREHENSIVE HEALTH INS. ASSOC.

POLICY PERIOD
1/1/94 - 1/1/95

COVERAGE	CURRENT POLICY PERIOD BALANCE	+	PRIOR BALANCE FORWARD	RETROSPECTIVE PREMIUM PAYMENT	=	CUMULATIVE BALANCE	WITHDRAWAL FROM PREMIUM STABILIZATION RESERVE	=	BALANCE FORWARD
COMP MEDICAL	($548,443)		$0	$0		($548,443)	$107,707		($440,736)

Exhibit 2
CASH BALANCES

COMPREHENSIVE HEALTH INS. ASSOC.

POLICY PERIOD
1/1/94 - 1/1/95

COVERAGE	CREDITED PREMIUM	-	CLAIMS PAID BY AETNA	-	CURRENT REQUIRED RESERVES	+	PRIOR REQUIRED RESERVES	-	OTHER CHARGES	-	RETENTION	=	CURRENT POLICY PERIOD BALANCE
COMP MEDICAL	$348,744		$474,619		$420,871		$89,848		$0		$91,545		($548,443)

Exhibit 3
PREMIUM STABILIZATION RESERVE

COMPREHENSIVE HEALTH INS. ASSOC.

POLICY PERIOD
1/1/94 - 1/1/95

RESERVE AT 1/1/94		$107,707
POLICY YEAR TRANSACTIONS		
CASH TRANSACTIONS	$0	
TOTAL		$0
LESS EXPERIENCE WITHDRAWALS		$107,707
TOTAL POLICY YEAR TRANSACTIONS		$107,707
RESERVE AT 1/1/94		$0
* ASSESSMENT MAILED ON 3/14/95	$600,000	

* This Assessment will be used to offset the deficit carried forward from the 1994 policy period.

Exhibit 4
EXPENSE COMPARISON

COMPREHENSIVE HEALTH INS. ASSOC.

POLICY PERIOD
1/1/94 - 1/1/95

	1994	1993
ASSUMPTIONS		
AVERAGE ENROLLEES	110	24
PAID PCTS	1,525	166
PAID CLAIMS	$474,619	[illegible]
INCURRED CLAIMS	$805,642	$244,758
EXPENSES		
CLAIMS SETTLEMENT	$19,342	$2,008
INDIVIDUAL ENROLLMENT AND BILLING	6,277	[illegible]
ADMINISTRATION	72,212	[illegible]
	97,831	$42,844

Exhibit 5
RESERVE COMPARISON

COMPREHENSIVE HEALTH INS. ASSOC.

POLICY PERIOD
1/1/94 - 1/1/95

CURRENT YEAR RESERVE COMPARED TO PARTIAL YEAR RUNOFF

COVERAGE	RESERVE AT 1/1/95	RUNOFF FROM 1/1/95 - 3/1/95	ADDITIONAL RUNOFF PROJECTED
COMPREHENSIVE MEDICAL	$420,871	$147,888	$272,983

Exhibit 6

STATEMENTS OF REVENUES, EXPENSES AND CHANGES IN FUND BALANCE (DEFICIT)

Years ended December 31, 1994 and 1993

		1994	1993
Revenues:			
Member assessments		$ -	338,874
Premiums earned		328,962	72,252
Interest income (note 3)		5,926	6,276
		334,888	417,402
Expenses:			
Claims Paid		474,619	154,910
Change in claims and claim adjustment expense reserves		331,023	89,848
Administrative services		72,212	35,422
Claims adjustment expenses paid	19,342	2,008	
Accounting services		8,775	1,680
Enrollment and billing		6,277	5,414
Sectarial services		3,026	5,624
Board meetings		2,690	11,923
Telephone		869	4,608
Postage		129	1,044
Printing		62	1,201
Actuarial services	-	9,536	
Legal		-	996
Bank fees		21	13
		919,045	324,227
Excess (deficiency) of revenues over expenses		(584,157)	93,175
Fund balance at beginning of year		93,175	-
Fund balance (deficit) at end of year		$ (490,982)	93,175

Exhibit 7
STATEMENTS OF CASH FLOWS

Years ended December 31, 1994 and 1993

	1994	1993
Cash flows from operating activities:		
Assessments collected from members	$ -	382,502
Premiums collected from insureds	348,744	88,375
Interest received	5,926	6,276
Claims and claim adjustment expenses paid	(493,961)	(156,918)
Cash paid to administrators and suppliers in excess of claims and other expenses paid by writing carrier	217,420	(197,555)
Net cash provided (used) by operating activities and net increase (decrease) in cash	(17,612)	46,899
Cash at beginning of year	46,899	-
Cash at end of year	$ 29,287	46,899
Reconciliation of excess (deficiency) of revenues over expenses to net cash provided (used) by operating activities:		
Excess (deficiency) of revenues over expenses	(584,157)	93,175
Adjustments:		
Decrease (increase) in funds held by writing carrier	217,420	(197,555)
(Decrease) increase in accounts payable	(1,680)	1,680
Increase in reserve for claims and claim adjustment expenses	331,023	89,848
Increase in unearned premiums	19,782	16,123
Increase in assessments collected in advance	-	43,628
Total adjustments	566,545	(46,276)
Net cash provided (used) by operating activities	$ (17,612)	46,899

STATE OF ALASKA

TONY KNOWLES, GOVERNOR

DEPARTMENT OF COMMERCE AND
ECONOMIC DEVELOPMENT

DIVISION OF INSURANCE

800 EAST DIMOND BLVD.
SUITE 560
ANCHORAGE, ALASKA 99515
PHONE: (907) 349-1230

December 16, 1994

REC'D

DEC 28 '94

C. D. Bykerk

Cecil D. Bykerk, Chairman
Sr. Executive V.P. & Chief Actuary
4 Actuarial
Mutual of Omaha Ins. Co.
Mutual of Omaha Plaza
Omaha, NE 68175

Re: Plan of Operation
Comprehensive Health Insurance Association
Amended November 1, 1994

Dear Mr. Bykerk:

You will find enclosed an approved and signed copy of the amended Plan of Operation for the Comprehensive Health Insurance Association. The original of this document has been filed with the Director's office of the Division of Insurance.

Sincerely,

Thelma Snow Walker

Thelma Snow Walker
Deputy Director

Enclosure

(achia)

08-H9LH

PLAN OF OPERATION

ALASKA

COMPREHENSIVE HEALTH INSURANCE ASSOCIATION

(As amended 11-1-94)

TABLE OF CONTENTS

ARTICLE I. NAME

This entity shall be known as the Comprehensive Health Insurance Association, herein referred to as the "ASSOCIATION". The ASSOCIATION is a nonprofit incorporated legal entity created by the State Legislature pursuant to Chapter 55 of the Alaska Insurance Laws herein referred to as the "ACT".

ARTICLE II. PLAN OF OPERATION

The ASSOCIATION shall perform its functions in accordance with the Act and this Plan of Operation as presently written or as may be hereinafter amended. The Plan of Operation shall become effective upon approval in writing by the Director of Insurance, herein referred to as the "DIRECTOR".

ARTICLE III. PURPOSE

It is the purpose of the ASSOCIATION to provide access to health insurance to all residents of Alaska who are presently denied adequate health insurance or who are considered uninsurable.

As a minimum, it is the purpose of the Plan of Operation to:

1. establish procedures whereby all the powers and duties of the ASSOCIATION under this Chapter will be performed;
2. establish procedures for handling assets of the ASSOCIATION;
3. establish the amount and method of reimbursing members of the Board of Directors under AS 21.55.020;
4. establish regular places and times for meetings of the Board of Directors.,
5. establish procedures for records to be kept of all financial transactions of the ASSOCIATION, its agents, and the Board of Directors;
6. provide that a member aggrieved by a final action or decision of the ASSOCIATION may appeal to the DIRECTOR within 30 days after the action or decision;
7. establish procedures whereby selection for the Board of Directors will be submitted to the DIRECTOR;
8. establish procedures for the collection of assessments from all members to offset deficits incurred or estimated to be incurred during the period for which the assessment is made;
9. establish the amount of assessment pursuant to AS 21.55.220 of the Act, which shall be due and payable within thirty days of the receipt of the assessment notice;
10. provided for the selection of an Administrator in accordance with AS 21.55.200 of the Act; and
11. contain additional provisions necessary or proper for the execution of the powers and duties of the ASSOCIATION.

ARTICLE IV. MEMBERSHIP

Pursuant to AS 21.55.010, Membership consists of all licensed hospital or medical service corporations in the state that offer subscriber contracts for major medical coverage, all health maintenance organizations or other managed care arrangements approved by the DIRECTOR, and all insurers licensed to transact health insurance in the state that offer policies for major medical coveage on an expense incurred basis. All members shall maintain membership in the ASSOCIATION as a condition of doing health insurance business, or being able to offer subscriber contracts in Alaska. Each, such commercial insurer, health care service contractor, and health maintenance organization or other managed care arrangement admitted after said date shall automatically become, effective on the date of its admission, a member of the ASSOCIATION. A member which ceases to be admitted after said date shall automatically cease to be a member effective on the day following the termination or expiration of its license to transact the kinds of coverage provided by said Act; provided, however, such member shall remain liable for any assessment or assessments based upon accrued net losses sustained by the ASSOCIATION prior to the cessation of its status as a member in the ASSOCIATION.

ARTICLE V. POWERS OF THE ASSOCIATION

The ASSOCIATION may:

1. exercise the powers granted to insurers under the laws of the state;
2. sue or be sued;
3. enter into contracts with insurers, similar associations in other states, or with other persons for the performance of administrative or other functions as necessary or proper for the execution of the powers and duties of the ASSOCIATION;
4. establish administrative and accounting procedures for the operation of the ASSOCIATION;
5. receive funds from sources other than members of the ASSOCIATION;
6. establish appropriate rates, rate schedules, rate adjustments, expense allowances, agent referral fees, claim reserve formulas and any other actuarial functions appropriate to the operation of the ASSOCIATION;
7. assess members of the ASSOCIATION in accordance with the provisions of the Act, and to make advance or interim assessments as may be reasonable and necessary for the organizational or interim operating expenses. Any interim assessments will be credited as offsets against the regular assessment which next follows the interim assessment;
8. select an Administrator in accordance with the Act, pursuant to the utilization of a request for proposal as part of the proposal process;
9. issue policies of insurance in accordance with the requirements of the Act;
10. establish procedures under which applicants and participants may have gnevances reviewed by the Board;
11. appoint appropriate legal, actuarial and other committees as necessary to provide technical assistance in the operation of the ASSOCIATION, policy, and other contract design, and any other function within the authority of the ASSOCIATION;
12. hire independent consultants;
13. review the Plan of Operation and submit proposed amendments, if any, to the DIRECTOR for approval;
14. review, consider and act upon any other matters deemed by it to be necessary and proper to the administration of the ASSOCIATION under the ACT; and

15. conduct periodic audits to assure the general accuracy of the financial data submitted to the ASSOCIATION, and the Board shall cause the ASSOCIATION to have an annual audit of its operations by an Independent Certified Public Accountant.

ARTICLE VI. DUTIES OF DIRECTOR

The DIRECTOR may:

1. approve the selection of the writing carrier by the ASSOCIATION and approve the ASSOCIATION's contract with the writing carrier including the coverages and premiums to be charged;
2. contract with the federal government or another unit of government to ensure coordination of the state plans with other governmental assistance programs;
3. undertake directly or through contracts with other persons studies or demonstration programs to develop awareness of the benefits of the ACT; and
4. formulate general policies and adopt regulations that are reasonably necessary to administer the ACT.

ARTICLE VII. BOARD OF DIRECTORS

The ASSOCIATION shall be managed by a Board of Directors, herein referred to as the "BOARD". The BOARD will be made up of seven individuals, who shall consist of:

1. five individuals selected by participating members, subject to approval by the DIRECTOR; and
2. two consumers selected by the DIRECTOR.

The DIRECTOR or DIRECTOR's designee shall serve as a nonvoting ex-officio member of the BOARD. In approving members of the BOARD, the DIRECTOR shall consider among other things, whether all types of participating members are fairly represented. The DIRECTOR shall annually review the BOARD membership and may request changes to the BOARD membership. Each DIRECTOR shall hold office for a term of three (3) years. Successors or vacancies of unexpired terms occurring on the Board will be nominated by the members of the ASSOCIATION or the remaining DIRECTORS. All nominations will be sent to the DIRECTOR for approval and appointment.

In determining voting rights at ASSOCIATION meetings, an ASSOCIATION member is entitled to vote in person or proxy. The vote shall be a weighted vote based upon the ASSOCIATION member's premiums for health insurance for major medical coverage on an expense incurred basis, or the ASSOCIATION member's subscriber fees, derived from or on behalf of state residents in the previous calendar year, as determined by the DIRECTOR.

The members of the BOARD shall (1) elect a Chairman, Vice Chairman and such other officers as are deemed necessary; and (2) select an administrating member ("ADMINISTRATOR"). The presence of four BOARD members shall constitute a quorum for the transaction of business, and the acts of the majority of the BOARD members present at a meeting at which a quorum is present shall be the acts of the BOARD; except that an affirmative vote of a majority of the full BOARD is required to:

1. approve contracts with any entities or organization(s) to perform administrative activities and duties on behalf of the ASSOCIATION;
2. levy assessments;
3. remove a BOARD member; or
4. initiate any legal proceeding.

An annual meeting of the BOARD shall be held at such time and place as the BOARD may determine so as to conduct all business deemed by it necessary and proper for the administration of the ASSOCIATION. At each annual meeting the BOARD shall:

1. review the operation and status of the ASSOCIATION including the previous year-end financial statements submitted to the DIRECTOR to assure compliance with the ACT;
2. review the Plan of Operation of the ASSOCIATION and submit proposed amendments, if any, to the DIRECTOR for approval;
3. review each outstanding contract or agreement and make necessary or desirable corrections, improvements or additions, including a detailed review of the performance of the ADMINISTRATOR;
4. review operating expenses and outstanding contractual obligations and determine if an assessment is necessary for the proper administration of the ASSOCIATION and, if so, the amount. If such assessment is deemed to be necessary, the BOARD shall levy such assessment in accordance with the Act and the Plan of Operation. The BOARD may abate or defer in part the assessment of a member if, in the opinion of the BOARD, payment of the assessment would endanger the ability of the member to fulfill its contractual obligations; and
5. review underwriting policies and practices and rates for coverage issued by the ASSOCIATION.

The BOARD shall hold other meetings at such times and with such frequency as it deems appropriate to conduct the business of the ASSOCIATION. Appropriate notification of such meetings shall be given.

The BOARD shall consider and decide what persons, organizations, if any, should be hired by the ASSOCIATION to implement and carry out broad directives of the BOARD made pursuant to its statutorily imposed duties.

Members of the BOARD may be reimbursed from the ASSOCIATION for reasonable expenses incurred by them as members, but may not otherwise be compensated by the ASSOCIATION for their services. The Chairman shall approve all requests for reimbursement, save his/her own, which shall be approved by the Vice Chairman. The costs of conducting meetings of the ASSOCIATION and its BOARD shall be borne by members of the ASSOCIATION.

A written record of the proceedings of such BOARD meeting shall be made. The original of these records shall be retained by the chairman of the BOARD. Copies of such minutes shall be furnished to each BOARD member and to the DIRECTOR. Copies of such minutes shall be provided to any member of the ASSOCIATION upon written request.

The BOARD shall submit, not later than March 1 of each year, a financial report of the preceding year in a form approved by the DIRECTOR.

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

ARTICLE VIII. OPERATION OF THE PLAN

1. OPERATIONS

The official address of the ASSOCIATION shall be as determined by the BOARD from time to time.

The BOARD may employ such persons, firms or corporations to perform such administrative duties as are necessary for the BOARD's performance of duties imposed on the ASSOCIATION. The BOARD may use the mailing address of such a person, firm, or corporation as the official office address of the ASSOCIATION. Such persons, firms, or corporations shall keep such records of their activities as may be required by the BOARD.

The BOARD may open one or more bank accounts for use in ASSOCIATION business. Reasonable delegation of deposit and withdrawal authority to such accounts for ASSOCIATION business may be made as is consistent with prudent fiscal policy.

Withdrawals from ASSOCIATION funds may only be made as necessary to carry out the obligations of the ASSOCIATION and in accordance with the ACT and the Plan of Operation. The BOARD (or the Chairman acting for the BOARD) shall have charge and custody of and maintain appropriate financial records of all funds of the ASSOCIATION, receive and give receipts for monies due and payable from any source whatsoever, and deposit all such monies in the name of the ASSOCIATION in such accounts or other depositories as shall be selected by the BOARD in accordance with the provisions of this Plan and the ACT

2. ENROLLMENT

A person may enroll in a state plan by applying to the writing carrier and payment of the appropriate premium. An employer that has in its employ one or more eligible persons enrolled in a state plan may make all or a portion of a state plan premium payment directly to the writing carrier.

Within 30 days after receiving the application, the writing carrier shall either reject the application for failing to comply with AS 21.55.300 and AS 21.55.310 or forward the eligible person notice of acceptance.. Except as provided below and in AS 21.55.130(c), of the ACT, insurance under a state plan is effective immediately upon receipt of the first quarterly premium, and is retroactive to the date of the application, if the applicant otherwise complies with the requirements of the ACT.

Insurance under a state plan is effective retroactively to the date that the person's previous contract or policy terminated if the person:

a. applies for a state plan within 60 days after the previous contract or policy, terminated;
b. is accepted by the writing carrier; and
c. pays a specified premium for the period of retroactive coverage.

A policyholder will have his/her insurance terminated by the ASSOCIATION under the following circumstances effective on the dates indicated:

a. failure of the policyholder to pay premiums due upon written notice and a grace period of thirty-one (31) days, and no benefits shall be paid for services performed during this grace period or any period beyond which premium has been paid;

b. at the request of the policyholder, as of the date of the policyholder's premium expires. Unearned premiums in excess of that due for the current month will be refunded to the policyholder; or

c. when the policyholder no longer meets the eligibility requirements of the ASSOCIATION, including, but not limited to:

1) being covered by another health insurance policy, subscriber contract, HMO or managed care plan;

2) if eligible to be covered by a plan subject to the requirements of AS 21.56.110-21.56.250; or

3) ceases to be a resident of Alaska

If a policyholder voluntarily discontinues coverage under this plan, they are not eligible to reapply for coverage for a period of twelve (12) months after termination of coverage.

3. ASSESSMENTS

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

4. ASSOCIATION MEMBERS LIABILITY

The ASSOCIATION shall make an annual determination of each ASSOCIATION member's liability, if any, and may make an annual fiscal year end assessment if necessary. The ASSOCIATION may also, subject to the approval of the DIRECTOR, provide for interim assessments against the members as may be necessary to assure the financial capability of the ASSOCIATION in meeting the incurred or estimated claims expenses of the state plans and operating and administrative expenses of the ASSOCIATION until the ASSOCIATION's next annual fiscal year end assessment. Such interim assessments need not be proportional, and shall be credited against amounts due at the next regular assessment.

Payment of an assessment is due within 30 days of receipt by a member of written notice of a fiscal year end or interim assessment. Disputes concerning liability to pay an assessment or the amount of the assessment shall not be cause to withhold payment. Such disputes shall be submitted to the BOARD as a grievance after payment of the assessment. Failure by a member to tender to the ASSOCIATION the assessment within 30 days shall be grounds for revocation of a member's certificate of authority.

A member insurer aggrieved by a final action or decision of the ASSOCIATION may appeal to the DIRECTOR within 30 days after such action or decision.

A member that ceases to do health insurance business in the state, or ceases to offer subscriber contacts in the state, due to revocation, suspension, or voluntary surrender of its certificate of authority remains liable for assessments resulting from the calendar year that the health insurance business ceased.

The ASSOCIATION may decline to levy an assessment against a member if the assessment would not exceed $10. Assessments paid by a member are a general expense of the member.

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

5. PUBLICIZING EXISTENCE OF STATE HEALTH INSURANCE

a. The ASSOCIATION, under a plan approved by the DIRECTOR, shall disseminate appropriate information to the residents of the state regarding the existence of the state plans and the means of enrollment. Means of communication may include use of the press, radio, and television, as well as publication in appropriate state offices and publications.

b. The ASSOCIATION shall devise and implement means of maintaining public awareness of the provisions of the Act regarding the state plans and shall administer the Act in a manner that facilitates public participation in the state plans.

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

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

ARTICLE IX. AGENTS

The ASSOCIATION or ASSOCIATION Administrator shall pay an agent's referral fee in an amount as established by the Board to the appropriate licensed insurance agent who refers an applicant to the ASSOCIATION if that application is accepted.

ARTICLE X. ADMINISTRATOR

1. Selection of writing carriers.

The BOARD shall develop bid specifications for members that wish to be selected as a writing carrier to administer a state plan. The selection of the writing carrier shall be based upon criteria

including the member's proven ability to handle a large number of health insurance cases or subscriber contracts, efficient claim paying capacity, and the estimate of total charges for administering the plan.

2. Duties of Writing carriers

The writing carrier shall:

a. administer the benefit plans as set forth in the ACT;

b perform the administrative and claims payment functions. The writing carrier shall provide these services for a period of three years, unless a request to terminate is approved by the DIRECTOR. The DIRECTOR shall approve or deny a request to terminate within 90 days of its receipt. A failure to make a final decision on a request to terminate within the specified period shall be considered an approval. Six months before the expiration of each three-year period, the BOARD shall invite submissions of proposals from members of the ASSOCIATION, including the writing carrier. The BOARD shall follow the provisions of AS 21-55.210 of the ACT in selecting a writing carrier for the subsequent three-year period;

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

d. submit to the BOARD and the DIRECTOR on a quarterly basis a report on the operation of the state plans. Specific information to be contained in the report shall be determined by the BOARD;

e. shall pay the claims and shall indicate that the claim was paid under a state plan. A claim payment shall include an explanation of benefits and a toll-free telephone number that can be used for inquiries regarding the claim;

f. be reimbursed from the state plan premiums received for its direct and indirect expenses for administering the plan. Direct and indirect expenses shall include a pro rata reimbursement for that portion of the writing carrier's administrative, printing, claims administration, management and building overhead expenses that are assignable to the maintenance and administration of the state plans. The BOARD shall approve cost accounting methods to substantiate the writing carrier's cost reports consistent with generally accepted accounting principles. Direct and indirect expenses may not include costs directly related to the original submission of policy forms before selection as the writing carrier;

g. all funds collected by the ADMINISTRATOR are funds of the ASSOCIATION. The ADMINISTRATOR shall be responsible for developing an investment policy, having it approved by the BOARD, and implementing such policy. The ADMINISTRATOR shall have general custodianship responsibility for the ASSOCIATION's funds; and

h. at all times when carrying out its duties under this chapter be considered an agent of the ASSOCIATION and carry out its duties in compliance with the terms of this Plan of Operation and the ACT.

ARTICLE XI. BOARD IMMUNITY

A member of the BOARD may not be held civilly or criminally liable for an act or omission if the act or omission was in good faith and within the scope of the BOARD's duties under the ACT.

ARTICLE XII. INDEMNIFICATION

The BOARD may obtain liability insurance to indemnify any person or member made a party of any action, suit or proceeding because such person or member served on the BOARD of a committee of the ASSOCIATION or was an officer or employee of the ASSOCIATION. Such indemnification shall be for all costs (including the amounts of judgments, settlements, fines or penalties) and expenses incurred in connection with such action, suit or Proceeding; provided, however, such indemnification shall not be provided on any matter in which the person or member shall be finally adjudged in any such action, suit or proceeding to have committed a breach of duty involving gross negligence, bad faith, dishonesty, wilful misfeasance or reckless disregard of the responsibilities of his or her office. In the event of settlement of a matter before final adjudication, indemnification shall be provided only if the ASSOCIATION is advised by independent counsel that the person or member to be indemnified did not, in counsel's opinion, commit such a breach of duty.

ARTICLE XIII. REPORTS, RECORDS AND ACCOUNTING

The initial accounting year of the ASSOCIATION shall end December 31, 1993. Succeeding accounting years shall be calendar years, or as so changed by the BOARD.

The BOARD shall make or have its ADMINISTRATOR make an annual report to the DIRECTOR as required by the ACT not later than March 1 of each year. Such report shall include a financial report for the preceding accounting year in a form as approved by the DIRECTOR and a review of the activities of the ASSOCIATION during the preceding year.

The ASSOCIATION shall conduct periodic audits to assure the general accuracy of the financial data submitted to the ASSOCIATION. The ASSOCIATION shall have an annual audit of its operations made by an independent certified public accountant. A copy of the audit report will be furnished to the DIRECTOR and all BOARD members, and will be available for inspection by ASSOCIATION members on request.

The ASSOCIATION is subject to examination by the DIRECTOR. All policy forms issued by the ASSOCIATION shall conform to the requirements of the ACT and must be filed with and approved by the DIRECTOR before their use.

The BOARD shall annually conduct a study of the claims loss experience of the ASSOCIATION and adjust the Plan of Operation to reflect the findings of the study with the approval of the DIRECTOR.

ARTICLE XIV. AMENDMENTS

This Plan of Operation may be altered or amended at any meeting of the BOARD. Amendments shall be by majority vote of the full BOARD, provided at least ten days' written notice is given of the intention to alter or amend the Plan of operation at such meeting. All amendments are subject to review and approval by the DIRECTOR before becoming effective.

ARTICLE XV. TERMINATION

The ASSOCIATION shall continue in existence subject to termination in accordance with requirements of a law or laws of the state of Alaska. In case of an enactment of a law or laws

resulting in termination of the ASSOCIATION, the ASSOCIATION, to the extent consistent with such law or laws, shall continue operating only to the extent necessary to process, verify and pay claims of losses. The ASSOCIATION shall perform other necessary functions in connection therewith, and complete the termination of the Alaska Comprehensive Health Insurance Association policies written by or through the ASSOCIATION.

ARTICLE XVI. STATE NOT LIABLE

The state is not liable for acts or omissions of the ASSOCIATION or a writing carrier under the ACT, nor is the state liable for payment of a claim under a state plan issued by a writing carrier.

ARTICLE XVII. ADMINISTRATIVE PROCEDURE ACT

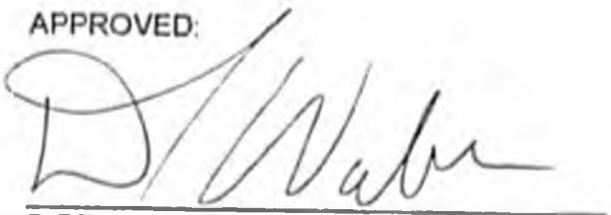
The ASSOCIATION is exempt from the Administrative Procedures Act (AS 44.62).

ARTICLE XVIII. TAX EXEMPTION

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

Dated this ____1ST__________day of November, 1994

APPROVED:



DIRECTOR OF INSURANCE

Dec 3, 1994

Date

Comprehensive
Health
Insurance
Association
P.O. Box 240723
Anchorage, AK 99524-0723

April 19, 1996

Senator Lyda Green
Room 423
State Capitol
Juneau, AK 99801-1182

The Honorable Senator Green

The ACHIA Board of Directors has reviewed the ACHIA legislation that was developed by the Department of Insurance. While this legislation will not solve the assessment problems entirely, the Board feels strongly that the proposed changes will allow more flexibility in addressing the current problems. If costs are to be reduced, we must be better able to manage the delivery of care to our otherwise uninsurable policyholders. Better care will also be a result of this legislation.

The Board feels that ACHIA is a benefit to the State of Alaska as well as its citizens. Additionally, ACHIA is a mechanism that allows the private insurance market to deal with an issue that might otherwise ultimately challenge the continuation of the private market. And thereby be placed more directly on the backs of the taxpayers.

We would be happy to answer any questions that you might have, particularly from the Board's point of view.

Finally, we encourage the positive consideration of this legislation. Without it, the assessment level will most likely not come down.

Sincerely,

Cecil D. Bykerk, FSA, MAAA
Chairperson, ACHIA

cc: Marianne Burke
Kate Campbell
ACHIA Board of Directors

- THANK YOU FOR INVITING ME TODAY AND ALLOWING ME THE OPPORTUNITY TO ADDRESS SOME OF THE ISSUES FACING CHIA AT THIS TIME
- I'M CHIEF ACTUARY FOR MUTUAL OF OMAHA, ONE OF THE LARGEST WRITERS OF INDIVIDUAL MAJOR MEDICAL POLICIES IN THE US TODAY
- FORMER PROFESSOR OF ACTUARIAL SCIENCE AND PAST VICE PRESIDENT OF THE SOCIETY OF ACTUARIES
- I'M CURRENTLY VICE CHAIR OF MONTANA COMPREHENSIVE HEALTH ASSOCIATION BOARD, AND I'VE BEEN ON OTHER SUCH BOARDS INCLUDING NEW MEXICO's
- I'VE BEEN HEAVILY INVOLVED IN HEALTH CARE REFORM ISSUES IN WASHINGTON, DC INCLUDING TESTIFYING BEFORE CONGRESS AS WELL AS SERVING ON INDUSTRY AND PROFESSIONAL COMMITTEES. MOST RECENTLY I SERVED ON THE AMERICAN ACADEMY OF ACTUARIES COMMITTEE WHICH ANALYZED THE KASSEBAUM/KENNEDY BILL
- BEFORE I BEGIN MY TESTIMONY, I WANT TO EXPRESS MY GRATITUDE TO DIRECTOR BURKE AND THE DIVISION's LIFE AND HEALTH ACTUARY KATIE CAMPBELL FOR THEIR SUPPORT OF THE BOARD. THEY HAVE BEEN A TREMENDOUS HELP TC ME PERSONALLY AS I ATTEMPT TO LEAD THE BOARD IN ITS DUTIES

- I BELIEVE THAT THE CHIA-TYPE APPROACH IS AN EXTREMELY IMPORTANT ELEMENT TO THE SOLUTION OF HEALTH CARE ACCESS PROBLEMS. FURTHERMORE, IT IS A CRITICAL PART OF ANY SOLUTION WHICH WILL MAINTAIN THE VIABILITY OF THE INDIVIDUAL MAJOR MEDICAL MARKET.
- I COMMEND THE ALASKA LEGISLATURE FOR BEING INTERESTED IN ADDRESSING AN ACCESS PROBLEM THAT EXISTS IN HEALTH CARE FINANCING.
- IT IS IMPORTANT TO NOTE AT THE OUTSET THAT CHIA-TYPE APPROACHES WERE NEVER MEANT TO BE SELF-SUPPORTING. IF THEY WERE, THE INDIVIDUALS COULD NOT AFFORD TO PURCHASE THE COVERAGE PROVIDED BY THE ASSOCIATION. THE ORIGINAL LEGISLATIVE HISTORY OF CHIA IN ALASKA RECOGNIZES THAT FACT
- CHIA-TYPE COVERAGE IS EXPRESSLY DIRECTED AT PROVIDING COVERAGE TO INDIVIDUALS WHO ARE UNINSURABLE. AS AN ACTUARY, I TRANSLATE UNINSURABLE INTO BEING UNABLE TO CALCULATE A PREMIUM THAT IS ACTUARIALLY SOUND.

- ONE OF THE IMPORTANT ELEMENTS OF CHIA COVERAGE IS THAT THE PARTICIPANTS ARE INDIVIDUALS WHO ARE TRYING TO PROVIDE FOR THEMSELVES AND EVEN THOUGH THEY ARE SUBSIDIZED, THEY ARE PAYING A SIGNIFICANT PORTION OF THE COSTS

- WITH THAT AS BACKGROUND, I WOULD LIKE TO TALK ABOUT CHIA'S HISTORY.
- I HAVE BEEN A CHIA BOARD MEMBER SINCE INCEPTION STARTING IN LATE 1992. I HAVE BEEN CHAIRPERSON SINCE JUNE 1994 TAKING OVER FROM ROSS BLAKER. ROSS IS THE AETNA REPRESENTATIVE ON THE BOARD AND IS LOCATED IN ANCHORAGE.
- CHIA STARTED OUT SLOWLY IN 1993 BUT HAS SHOWN STEADY GROWTH WITH YEAREND NUMBERS OF 64, 128 AND 184. ALTHOUGH YEAREND 1995 WOULD SEEM TO BE TRACKING ON A STRAIGHT LINE, A CLOSER LOOK SUGGESTS THAT THE GROWTH MAY BE LEVELING OFF
- ATTACHMENT 1 OF DIRECTOR BURKE'S LETTER OF FEBRUARY 12TH SHOWS MONTHLY PARTICIPATION TO BE ESSENTIALLY LEVEL SINCE AUGUST WITH MONTHLY NUMBERS OF 18[illegible] 181, 185, 191, 184, 192 AND WITH 198 FOR FEBRUARY 1996

- THIS LEVELING OFF WAS NOT TAKEN INTO ACCOUNT IN SOME PROJECTIONS THAT I UNDERSTAND YOU RECEIVED A COUPLE OF MONTHS AGO. THOSE PROJECTIONS ASSUMED STRAIGHT LINE GROWTH WHICH IS FORTUNATELY NOT TAKING PLACE
- THIS IS CONSISTENT WITH MY EXPERIENCE ON THE MONTANA BOARD. ALTHOUGH NO STATE IS QUITE LIKE ALASKA, MONTANA MAY COME AS CLOSE AS ANY. MONTANA REACHED A PLATEAU IN ITS THIRD FULL YEAR OF OPERATION, BOUNCED A LITTLE HIGHER IN ONE YEAR AND HAS FALLEN FOR THE LAST THREE YEARS.
- I WOULD NOW LIKE TO TALK ABOUT WHAT THE BOARD OF CHIA HAS BEEN DOING FOR THE LAST THREE YEARS.
- FIRST WE HAVE PROVIDED THE NECESSARY RESOURCES TO GET THE POOL IN OPERATION; RECRUITED AN ADMINISTRATOR TO PROVIDE FOR THE DAY-TO-DAY WORK OF ENROLLING NEW PARTICIPANTS, COLLECTING PREMIUMS AND PAYING CLAIMS; MADE ASSESSMENTS TO COVER LOSSES AS NECESSARY; MADE SURE THAT THE PROGRAM MEETS THE REQUIREMENTS OF ALASKA LAW AND MADE REPORTS BACK TO THE ADMINISTRATION AND THE LEGISLATURE.

- INITIALLY, IT WAS VERY DIFFICULT TO KNOW WHAT TO EXPECT BY WAY OF NUMBERS OF PARTICIPANTS, CLAIM LEVELS, NECESSARY RESERVES, ETC.
- WHILE THE LEGISLATION ALLOWS US TO SET PREMIUMS AT TWICE THE GOING RATE FOR SIMILAR INDIVIDUAL MAJOR MEDICAL POLICIES IN THE MARKETPLACE, AND I EMPHASIZE INDIVIDUAL, THE BOARD CHOSE FOR VARIOUS REASONS TO SET THEM AT 175% OF STANDARD PREMIUM LEVELS
- PREMIUM LEVELS HAVE NOT CHANGED SINCE INCEPTION BUT SUCH AN UPDATE IS IN THE WORKS NOW. UPDATED PREMIUMS WILL AGAIN BE TARGETED AT 175% OF STANDARD RATES. INCREASES WILL GENERALLY RANGE FROM 25 TO 40%
- AT THIS POINT, I WANT TO CLARIFY ANY MISCONCEPTIONS ABOUT PREMIUM LEVELS CHARGED BY CHIA. I WOULD REFER YOU TO PAGE 6 OF OUR 1994 REPORT. THIS PROGRAM BASES RATES ON AGE AS WELL AS PLAN DESIGN. THUS, WHILE THE AVERAGE PREMIUM MAY BE IN THE $300 RANGE, A $500 DEDUCTIBLE PLAN WILL COST A 60 YEAR OLD $694 A MONTH. CARE MUST BE TAKEN WHEN THIS IS COMPARED TO GROUP PREMIUMS WHICH ARE SUBSIDIZED BY THE EMPLOYER AND WHICH DON'T TAKE AGE INTO ACCOUNT AND MAY BE FAMILY COVERAGE.

- IT IS IMPORTANT TO NOTE THAT CHIA PARTICIPANTS ARE PAYING PREMIUMS WHICH ARE SIGNIFICANTLY MORE THAN STANDARD AND CHIA IS NOT COMPETING WITH THE COMMERCIAL MARKET. AT LEAST SOME PREMIUM IS BEING PAID BY THE INDIVIDUALS COVERED. ELIMINATING CHIA WOULD MOST LIKELY SHIFT MOST THE COST TO THE STATE THROUGH MEDICAID. HOPEFULLY, BY WORKING THROUGH CHIA AND A CASE MANAGER, WE WILL BE ABLE TO MANAGE THE COSTS FOR THESE INDIVIDUALS BETTER WHILE PROVIDING BETTER CARE
- OUR REPORT FOR 1993 MADE SUGGESTIONS FOR LEGISLATIVE CHANGES TO FACILITATE EASIER ADMINISTRATION AND TO CLEAN THE SECTION UP A BIT. THESE CHANGES WERE ACCEPTED AND ENACTED IN 1994 AND IMPLEMENTED IN 1995.
- AS THE BOARD TRACKED THE EMERGING EXPERIENCE DURING 1995, WE SAW A MARKED INCREASE IN CLAIMS. NEEDLESS TO SAY WE WERE VERY CONCERNED AND ENTERED INTO DISCUSSIONS WITH THE DIVISION AND THE ADMINISTRATOR ABOUT WHERE THE POOL WAS GOING.

- MANY SUGGESTIONS WERE THROWN OUT FOR CONSIDERATION. HOWEVER, MANY OF THESE WERE NOT PERMITTED BY CURRENT STATUTE.
- ABOUT THE ONLY THINGS THAT THE BOARD COULD DO WAS RAISE PREMIUMS (WHICH WE ARE ACTIVELY PURSUING, BUT WILL HAVE LIMITED IMPACT), INSTITUTE A CASE MANAGER THAT WOULD HAVE TO WORK TO GET PARTICIPANTS TO VOLUNTARILY AGREE TO COST SAVING MEASURES, NEGOTIATE REDUCED ADMINISTRATIVE FEES FOR THE NEW CONTRACT TO BEGIN JANUARY 1, 1996 (AND I WOULD REFER YOU TO ATTACHMENT 5 OF THE DIRECTOR's LETTER) OR SUGGEST LEGISLATIVE CHANGES WHICH WE ARE PARTICIPATING IN RIGHT NOW.
- THIS MIGHT BE AN APPROPRIATE TIME TO CLEAR UP ANOTHER MATTER REGARDING THE ROLE OF THE ADMINISTRATOR WHICH HAPPENS TO BE AETNA. THE ASSOCIATION CREATED, ACTS ESSENTIALLY LIKE AN INSURER. CHIA BEARS THE RISK AND THE LIABILITY ALTHOUGH IT HAS THE ADVANTAGE OF BEING ABLE TO MAKE ASSESSMENTS ON ITS MEMBER COMPANIES FOR ANY SHORTFALL

- AETNA WAS SELECTED AS THE ADMINISTRATOR AND ACTS AS CHIA's EMPLOYEE. AETNA RECEIVES A FEE FOR ITS SERVICES AND BEARS NO MORE RISK THAN ANY OTHER ASSOCIATION MEMBER COMPANY. IN OTHER WORDS, IT PAYS THE SAME PERCENTAGE OF ITS HEALTH PREMIUM AS MUTUAL OF OMAHA DOES OR BLUE CROSS OF WASHINGTON AND ALASKA WHEN AN ASSESSMENT IS LEVIED
- HAVING SAID THAT, I WANT TO THANK AETNA ONE MORE TIME FOR COMING FORWARD THREE PLUS YEARS AGO AND AGREEING TO BE ADMINISTRATOR WHEN NO ONE ELSE WAS COMING FORWARD. AETNA WAS NOT PERFORMING THIS ROLE ANYWHERE ELSE AND IT HAD GOTTEN OUT OF THE INDIVIDUAL MARKETPLACE SEVERAL YEARS AGO. IT WAS NOT A NATURAL FIT, BUT THEY VOLUNTEERED ANYWAY
- IT IS IMPORTANT TO NOTE THAT WE WERE APPROACHED BY TPA's (THIRD PARTY ADMINISTRATORS) BUT THE LAW DID NOT ALLOW US TO CONSIDER THEM.

- THE RFP SENT OUT IN THE FALL OF 1995 AGAIN ONLY RESULTED IN ONE COMPANY WHICH WAS QUALIFIED UNDER STATUTE COMING FORWARD WITH A PROPOSAL, AETNA. INSTEAD OF REDUCED FEES, THE PROPOSAL INCLUDED FEES THAT WERE AROUND 25% HIGHER AND THAT DIDN'T INCLUDE THE COST OF A DEDICATED CASE MANAGER WHICH WAS ESSENTIAL.
- SINCE THEN, AETNA HAS AGREED TO ADD THE CASE MANAGER FOR AN ADDITIONAL 10% INCREASE IN FEES. WE ARE PURSUING CONTRACT LANGUAGE AT THIS TIME.
- HOWEVER, THE NECESSARY FEE LEVELS WILL PUT CHIA's ADMINISTRATIVE FEES AT THE HIGHEST LEVEL OF ANY STATE RISK POOL
- THEREFORE, I SUPPORT PROPOSED CHANGES TO THE LAW THAT WOULD GIVE THE BOARD GREATER FLEXIBILITY IN THE SELECTION OF ADMINISTRATORS
- ATTACHMENT 6 TO THE DIRECTOR's LETTER PROVIDES A COMPARISON OF THE ASSESSMENT LEVELS OF THE VARIOUS STATES THAT MAKE ASSESSMENTS BASED ON HEALTH PREMIUM WRITTEN. CHIA's LEVEL IS NOT OUT OF LINE BEING AROUND ONE HALF OF ONE PERCENT OF THE COLLECTED PREMIUM.

- WHILE THE SIGNS INDICATING SOME LEVELING OFF IN ENROLLMENT ARE HOPEFUL, WE CLEARLY NEED TO FIND WAYS TO REDUCE CLAIM COSTS IN THE POOL AND TO REDUCE THE GAP BETWEEN CHIA PREMIUMS AND ACTUAL COSTS.
- THEREFORE, WE SUPPORT THE SUGGESTIONS IN THE DIRECTOR's LETTER REGARDING ADMINISTRATOR SELECTION AS WELL AS FLEXIBILITY IN SETTING DEDUCTIBLES, OUT-OF-POCKET LIMITS AND COINSURANCE PERCENTAGES. HOWEVER, WE WOULD CAUTION THAT LENGTHENING THE PRE-EX PERIOD AND REDUCING THE LIFETIME MAXIMUM WILL HAVE LITTLE LONG TERM EFFECT AND COULD JUST INCREASE MEDICAID COSTS FOR THE STATE.
- WE ARE ACTIVELY WORKING WITH THE DIVISION IN REVIEWING POSSIBLE CHANGES WHICH WILL MAXIMIZE THE MANAGEMENT OF CHIA
- THANK YOU AGAIN FOR ALLOWING ME TO COME BEFORE YOU AND WOULD BE PLEASED TO ADDRESS ANY QUESTIONS THAT YOU MIGHT HAVE.

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LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

130 Seward Street, Suite 409
Juneau, Alaska 99801-2105

MEMORANDUM January 22, 1996

SUBJECT: Transfer of postsecondary functions by E.O. 97
(Work Order No. 9-LS1557)

TO: Senator Lyda Green
Attn: Mike Tibbles

FROM: Michael F. Ford
Legislative Counsel

You have asked in what way does executive order 97 reduce the oversight power of the legislature or add to the authority of the executive branch. As explained in this memo, the executive order does make several changes to existing law, including the removal of legislators from the existing Alaska Commission on Postsecondary Education.

The executive order repeals the Alaska Commission on Postsecondary Education and transfers its duties to the Alaska Student Aid Corporation and to the Department of Education. Under AS 14.42.015(7), two members of the legislature presently serve on the commission. Under the executive order, the new board that governs the corporation does not have any legislative members. Therefore the executive order does result in removal of legislators from existing positions on an executive branch commission.

The presence of legislative members on the commission does raise constitutional issues. We believe that because the commission has regulatory powers, the placing of legislative members on the commission violates the Alaska Constitution's separation of powers doctrine. See Bradner v. Hammond, 553 P.2d 1 (Alaska 1976). In addition to the separation of powers doctrine, there is a constitutional question regarding dual office holding prohibited under Article II, sec. 5 of the Alaska Constitution. This provision provides that legislators are prohibited from serving "in any other office or position of profit." In that members of the commission do not receive compensation, we believe that service on the commission does not constitute dual office holding as prohibited by the constitution, but the Attorney General has reached the opposite conclusion. See A.G. file no. 663-88-0371, February 29, 1988.

In addition to the elimination of legislative members of the commission, the transfer of functions to the corporation also results in elimination of the legislative power over confirmation of the governor's appointees. Under AS 14.42.015(c), the governor's

appointees to the commission are subject to legislative confirmation. The proposed public corporation would have four public members (see sec. 8 of E.O. 97), but because the members serve on a public corporation, the members are not subject to legislative confirmation. See Walker v. Alaska State Mortgage Authority, 416 P.2d 245 (Alaska 1966).

Finally you should note that one of the functions of the commission is to review the annual budget and capital outlay requests of the University of Alaska. This function is being transferred to the Department of Education (Sec. 4 of E.O. 97). While I cannot say this directly affects legislative oversight, because legislators at present are members of the commission this change will remove one existing way in which members of the legislature also look at the budget of the University of Alaska.

In summary, the changes to the membership of the board, the elimination of legislative power of confirmation, and to a lesser degree the shift in functions of the commission appear to affect the oversight power of the legislature. Please contact me if you have further questions.

MFF:klb
96-018.klb

ALASKA COMMISSION ON POSTSECONDARY EDUCATION
and the
ALASKA STUDENT LOAN CORPORATION:

A NEW ROLE
as
THE ALASKA STUDENT AID CORPORATION

A Position Paper

by

Dr. Joe L. McCormick
Executive Director
ACPE

June, 1995

Introduction

In recent years, several concerns have been raised about the proper role of the Alaska Commission on Postsecondary Education. Problems associated with the administration of the Alaska Student Loan Program, the changing role of the University of Alaska System to include a community college mission in the state, and the economic downturn of the state's revenues are all contributing factors in an examination and discussion of what the proper role of ACPE should be for the state of Alaska.

Almost six years ago, the House Research Agency Report 89-A (May, 1989) recommended, " *The program needs to be reviewed with the objective of containing costs while continuing to provide Alaskans access to postsecondary opportunities.* " The report went on to say, " *Without significant changes, the program is unlikely to satisfy the educational, social, and economic needs of Alaska residents and it is only a matter of time before the program will be in crisis.* " Specifically, the report recommended policy changes to the Alaska Student Loan Program that would:

- maximize the utilization of federal student aid programs before relying on ASLP
- make the ASLP a totally self-sustaining, revolving student loan fund
- expand grants to needy students, especially Alaska Natives and high school graduates with good grades
- encourage Alaska residents to attend Alaska schools

Four years later, in October 1993 , the Division of Legislative Audit recommended that the ACPE prepare: *(1) a revised mission which addresses Alaska's current financial aid environment, (2) a long range operational plan capable of servicing the entire student loan business cycle, and (3) an assessment of the commission's current capabilities to implement this plan.* Again, in a December 1994 audit of the financial soundness of the ASLP, the Division of Legislative Audit reiterated the need to: "*re-examine the mission and make administrative and programmatic changes to the program.*"

Since 1993, the ACPE has taken major steps toward addressing these and other important concerns of the Commission. This paper describes what has been done, what is currently being done, and what still needs to be done to secure the financial future of the Alaska Student Loan Program. More important, this paper recommends a course of action that will fully address the concerns repeatedly expressed by the Division of Legislative Audit over these past two years. Specifically, this position paper calls for:

1. A total revision of the mission of the ACPE and the ASLC combined into one new Alaska Student Aid Corporation (ASAC),
2. A higher standard of eligibility for schools to participate in the Alaska Student Loan Program, and
3. The accrual of interest for the entire life of an Alaska Student Loan and the capitalization of said interest at appropriate periods throughout the life of the loan.