ALASKA LEGISLATURE COMMITTEE FILES 1997-1998 8672
9313 HOUSE LABOR & COMMERCE

CORRECTION

THE FOLLOWING DOCUMENT(S)
HAVE BEEN REFILMED TO
ASSURE LEGIBILITY OR PAGINATION

Central Microfilm Services
Departement of Education
State of Alaska

Rev. 6/98

FEB 13 1997

TONY KNOWLES, GOVERNOR

DEPARTMENT OF COMMERCE AND ECONOMIC DEVELOPMENT

DIVISION OF INSURANCE

P.O. BOX 110805
JUNEAU, ALASKA 99811-0005
PHONE: (907) 465-2515
FAX: (907) 465-3422
TDD: (907) 465-5437

February 13, 1997

The Honorable Norman Rokeberg
House of Representatives
State Capitol, Room 24
Juneau, AK 99801-1182

Dear Representative Rokeberg:

As you requested, I am enclosing a copy of the Health Insurance Portability and Accountability Act of 1996 (the Kassenbaum/Kennedy federal law), a preliminary draft of the proposed Alaska legislation implementing the federal law, and an overview of the federal law which you may find informative. The proposed Alaska legislation is currently being reviewed by Law and, accordingly, we have marked the document as a draft. We do not anticipate any significant changes between the draft and the final document.

I look forward to the work session scheduled on Wednesday, February 19 and appreciate the opportunity to work with the labor and commerce committee regarding this proposed legislation.

Very truly yours,

Marianne K. Burke
Director

MKB/cw4360.ins
021307a
Enclosures

08-H11LH

EXPLANATION OF PROPOSED LEGISLATIVE CHANGES TO TITLE 21, CHAPTER 55

AS 21.55.020

The current language in this section does not clearly state the voting methodology to be used in board meetings as compared to association meetings. The current language defines the voting methodology to be used at association meetings as premium weighted. However, this methodology is not appropriate for board meetings, since the public members would not have a vote and the small insurers would essentially have no vote due to the fact that the Alaska health insurance market is overwhelmingly dominated by only two carriers.

Recommended changes to this section clarify that each member receives only one vote at board meetings giving proper representation of the members of the board. Recommended changes to this section also establish the terms of members of the board.

AS 21.55.100
AS 21.55.120

These changes would allow the board greater flexibility in developing cost-saving health benefit plans for high risk individuals. For example, the current legislation would not allow the development of a PPO structure with proper incentives for its use, such as reduced copayments and out of pocket maximums. Many states with high risk pools allow for cost containment features in their benefit plans such as penalties for failing to pre-certify treatment and increased copayments for use of non-preferred providers.

AS 21.55.150

These changes would eliminate the conflict between the requirement that the premium rates not be excessive or inadequate and the requirement that premium rates not be greater than 200% of standard premium rates. CHIA is essentially a pool for uninsurable health insurance risks, which means that the premium rates will not be adequate to cover the costs.

Also, the requirements regarding the calculation of the premium rates are modified slightly to allow additional flexibility in determining the premium rates. Current statute requires that the premium rates be based on the standard rates of the top 5 insurers in the state. Since there are fewer than 5 significant individual comprehensive health insurers in the state, this basis for calculating the premium rates results in the use of rates that are not necessarily appropriate for the Alaska market.

March 15, 1996 (2:05pm)

AS 21.55.200
AS 21.55.500(13)
These changes would allow greater flexibility in selecting an administrator. The changes strengthen the criteria under which a plan administrator will be evaluated. This is an important change, since the nature and structure of a high risk pool such as CHIA create the need for special reporting and analysis.

The number of potential administrators is increased by eliminating the requirement that the administrator be an insurer. Greater potential savings in administrative costs may be achieved through opening the door to many other entities that have an expertise in administration of health insurance type contracts. The larger number of potential administrators from which to select should result in better negotiation in determining administrative fees and services. Since inception only one insurer has offered to administer the plan.

AS 21.55.210
Changes were made to allow greater flexibility in evaluating an administrator and in setting the terms of the administrative contract.

Specific language was added to specifically allow termination for cause. The administrative contract would specify the conditions under which the administrator would be allowed to terminate the contract.

AS 21.55.220
A change was made to excuse members from assessment if the assessment amount is minimal. This would allow the board to determine the level of assessment at which it becomes cost prohibitive to assess a member.

AS 21.55.330
This change would help clarify that monthly premium modes would be acceptable.

The misnomer, "writing carrier", has been changed to "plan administrator". This change should help clarify the administrator's role as an administrator not insurer.

AS 21.55.500
The change to the definition of "residents who are high risks" would simplify the eligibility requirements by allowing an individual with only one declination to be eligible for coverage. Currently individuals must wait to receive two formal declinations in order to prove eligibility under the plan which often results in a long waiting period for the individual before they can be covered under the CHIA plan.

December 5, 1996 (12:13pm)

*Sec. x. AS 21.55.020 repealed and reenacted to read:

(a) The board of directors of the association shall be made up of seven individuals. Five board members shall be selected by association 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. A member of the board serves for a term of three years and may be reappointed to an unlimited number of terms. The term of a board member shall continue until a successor is appointed.

(b) In approving members of the board, the director shall consider, among other things, whether all types of participating members are fairly represented.

(c) 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. In determining voting rights at board meetings, a board member is entitled to one vote in person or proxy.

(d) 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.

(e) The board shall study and prepare a report 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. The board shall notify the legislature that the report is available.

(f) In this section, "board" means the board of directors of the association.

*Sec. x. AS 21.55.100(a) is amended to read:

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 <u>at least one plan related to the deductible, copayment and calendar year maximums</u> [THREE ALTERNATIVES RELATED TO DEDUCTIBLES] as described in as 21.55.120 and may offer additional deductible<u>, copayment and calendar year maximum</u> alternatives <u>as approved by the director</u>.

*Sec. x. AS 21.55.100(d) is amended to read:

(d) The association may make available to residents who are high risks coverage through a health maintenance organization or other managed care arrangement <u>if</u> [AS] approved by the director. <u>Deductibles, copayment and calendar year maximum limits provided through such organizations or arrangements are not subject to the limits described in AS 21.55.120, but such limits must be approved by the director.</u>

*Sec. x. AS 21.55.120 (a) is amended to read:

Section 21.55.120 DEDUCTIBLES AND COPAYMENTS. (a) A state plan other than a Medicare supplement plan may require deductibles of at least $500 a person, as determined by the board and approved by the director [$200 A PERSON, $500 A PERSON, OR $1,000 A PERSON]. The amount of the deductible may not be greater when a service is rendered on an outpatient basis than when that service is offered on an inpatient basis. Expenses incurred during the last three months of a calendar year and actually applied to an individual's deductible for that year shall also be applied to that individual's deductible in the following calendar year. [THE $200 MAXIMUM, THE $500 MAXIMUM, AND THE $1,000 MAXIMUM MAY BE ADJUSTED YEARLY TO CORRESPOND WITH THE CHANGE IN THE MEDICAL CARE COMPONENT OF THE CONSUMER PRICE INDEX, AS ADJUSTED BY THE DIRECTOR. THE BASE YEAR FOR THE COMPUTATION SHALL BE THE FIRST FULL CALENDAR YEAR OF OPERATION OF THE ASSOCIATION.]

*Sec x. AS 21.55.120(b) is amended to read:

(b) A state plan other than a Medicare supplement plan shall require a maximum copayment of 40 [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.

*Sec x. AS 21.55.120(c) is amended to read:

(c) The [EXCEPT AS PROVIDED IN (e) OF THIS SECTION, THE] sum of the deductible and copayments required in any calendar year under a plan may not exceed a

maximum limit of five times the deductible [$2,000 PER COVERED INDIVIDUAL] as determined by the board and approved by the director. 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.

*Sec. x. AS 21.55.150 is amended to read:

(a) The association may not charge a rate for coverage issued by or through the association that is [EXCESSIVE, INADEQUATE, OR] unfairly discriminatory. Premium rates must be submitted to the director for approval prior to use.

(B) The Association may [SHALL] use separate scales of premium rates based on age and geographic location of the insured. The association may use separate scales of premium rates based on other factors, including use or nonuse of tobacco, if approved by the director.

(c) The board shall determine standard risk premium rates by considering the premium rates charged by [FIVE] members of the associatio offering, to residents of the state, [THAT INSURE, OR HAVE SUBSCRIBER CONTRACTS WITH, THE LARGEST NUMBER OF INDIVIDUALS IN THE STATE UNDER PLANS WITH] health insurance 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 standard risk premium rates determined by the board [AVERAGE OF THOSE FIVE ESTIMATES].

*Sec. x. AS 21.55.200 is amended to read:

SELECTION OF PLAN ADMINISTRATORS [WRITING CARRIERS]. The board [ASSOCIATION] shall develop bid specifications and select a plan administrator through a competitive bidding process [FOR MEMBERS THAT WISH TO BE SELECTED AS A WRITING CARRIER TO ADMINISTER A STATE PLAN]. The selection of the plan administrator [WRITING CARRIER] shall be based upon criteria including the plan administrator's [MEMBER'S] proven ability to handle health insurance coverage to individuals [A LARGE NUMBER OF HEALTH INSURANCE CASES OR SUBSCRIBER CONTRACTS], efficient claim paying capacity,[AND] the estimate of total charges for administering the plan[.], the plan administrator's ability to apply effective cost containment programs and procedures and to administer the plan in a cost efficient manner, and the financial condition and stability of the plan administrator.

*Sec. x. AS 21.55.210 is repeal and reenacted to read:

DUTIES OF PLAN ADMINISTRATORS. (a) The plan administrator shall perform the administrative and claims payment functions required by this section. The plan administrator shall provide these services for a period specified in the contract between

the association and the plan administrator subject to [REMOVAL FOR CAUSE AND SUBJECT TO] any terms, conditions, and limitations of the contract between the association and the plan administrator. At least six months before the expiration of each contract period, the board shall invite eligible entities, including the plan administrator, to submit bids to serve as the plan administrator. The board shall follow the provisions of AS 21.55.210 in selecting a plan administrator for the subsequent contract period.

(b) The plan administrator shall provide to all eligible persons enrolled in a state plan an individual policy, 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 must indicate that coverage was obtained through the association.

(c) The plan administrator shall submit to the board and the director on a regular basis reports on the operation of the state plans. Specific information to be contained in the reports shall be determined by the board and shall be specified in the contract between the association and the plan administrator.

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

(e) The plan administrator shall be paid from state plan receipts for service rendered in connection with administering the plan.

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

*Sec. x. AS 21.55.220(a) is amended to read:

PREMIUM PAYMENTS; CLAIMS EXPENSES; ASSESSMENTS (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 plan administrator [WRITING CARRIER].

*Sec. x. AS 21.55.220(b) is amended to read:

(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 plan administrator [WRITING CARRIER].

*Sec. x. AS 21.55.220(d) is amended to read:

(d) The board [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 board [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 board [ASSOCIATION] may decline to levy an assessment against a member if the assessment would be minimal [NOT EXCEED $10]. Assessments paid by a member are a general expense of the member.

*Sec. x. AS 21.55.310 is amended to read:

APPLICATION BY ENROLLEE. A person may enroll in a state plan by applying to the plan administrator [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; and

(4) payment of the first premiums.

*Sec .x. AS 21.55.320 is amended to read:

NOTICE OF ACCEPTANCE OR REJECTION. Within 30 days after receiving the certificate described in AS 21.55.310, the plan administrator [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.

*Sec. x. AS 21.55.330(a) is amended to read:

EFFECTIVE DATE. (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.

*Sec. x. AS 21.55.330(b) is amended to read:

(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 plan administrator [WRITING CARRIER]; and

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

*Sec. x. AS 21.55.400 is amended to read:

The director may

(1) approve the selection of the plan administrator [WRITING CARRIER] by the association and approve the association's contract with the plan administrator [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. x. AS 21.55.410 is amended to read:

The state is not liable for acts or omissions of the association or a plan administrator [WRITING CARRIER] under this chapter, nor is the state liable for payment of a claim under a state plan issued by a plan administrator [WRITING CARRIER].

*Sec. x. AS 21.55.500(10) is amended to read:

(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 one [TWO] association member[S] 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;

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

(C) meet other requirements adopted by regulation by the director that are consistent with this chapter and that indicate that a person is unable to obtain coverage substantially similar to that which may be obtained by a person who is considered a standard risk;

*Sec. x. AS 21.55.500(11) is amended to read:

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

plan administrator [WRITING CARRIER];

*Sec. x. AS 21.55.500(13) is amended to read:

(13)"plan administrator" ["WRITING CARRIER"] means the eligible entity or entities [INSURER OR INSURERS] selected by the board [ASSOCIATION] and approved by the director to administer a state plan.

*Sec. x. AS 21.55.120(d) and 21.55.120(e) are repealed.

SECTIONAL ANALYSIS

Section 1. PURPOSE. The purpose of this Act is to implement the minimum federal standards for health care insurance enacted under P.L. 104-191 (Health Insurance Portability and Accountability Act of 1996)

Sec. 3. AS 21.12.050
This section defines "health care insurance" which is consistent with the definition of "health insuance coverage" in P.L. 104-191 adding Sec. 2791(b) (42 U.S.C. 300gg-91(b)). The federal definition differs from the current state definition and since Alaska's definition is more broad, the federal definition was defined as a subset of the Alaska definition.

Sec. 2, Sec. 4 - Sec. 20. Required Coverages or Offers of Coverage
References to health insurance terms in these sections were changed to be consistent with the new definitions, "health care insurance" in AS 21.12.050 and "health care insurer" in AS 21.54.900.

Use of the terms "health care insurance plan" and "health care insurer" generally clarifies that the applicability of these sections include MEWAs and, in three provisions, HMOs. This results from the use of the term "health care insurer" which is defined very broadly to include all entities that transact health care insurance. Note that the definition of "health care insurance plan" excludes limited benefit policies and supplemental coverages. In the cases where the provision is to apply to these types of policies it is explicitly added.

The changes to these sections were intended to make the sections consistent with each other in terms of applicability and with the newly defined health insurance terms under the federal law.

Note that:

Sec. 10. AS 21.42.345 was modified to conform with the minimum federal standards pursuant to P.L. 104-191 amending the Public Health Service Act (PHSA) to add Sec. 2701(f) (42 U.S.C. 300gg(f)) regarding enrollment periods for dependents. The current provision applies to both individual and group plans while the federal law applies only tc group plans. However, for simplicity the changes made to conform to the federal law were made to both individual and group policies.

Sec. 9. AS 21.42.347 relating to costs of childbirth was modified to conform with the minimum federal standards pursuant to P.L. 104-191 adding Sec 2751 to PHSA (42 U.S.C. 300gg-51).

Sec. 21. Sec. 21.53.090
Under federal law long term care contracts with certain federally defined characteristics may receive favorable tax treatment. Since this creates a separate class of long term care policies and need for additional protections, the amendments to this section expand the director's authority to write specific regulations for this purpose.

Sec. 22.

This section adds several new sections to AS 21.54 to conform with the minimum federal standards for health care insurance in the group market as follows:

Sec. 21.54.100

This section is added to conform with the minimum federal standards pursuant to P.L. 104-191 adding Sec. 2702 to PHSA (42 U.S.C. 300gg-1) regarding unfair discrimination in the offer of or enrollment under a health care insurance plan.

Sec. 21.54.110

This section is added to conform with the minimum federal standards pursuant to P.L. 104-191 Sec. 2701(a)-(b) to PHSA (42 U.S.C. 300gg(a)-(b)) relating to preexisting condition exclusions.

Sec. 21.54.120

This section is added to conform with the minimum federal standards pursuant to P.L. 104-191 adding Sec. 2701(c)-(e) to PHSA (42 U.S.C. 300gg(c)-(e)) relating to creditable coverage. Creditable coverage is used in determining the allowable preexisting condition waiting period or exclusion. Note that the federal law allows the states discretion in determining an allowable break in coverage in determining creditable coverage. AS 21.56 allowed a 90 day break in coverage for small employer groups and this was maintained in this section and as a result would apply to large employers as well.

Sec. 21.54.130

This section is added to conform with the minimum federal standards pursuant to P.L. 104-191 adding Sec. 2712 to PHSA (42 U.S.C. 300gg-12) relating to guaranteed renewability, modification and termination of coverage. Subsection (f) of this section was added to allow an insurer to terminate an individual's coverage if the individual has committed fraud or intentional misrepresentation. This is not part of the federal law but was considered an oversight by the NAIC and HCFA.

Sec. 21.54.140

This section is added to conform with the minimum federal standards pursuant to P.L. 104-191 adding Sec. 703 to ERISA (29 U.S.C. 1183) relating to guaranteed renewability for MEWA plans.

Sec. 21.54.150

This section is added to conform with the minimum federal standards relating to mental health benefits parity pursuant to the amendment to P.L. 104-191 adding Sec. 2705 to PHSA (42 U.S.C. 300gg-5).

Sec. 21.54.160

This section defines the health plans that are not subject to the minimum federal standards and are termed "excepted benefits" in the federal law. These "excepted benefits" are explicitly defined in P.L. 104-191 adding Sec. 2791(c) to PHSA (42 U.S.C. 300gg-91(c)). These health plans are basically limited benefit and supplemental health insurance plans. The definition of "health care insurance plan" as proposed in this bill excludes "excepted benefits".

Article 3. Sec. 21.54.900

This section adds new definitions necessary to conform with the minimum federal standards. The definitions are consistent with the definitions in P.L. 104-191

adding Sec. 2701(b), Sec. 2701(e), Sec. 2705(e) and Sec. 2791 to PHSA (42 U.S.C. 300gg(b), 42 U.S.C. 300gg(e), 42 U.S.C. 300gg-5(e), 42 U.S.C. 300gg-91 respectively)

Sec. 23. - Sec. 31.
These sections amend AS 21.55 relating to the Comprehensive Health Insurance Association. P.L. 104-191 adding Sec. 2744 to PHSA (42 U.S.C. 300gg-44) allows a state to use a qualified high risk pool to guarantee portability of health insurance coverage to federally eligible individuals. The amendments to this section allow a "federally defined eligible individual" defined in P.L. 104-191 adding Sec. 2741(b) to PHSA (42 U.S.C. 300gg-41(b)) to participate in the CHIA. Use of Alaska's high risk pool (CHIA) would be the least disruptive mechanism allowed under the federal law to reform the individual health insurance market in Alaska and therefore was the selected mechanism. Experience in other states such as Washington, New Jersey, and New York relating to the alternative mechanisms allowed in the federal law has resulted in significant increases in claims and premiums and decreases in the number of individuals insured and the number of insurance companies writing individual health insurance.

Sec. 32. - Sec. 39
These sections amend AS 21.56 relating to health insurance coverage for small employers to remove any conflicts with the minimum federal requirements under P.L. 104-191. Certain sections of AS 21.56 were repealed and reenacted under AS 21.54 because under federal law those provisions apply to both large and small employer groups. The sections in AS 21.56 relating to guaranteed issue were amended to conform with the federal minimums for small employer groups pursuant to P.L. 104-191 adding Sec. 2711 to PHSA (42 U.S.C. 300gg-11). To the extent possible the provisions in AS 21.56 were not modified unless they would prevent application of the federal minimums.

Sec. 33. AS 21.56.075
This is a new section that requires members of the Small Employer Reinsurance Association to report to the director on an annual basis the total amount of small employer health insurance premiums written in the state. While not required by federal law, this section will significantly improve the ability of the Association to assess Association members for losses.

Sec. 40. AS 21.84.590
This amendment clarifies that the minimum federal standards apply to Fraternal Benefit Societies.

Sec. 41. - Sec 43.
These sections amend AS 21.86 relating to HMOs in order to conform with the minimum federal standards pursuant to P.L. 104-191 adding Sec. 2701(g) to PHSA (42 U.S.C. 300gg(g)).

Sec. 44. AS 21.87.340
Amendments in this section clarify that the minimum federal standards apply to Hospital and Medical Service Corporations.

Sec. 45. AS 21.90.900(29)
The definition of policy is modified to extend to group certificates issued in Alaska when the group policy is issued and delivered outside of Alaska to ensure consistency in application of state law to all group health care plans covering individuals resident in Alaska. The new minimum federal standards apply to such certificates and without this amendment Alaska may have difficulty asserting regulatory authority over such certificates. Failure to regulate group certificates could result in the federal government determining that Alaska is not substantially enforcing the minimum federal standards resulting in federal regulation of Alaska's health insurance market.

Sec. 46. AS 21.90.900
This section adds the definition of "medical care" as defined in P.L. 104-191 adding Sec. 2791(a)(2) to PHSA (42 U.S.C. 300gg-91(a)(2)) which is necessary in order to define "health care insurance".

Official Business

COMMITTEE:

HOUSE LABOR AND COMMERCE

DATE: February 19, 1997

Subject of meeting:

KASSENBAUM/KENNEDY HEALTH CARE INSURANCE BILL

SIGN-IN

PLEASE PRINT!

NAME	ADDRESS (MAILING) & (ZIP)	PHONE	REPRESENTING	DO YOU WANT TO TESTIFY?
Mariame Burke		465 2515	Div of Ins	Yes

AGENDA

Good Afternoon

This Meeting Of The House Labor & Commerce Committee Is Called To Order
On February 19 1997 At _____PM

For The Record The Committee Members Present Are:

Rep. Norman Rokeberg, Chairman - On Teleconference at the
Rep. John Cowdery, Vice Chairman
Rep. Bill Hudson
Rep. Joe Ryan
Rep. Jerry Sanders
Rep. Tom Brice
Rep. Gene Kubina

If A Committee Member Arrives Late Announce: Representative (Name) Has (Joined) (Left) The Committee At (Time).

A Quorum (Is) (Is Not) Present.

On Today's Calendar We Are Continuing The hearing on:

Overview -of the Kassenbaum/Kennedy Health Care Insurance Bill
Ms. Mairanne K Burke, Director - Division of Insurance,
Department of Commerce & Economic Development

1 I understand that many states are just implementing the minimum requirements. Have you been contact with any other states and what they are doing?

2. Is the Governor plan to introduce a bill, implementing the Kassenbaum/Kennedy Bill?
If so when?, What's the deadline for states?

For The Record, Please Clearly State Your Full Name, Your Affiliation And Title. If You Have

Alaska State Legislature

SLATURE
atives

Shirley Armstrong
Legislative Assistant
Representative Norman Rokeberg

INTERIM
716 WEST 4TH AVENUE, SUITE 200
ANCHORAGE, AK 99501
PHONE (907) 258-8191

SESSION
ALASKA STATE CAPITOL
JUNEAU, AK 99801-1182
PHONE (907) 465-4968
FAX (907) 465-2040

Labor and Commerce Committee

2/19/97

Attn: Christy Henies

Attached is the information you requested.

Shirley Armstrong
(907) 465-4968
FAX (907) 465-2040

Send copy of map when info.

Author: Marianne Burke at dced_jun1
Date: 2/5/97 8:28 AM
Priority: Normal
TO: Shirley Armstrong at LAA_TRANS
Subject: Re: Labor & Commerce Executive Summary Kassenbaum/Kennedy Bi

I certainly understand that things can come up at the last minute. I am grateful that Rep Rokeberg recognizes the importance of the legistation and is willing to give me the opportunity to present the overview and answer questions. Unfortunately, I have a court hearing, a Review and Advisory Committee meeting(workers comp) and investigative matters scheduled next week and must be in Anchorage. I will be back in Juneau the evening of Tuesday, the Feb. 18. I will work my schedule around whatever will work that week or anytime before the 28th. Judge Hunt has scheduled a hearing on a long standing liquidation for the 28th. Agin, please let Rep. Rokeberg know how much I appreciate his interest and help.

_____ Reply Separator _____

Subject: Labor & Commerce Executive Summary Kassenbaum/Kennedy Bill
Author: Shirley Armstrong at JNU_LAA
Date: 2/4/97 9:51 PM

2/5/97

Ms. Marrianne K. Burke, Director
Division of Insurance, Dept. of Commerce & Economic Development

I received your outline of the items you will cover in your Executive Summary of the new federal insurance requirements for health insurance.

Unfortunately, we will not be able to have your summary on Friday, February 7, 1997. The meeting has been canceled due to unexpected travel by some members of the committee. Rep. Rokeberg considers this subject very important and would like the full committee available for the briefing.

We would like to schedule your presentation for Wednesday, February 12, 1997, if it fits your schedule. Please give me a call tomorrow at 465-4968 or 465-4954 to confirm.

Your presentation will be the only agenda item in order to allow questions by the members of the committee.

Sincerely,

Shirley Armstrong, Staff Rep Rokeberg & L&C Committee

STATE OF ALASKA
DEPARTMENT OF COMMERCE
& ECONOMIC DEVELOPMENT

MARIANNE K. BURKE
DIRECTOR
DIVISION OF INSURANCE

3601 C STREET, SUITE 1324
ANCHORAGE, AK 99503-5948
PHONE: (907) 269-7900
FAX: (907) 269-7912
TDD: (907) 465-5437

STATE OFFICE BLDG., 9TH FL
333 WILLOUGHBY AVENUE
P.O. BOX 110805
JUNEAU, ALASKA 99811-0805
PHONE: (907) 465-2515
FAX: (907) 465-3422

Author: Shirley Armstrong at LAA_TRANS
Date: 2/4/97 9:34 PM
Priority: Normal
Receipt Requested
TO: Marianne_Burke@commerce.state.ak.us at CC2MHS1
Subject: Labor & Commerce Executive Summary Kassenbaum/Kennedy Bill

2/5/97

Ms. Marrianne K. Burke, Director
Division of Insurance, Dept. of Commerce & Economic Development

I received your outline of the items you will cover in your Executive Summary of the new federal insurance requirements for health insurance.

Unfortunately, we will not be able to have your summary on Friday, February 7, 1997. The meeting has been canceled due to unexpected travel by some members of the committee. Rep. Rokeberg considers this subject very important and would like the full committee available for the briefing.

We would like to schedule your presentation for Wednesday, February 12, 1997, if it fits your schedule. Please give me a call tomorrow at 465-4968 or 465-4954 to confirm.

Your presentation will be the only agenda item in order to allow questions by the members of the committee.

Sincerely,

Shirley Armstrong, Staff Rep Rokeberg & L&C Committee

January 28, 1997

Shirley:

Re L&C schedule.

HNR says if possible to put the following on for the 7 February committee meeting (sounds like it might take all meeting). The title is mine but the subject matter will be:

OVERVIEW OF FEDERAL KASSEBAUM-KENNEDY INSURANCE LEGISLATION AND EFFECT ON ALASKA'S INSURANCE LAWS
Marianne Burke, Director, Division of Insurance

Basically, the federal law gives a timeline for certain things to be done. If these certain things aren't done, then the feds came come in and take over. Long term impact on Alaska could be a loss of $30 million in general fund revenue.

I told her:

a. You would call her to confirm date.

b. Packet of materials for this overview needed to be in to you 3 DAYS before the time the committee was to meet.

She said okay, just let her know if this date is okay.

HNR says okay with him if okay with you.

Janet

AMERICANS FOR RESPONSIBLE REFORM

1275 Pennsylvania Avenue, NW
Suite 1100
Washington, DC 20004
(202) 637-0333
fax (202) 639-0317

FEB 2 5 1997

February 20, 1997

Representative Norman Rokeberg, Chairman
House Labor and Commerce Committee
State Capitol
Juneau, AK 99801-1182

Dear Chairman Rokeberg,

I recently had a conversation with House Labor and Commerce Committee aide Shirley Armstrong, who informed me that you and your committee will be considering legislation to implement the Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Americans for Responsible Reform (ARR) is a coalition of national associations representing over 1 million self-employed individuals and small businesses nationwide. ARR members are united in their support for free market approaches to making health care coverage more affordable and more accessible, and we played an active role in providing input while HIPAA was being considered in the Congress.

I thought you may have an interest in an overview of the law that we drafted to aide state officials. I have also enclosed one of our coalition member association's publication on high risk pools. We have actively supported the use of a high risk pools in many states to comply with the federal law. I addition, I am sending findings we have made on the impact of New Jersey's substantial individual market reforms. I hope you find these materials useful as you and your colleagues face the challenge of implementing HIPAA.

If I can provide you with any additional service, please don't hesitate to call.

Best Regards,

Christy Hines
Director of Public Affairs

enclosures

AMERICANS FOR RESPONSIBLE REFORM

1275 Pennsylvania Avenue, NW
Suite 1100
Washington, DC 20004
(202) 637-0333
fax (202) 639-0317

KASSEBAUM/KENNEDY HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996

SUMMARY OF MAJOR PROVISIONS RELATING TO GROUP AND INDIVIDUAL INSURANCE ACCESSIBILITY AND PORTABILITY

January 5, 1997

I. SUMMARY

The Kassebaum/Kennedy Health Insurance Portability and Accountability Act of 1996 ("HIPAA" or "the Act")[1] establishes a number of important reforms in both the individual and group markets for health care coverage. HIPAA's major group and individual reforms include:

- *Guaranteed enrollment for individuals eligible for coverage under a group health plan.* HIPAA provides that an individual who is eligible to enroll in a group plan, including an employer self-funded plan, may not be denied coverage on the basis of health status. Such individuals also may not be charged a premium higher than the rate charged for other similarly situated individuals.

- *Limitations on preexisting condition exclusion periods under group plans.* Group plans may not impose a preexisting condition exclusion period of more than 12 months (18 months for late enrollees). Exclusions may be imposed only for conditions for which medical advice, diagnosis, care or treatment was recommended or received within 6 months prior to the date of enrollment. In addition, any exclusion period imposed must be reduced by the length of any prior period of "creditable coverage" under a group or individual health plan.

- *Guaranteed issue of small group policies.* Insurance carriers offering health plans in the small employer market may not decline to issue a plan to any small employer (2 to 50 employees) that applies for coverage.

- *Guaranteed availability of individual health insurance for individuals with prior group coverage.* HIPAA ensures that certain "eligible individuals" with prior group coverage cannot

---

[1]Pub. L. No. 104-191 (August 21, 1996). H.R. Conf. Rep. No. 104-736, 104th Cong., 2d Sess. (1996).

be denied coverage in the individual market and cannot have coverage delayed due to a preexisting condition. HIPAA defines an "eligible individual" as an individual who has at least 18 months of prior "creditable coverage," the most recent of which was under a group, government or church health plan, with no lapses in coverage of more than 62 days; who is now ineligible for coverage under a group plan or Medicare or Medicaid; and who satisfies certain other conditions. HIPAA's guarantee of accessibility in the individual market may be enforced through a federal "fall-back mechanism" under which insurers and HMOs doing business in the individual market must guarantee issue at least two representative policies to eligible individuals. States, however, may choose to adopt an "alternative mechanism," in which case the federal guaranteed issue requirements will not take effect in the state. A state "alternative mechanism" could be a program such as a risk pool, a reinsurance plan or any other program (or combination of programs) that ensures access to coverage for eligible individuals and meets certain requirements established by HIPAA.

- *Guaranteed renewal of individual policies.* HIPAA provides that insurers and HMOs that offer individual coverage generally must renew and continue coverage in force at the option of the individual. In other words, an individual who has health care coverage cannot be dropped if he or she become ill or is injured and requires medical care. If an insurer or HMO discontinues a certain plan, the company must offer individuals covered under that plan the option of purchasing any other coverage offered by the company to individuals.

II. GROUP COVERAGE

HIPAA's group coverage provisions are designed to ensure that individuals who are eligible for coverage under a group plan, including an employer self-funded plan, cannot be denied coverage or have their coverage terminated based on health status. The Act permits exclusions of up to 12 months for preexisting conditions, but only if the condition is one for which medical advice, diagnosis, care, or treatment was received within 6 months prior to the time of enrollment. If an exclusion period is imposed, it must be reduced by the length of any prior period of "creditable coverage." HIPAA provides that an individual covered under a group plan may not, on the basis of health status, be charged a premium or contribution greater than that charged to a "similarly situated" individual.

A. General Applicability of Group Coverage Provisions

1. **General Rule--** HIPAA's group portability and accessibility requirements generally apply to employee group plans that provide coverage for medical care.

2. **"Excepted Benefits"--** certain "excepted benefits" that are secondary or incidental to non-medical coverage are not subject to the Act's group coverage provisions. These include:

- o coverage only for accident, or disability income insurance or both;
- o coverage issued as a supplement to liability insurance;
- o liability insurance, including general liability insurance and automobile liability insurance;
- o workers compensation or similar insurance;
- o credit-only insurance;
- o coverage for on-site medical clinics;
- o other similar insurance coverage, as specified by regulation, under which benefits for medical care are secondary and incidental to other insurance benefits.

3. **Additional Exempted Benefits--** subject to certain conditions, certain other types of benefits, including benefits for long-term care, Medicare supplemental insurance and hospital indemnity insurance, are not subject to the Act's group coverage provisions.

B. General Rule Regarding Guaranteed Availability of Group Coverage-- group plans may not establish rules for eligibility (including continued eligibility) for any individuals or their dependents based on health status, medical condition (physical or mental), claims experience, receipt of health care, evidence of insurability or disability.

C. Allowable Preexisting Condition Exclusions

1. **Six-month look-back/12-month exclusion (18 months for late enrollees)--** preexisting condition exclusions are allowable only if the exclusion relates to a condition (physical or mental) for which medical advice, diagnosis, treatment or care was received within a 6-month period preceding the date of enrollment. Any exclusion imposed may not extend for more than 12 months (18 months for late enrollees) after the enrollment date.

2. **No exclusions allowed for pregnancy or for newborns or adopted children covered promptly--** no exclusions are allowed for pregnancy or for newborns or adopted children who are covered by "creditable coverage" (see below) within 30 days after birth or placement for adoption.

3. **Credit for prior coverage--** any preexisting condition exclusion imposed must be reduced by the length of the aggregate period of prior "creditable coverage." Prior coverage must be credited so long as there have been no lapses in coverage longer than 62 days. Waiting periods and affiliation periods are not considered to be lapses.

   a. Creditable coverage includes:

- o any group coverage;
- o any individual coverage;
- o Medicare;
- o Medicaid;
- o CHAMPUS;
- o Indian health service or tribal organization coverage; state high risk pool; FEHBP; Peace Corps health coverage; or any "public health plan."

b. Carriers have two options for crediting prior coverage toward preexisting condition exclusions:

i. Carriers may credit prior coverage without regard to specific benefits covered during the prior period; or

ii. Carriers may choose an "alternate method" under which prior coverage is credited based on coverage of benefits within each of several categories of benefits. Categories, which are intended to reflect "significant" differences in types of benefits, are to be specified by regulation. A carrier that chooses the alternate method must count a period of creditable coverage with respect to any category of benefits if any level of benefits were provided within that category under the prior coverage.

4. **State Law Preemption--** in general, state law requirements that differ from HIPAA's group coverage provisions are not preempted, except to the extent that a state requirement would prevent the application of a requirement established by the Act. With respect to standards for the application of preexisting condition exclusions, state law is preempted, except to the extent that a state requirement--

a. limits the preexisting condition "look-back" period to less than 6 months;

b. allows lapses in coverage of more than 62 days;

c. allows more than 30 days for newborns and adopted children to become covered; or

d. prohibits preexisting condition exclusions entirely.

D. Allowable Variations in Premium Rates

1. **Similarly Situated Individuals--** an individual covered under a group plan may not be charged a premium or contribution greater than that charged to a "similarly situated" individual on the basis of any factor related to health status. Premium rates are permitted

to vary for different groups of similarly situated employees -- for example, full-time vs. part-time employees or employees located in different geographical areas.

2. **Employers--** the Act places no restriction on the amount an employer may be charged for group coverage.

E. Guaranteed Issue of Small Group Plans

1. **General Rule--** carriers offering coverage in the small group market must accept every "small employer" that applies for coverage. A "small employer" is defined as an employer who employed an average of at least 2 but no more than 50 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year. There is no similar rule for carriers offering coverage in the large group market.

2. **Bona Fide Association Exemption--** plans offered solely through one or more "bona fide associations" are not subject to the small group guaranteed issue requirement. A "bona fide association" is defined as an association that--

   a. has been actively in existence for at least 5 years;

   b. has been formed and maintained in good faith for purposes other than obtaining insurance;

   c. does not condition membership in the association on health status;

   d. makes health insurance coverage offered through the association available to all members regardless of the member's health status;

   e. does not make health insurance coverage offered through the association available other than in connection with a member of the association; and

   f. meets such additional requirements as may be imposed under state law.

F. Guaranteed Renewability of Group Plans

1. **Guaranteed Renewal--** carriers must renew large and small group plans, except in cases of non-payment, fraud, etc.

2. **Cancellation of Forms--** a carrier may cancel a form with 90-day notice and an offer to provide replacement coverage.

3. **Exit From Market**-- a carrier may cancel all forms in a state with 180-day notice but must stay out of the state group market for five years.

G. Disclosure of Information by Small Group Carriers to Small Employers

1. **Required Disclosures**-- at the small employer's request, a carrier must disclose:

   - o the right of the carrier to change premium rates and factors that could affect changes in rates;
   - o the provisions of coverage relating to renewability;
   - o any preexisting condition provisions;
   - o benefits and premiums under all forms of coverage for which the small employer is qualified.

2. **Solicitation and Sales Materials**-- solicitation and sales materials must disclose the availability of the information specified in section G.1., above.

3. **Form of Information**-- the required information must be provided in a manner reasonably understandable to small employers and must be sufficient to inform small employers of their rights and obligations under the contract or policy for health care coverage.

H. Effective Date of Group Provisions-- the Act's group coverage provisions generally are effective for group health plans and health insurance offered in connection with group health plans for plan years beginning after June 30, 1997.

III. INDIVIDUAL COVERAGE

HIPAA's individual health coverage requirements ensure that individuals who lose group coverage can obtain coverage under an individual health insurance plan or HMO contract. The Act contains a federal "fall-back" mechanism for ensuring individual health insurance availability, which requires insurers and HMOs doing business in the individual market in a state to guaranteed issue at least two representative plans to individuals who qualify as "eligible individuals" -- i.e., individuals who have at least 18 months prior creditable coverage, the most recent of which was group coverage (including a government plan or a church plan), and who satisfy certain other conditions. States, however, may adopt an "acceptable alternative mechanism," which would supersede the federal fall-back. HIPAA establishes certain criteria that state alternative mechanisms must satisfy to be deemed "acceptable" by the Secretary of Health and Human Services (HHS). HIPAA also provides for guaranteed renewal of coverage for individuals who have it.

A. **General Applicability of Individual Coverage Provisions**-- the Act's individual market requirements apply only to carriers who offer coverage in the individual market.

B. **Single-Life Groups**-- Carriers offering single-life group plans are not considered to be doing business in the individual market if the state regulates such plans as small group coverage.

C. **The Federal "Fall-Back" Option for Ensuring Individual Health Coverage Accessibility**-- unless a state has implemented an "acceptable alternative mechanism" for guaranteeing accessibility of coverage to individuals who lose group coverage (or intends to implement such a mechanism and has complied with certain requirements for doing so), carriers operating in the state must comply with the federal "fall-back" mechanism.

1. **General Rule Under the Federal Fall-Back**-- a carrier offering coverage in the individual market may not decline coverage to an "eligible individual" and may not impose any preexisting condition exclusion with respect to such coverage (see below for type of coverage that must be offered).

2. **Definition of an "Eligible Individual"**-- an "eligible individual" is an individual who--

   a. has an aggregate 18 months or more of previous "creditable coverage," the most recent of which was a group health plan, government plan or church plan, with no lapses in coverage longer than 62 days (see section II.C.3 above for an explanation "creditable coverage");

   b. is not eligible for coverage under a group health plan, Medicare or Medicaid and does not have any other health insurance coverage;

   c. if eligible for COBRA or a "similar State program," exercised that option and exhausted the available coverage;

   d. was not terminated from the most recent prior coverage due to nonpayment or fraud.

3. **Under the Federal "Fall-back" Mechanism, Carriers have two options regarding the type of coverage that must be offered to eligible individuals:**

   a. **Two Most Popular Plans**-- carriers may offer eligible individuals a choice of their two most popular plans (those with highest premium volume); or

   b. **Two Representative Plans**-- carriers may offer a choice of two policy forms with

representative coverage as follows:

i. **Lower cost plan** -- actuarial value of benefits under this plan must be 85% - 100% of the weighted average value of benefits under all individual insurance coverage issued by the carrier in the state or the weighted average value of benefits provided by all carriers in individual market in the state (which weighted average to use is the carrier's option).

ii. **Higher cost plan** -- actuarial value of benefits must be 15% higher than the value of the lower cost plan and 100% - 120% of the weighted average of benefits as above.

4. **Effective Date**-- unless a state makes certain required preparations to implement an acceptable alternative mechanism in accordance with a specified timetable (see below), the federal fall-back mechanism becomes effective July 1, 1997.

D. Alternative State Mechanisms

1. **To be an acceptable alternative to the federal fall-back mechanism, a state mechanism must satisfy the following general requirements--**

a. all "eligible individuals" must be provided "a choice of health insurance coverage" (the term "eligible individual" has the same meaning as under the federal fall-back mechanism);

b. coverage may not impose any preexisting condition exclusions;

c. the choice of coverage must include at least one policy form that is comparable to comprehensive coverage offered in the individual market in the State or which is comparable to a "standard option of coverage available under the group or individual health insurance laws. . ." of the State; and

d. the mechanism adopted must be one that either--

i. "provides for risk adjustment, risk spreading, or a risk spreading mechanism. . . or otherwise provides for some financial subsidization for eligible individuals. . ."; or

ii. "provides each eligible individual a choice of all individual health insurance coverage otherwise available."

2. **Examples of Mechanisms That May be Acceptable**-- so long as the Act's general

requirements are satisfied, states may adopt any "private or public individual health insurance mechanism" as an alternative to the federal fall-back. HIPAA provides examples of a number of alternative mechanisms that may be deemed acceptable. These include:

a. a "health insurance coverage pool or programs";

b. "mandatory group conversion policies";

c. "guaranteed issue of one or more individual plans";[2]

d. "open enrollment by one or more health insurance issuers"; or

e. "any combination of these mechanisms."

3. **Other Mechanisms That May Be Deemed Acceptable--** the following alternative mechanisms will be deemed acceptable under HIPAA so long as HHS finds that they satisfy the requirements discussed above for acceptable alternative mechanisms and are implemented in a manner consistent with the Act's intent:

   a. the NAIC "Small Employer and Individual Health Insurance Availability Model Act" (adopted by NAIC June 3, 1996), insofar as it applies to individual health insurance;

   b. the NAIC "Individual Health Insurance Portability Model Act" (adopted by NAIC on June 3, 1996); or

   c. a "qualified high risk pool," which is defined as a high risk pool that--

      i. provides all eligible individuals health insurance coverage (or comparable coverage) that does not impose any preexisting condition exclusions; and

      ii. provides for premium rates and covered benefits "consistent with" the standards contained in the NAIC "Model Health Plan for Uninsurable Individuals Act" (version in effect on August 21, 1996).

Note: the NAIC model acts will need to be modified in some areas (for example, preexisting condition exclusions applicable to eligible individuals) to comply with HIPAA's requirements.

---

[2]Although this section of HIPAA states that guaranteed issue of "one or more individual plans. . ." (emphasis added) would be acceptable, a state presumably would need to require guaranteed issue of at least two plans so as to satisfy HIPAA's broader requirement that eligible individuals be provided with "a choice of health insurance coverage."

4. **Timetable for Implementing State Alternatives**-- in states that decide not to adopt an alternative mechanism or fail to comply with the required timetables for implementing an alternative, HIPAA's fall-back mechanism for individual coverage will take effect on July 1, 1997. However, in states that comply with the following timetables, the fall-back mechanism will not take effect:

   a. **Timetable for Most States**-- by no later than April 1, 1997, the state must notify the Secretary of HHS that it has enacted (or intends to enact no later than January 1, 1998) legislation implementing an alternative mechanism and must provide HHS with information needed to review the mechanism and its implementation, as required by HHS. The mechanism must be in effect no later than January 1, 1998.

   b. **Delay Permitted for Certain States**-- states with legislatures that do not meet between August 21, 1996 and August 21, 1997 have more time to enact the necessary legislation, but the Act is unclear on exactly how much more time. A reasonable reading of the Act, as it is now written, would give such a state until April 1, 1998 to notify HHS that it has enacted (or intends to enact no later than July 1, 1998) legislation implementing an alternative mechanism and provide HHS with information about the mechanism. The mechanism would need to be in effect no later than July 1, 1998.

E. Guaranteed Renewal of Individual Coverage.

1. **General Rule**-- carriers that offer individual coverage must renew and continue coverage in force, at the option of the individual.

2. **Exceptions**-- a carrier may discontinue coverage for any of the following reasons (but in no case may coverage be terminated based on health-status related factors of enrolled individuals or persons who may become eligible for coverage):

   a. **Nonpayment of Premiums or Fraud.**

   b. **Termination of Plan or Discontinuation of All Coverage**-- if a carrier discontinues a certain plan, it must offer individuals covered under that plan the option of purchasing any other individual coverage offered by the carrier. A carrier may discontinue all coverage in the individual market in a state, but must comply with certain notice requirements and may not reenter the market for 5 years.

   c. **Uniform Modification of Coverage**-- a carrier may modify an individual plan so long as the modification is effective on a uniform basis among all individuals covered by that plan.

   d. **Movement Outside Service Area**-- in the case of a carrier that offers coverage

through a network plan, coverage may be discontinued if the individual moves outside the service area.

e. **Association Membership Ceases**--if the case of coverage offered through an association, coverage may be discontinued if the individual ceases to be a member of the association.

AMERICANS FOR RESPONSIBLE REFORM

1275 Pennsylvania Avenue, NW
Suite 1100
Washington, DC 20004
(202) 637-0333
fax (202) 639-0317

CAUSE FOR ALARM: EXCESSIVE COST AND DECLINING ENROLLMENT IN NEW JERSEY'S INDIVIDUAL HEALTH INSURANCE MARKET UNDERSCORE THE NEED FOR REFORM[1]

February 7, 1997

SUMMARY OF FINDINGS

An analysis performed by Americans for Responsible Reform (ARR) of data maintained by the New Jersey Individual Health Coverage Program Board reveals a number of disturbing trends in the state's heavily regulated market for individual health insurance. Sweeping insurance reforms implemented in 1993 were intended to increase the availability and affordability of insurance for individuals. Instead, they appear to have had precisely the opposite effect. Among other things, data supplied by the Board show that:

- ***Average prices for the most popular health insurance plans in the individual market are now approximately double the national average prices for equivalent coverage.***

- ***The number of persons with coverage in the individual market declined steadily in the first three quarters of 1996 (the most recent period for which there are data). Between January 1 and September 30, 1996, the number of persons covered in the individual market fell by 22,498 -- a 10.2% decline. Moreover, the decline in individual coverage is accelerating.***

- ***Families have been especially hard hit. The number of families covered by individual insurance has been dropping steadily for nearly two years. Over the last 21 months, the number of families with coverage in the individual ....arket fell by 30%.***

- ***The number of New Jersey residents without health insurance is higher than ever before, and rising at a rate equal to six times the national average.*** According to U.S.

---

[1]This document has been prepared by and for Americans for Responsible Reform. Duplication of any part of this document is prohibited without the written consent of Americans for Responsible Reform.

Census figures, approximately 1.12 million residents of New Jersey -- 14.2% of the population -- were without health insurance at the end of 1995. A number of studies have shown that for the vast majority of the uninsured, the primary obstacle to obtaining coverage is affordability. Excessive price inflation in New Jersey's individual market clearly is making this problem worse.

- ***Those persons remaining in the individual market increasingly are being driven to plans with high deductibles and high copayments or HMOs.*** Certainly, there is nothing wrong with HMOs. But it is wrong to create a system where the only affordable coverage is an HMO. If that is what the General Assembly intends to do, then this issue deserves a full and open debate.

These trends are closely consistent with the type of market deterioration warned about by economists and actuarial experts who testified before the New Jersey General Assembly and the Department of Insurance during 1996. Those witnesses cautioned that the restrictions on individual insurance now in effect such as flat community rating, guaranteed issue of all plans, limitation of consumer choice to five standardized plans, and inflexible loss ratio requirements were causing the price of individual insurance to rise to unaffordable levels, leading many individuals to forego coverage -- especially younger persons with lower incomes, families on a tight budget and persons in good health. As these groups have lost the ability to find affordable coverage and dropped out of the insurance pool (or never joined in the first place), the price of insurance has risen to even higher levels since fewer and fewer people are sharing the cost of health care.

The problems now evident in the individual market have been and, if uncorrected, will continue to be extremely damaging to ARR's approximately 30,000 small business and individual members in New Jersey, many of whom are self-employed and rely on the individual market to purchase coverage for themselves and their families.

BACKGROUND

In 1992, New Jersey enacted a program of sweeping individual and small business health insurance reforms. In the individual insurance market, the 1992 reforms include flat community rating combined with guarantee issue of all plans, the limiting of plan availability to five standard plans and the imposition of a 75-percent loss ratio on all plans. These restrictions were implemented beginning in August 1993. Authority to develop the required standard plans and to administer the reforms was placed largely in the hands of a newly-created entity, the Individual Health Coverage Program Board. Four of the standard plans developed by the Board -- plans B, C, D and E -- provide major medical coverage, have identical benefits and differ only in their copayment levels. Each plan is available with an annual deductible of $250, $500 or $1,000. The fifth plan -- plan A -- covers catastrophic care and is available with a deductible of $250 only. See attachment: "Snapshot of New Jersey Individual Standard Health Benefits Plans."

DISCUSSION OF FINDINGS

An analysis of data maintained by the New Jersey Individual Health Coverage Program Board on the cost of health insurance coverage and enrollment levels in the state's market for individual insurance reveals a number of serious problems that have had significant adverse effects on the affordability and availability of individual health insurance coverage. The problems now evident in the individual market -- excessive prices and declining enrollment -- are closely consistent with the scenario of continuing market deterioration warned about by economists and actuarial experts who testified before the New Jersey General Assembly and the Department of Insurance in 1996 on the subject of individual market reform. A discussion of our findings follows.

1. The current system has pushed the price of insurance to unaffordable levels for many individuals, including self-employed persons.

- *Average prices for the most popular health insurance plans in the individual market are now approximately double the national average for equivalent coverage.*

Table 1 on page 4 compares the average prices for single subscriber coverage under the three most popular insurance plans in New Jersey's individual market (plans B, C and D, each with a deductible of $1,000) with national average prices for comparable coverage. In each case, the average price of coverage for an individual in New Jersey is approximately double the national average price for equivalent coverage.

Proponents of the current regulatory scheme emphasize that median rates for the two individual plans with the highest enrollment levels -- plans C and D with $1,000 deductibles -- have increased only modestly over the last two years. This, however, does not tell the whole story. The more relevant comparison for purposes of judging the affordability of coverage is the difference between the rates individuals nationwide pay for coverage and what they pay in New Jersey. As Table 1 shows, individuals in New Jersey are now paying approximately double what they would pay if they lived elsewhere.

Moreover, focusing solely on rate increases for plans with $1,000 deductibles (the highest deductible allowed for standard plans[2]) is misleading because it ignores the effect of adverse selection. As the Individual and Small Employer Program Boards stated in their April 1996 Progress Report:

---

[2]The Individual Board just recently allowed higher deductibles for plans sold to accompany a medical savings account.

> [In the individual market, p]olicy holders themselves, as well as insurance agents, have caused further instability [in rates] because individuals with medical conditions have selected the $250 and $500 deductible plans, leading carriers to raise rates to reflect claims experience under those plans. For individuals with expensive medical conditions, the low deductible plans were a relative bargain, even as rates increased.[3]

As the Boards recognize, a contributing factor to the sharp increases in rates for plans with $250 and $500 deductibles is the fact that persons in poorer health tend to choose them over plans with a higher deductible. **According to the Boards' own figures, between May 1994 and October 1996, the average price of plan D with a $250 deductible increased at an annual rate of 48.8 percent. The average price of plan D with a $500 deductible increased at an annual rate of 39.9 percent.**[4] These price increases are far in excess of the increases for plans with $1,000 deductibles, the prices of which are already double the national average.

Table 1

Comparison of New Jersey Average and Median Price of Individual, Single Subscriber Coverage with National Average Price for Equivalent Coverage

Plan ($1,000 deductible)	Average Price	Median Price[5]	Nat'l Avg. Price for Equivalent Coverage
Plan B	$2,176	$1,975	$1,100
Plan C	$2,521	$2,036	$1,280
Plan D	$3,224	$2,686	$1,470

Sources: Data derived from New Jersey Individual Health Coverage Program Board rate matrix (10/15/96); national average prices are according to information supplied by a national actuarial consulting firm.

---

[3]New Jersey Individual Health Coverage Program Board and Small Employer Health Benefits Program Board, *Progress Report: Reform of New Jersey's Individual and Small Employer Health Coverage Markets, August 1993 - April 1996*, at pp. 10-11.

[4]Note that the greater rate of increase in price for plan D with a $250 deductible as compared to the increase in price for the same plan with a $500 deductible further confirms the effect of adverse selection. Persons in poorer health tend to choose the plan with the lower deductible, causing its cost to climb more precipitously.

[5]Median prices are included for purpose of comparison. Whether the average or the median price is a better measure of the cost of coverage is subject to debate. In either case, the cost to New Jersey residents greatly exceeds the national average.

The same factors contributing to the increases in rates for lower-deductible plans are causing prices for plans with $1,000 deductibles to increase at more moderate rates. In other words, persons in good health are over-represented in these higher-deductible plans, moderating the upward pressure on rates. Any discussion of affordability of coverage in the individual market that focuses solely on price increases experienced by $1,000-deductible plans ignores this reality. It is important to look at the overall change in prices for all plans offered in the market to get a true picture of what is happening. When all factors are considered, it is clear that consumers in New Jersey are paying prices that are far in excess of national averages and, as discussed below, far above what the market can sustain.

2. There is considerable evidence that the inflated cost of coverage is causing more and more individuals to drop their insurance or never purchase it in the first place.

Enrollment records maintained by the Individual Board show that:

- *The number of persons with coverage in the individual market declined steadily in the first three quarters of 1996 (the most recent period for which there are data).* Between January 1 and September 30, 1996, the number of persons covered in the individual market fell by 22,498 -- a 10.2% decline from the market's peak at the end of 1995.

Table 2 on page 6 shows quarterly figures for the number of persons covered in New Jersey's individual health insurance market from the fourth quarter of 1994 through the third quarter of 1996. The total number of persons covered is comprised of persons covered by nonstandard plans, which are any plans issued prior to the implementation of reforms in August 1993, and persons covered by standard plans, which are the only type of plans consumers have been permitted to purchase since that time. As one would expect, the number of persons covered by nonstandard plans (Table 2, second column) has declined steadily, since consumers no longer may purchase those plans.

Similarly, following reform, as individuals were forced to convert from nonstandard to standard plans, the number of persons covered by standard plans (Table 2, third column) increased through the fourth quarter of 1995, to a high of 186,130. In addition, the total number of persons covered by both all plans (Table 2, fourth column) initially rose through the fourth quarter of 1995, when it reached a high of 220,384.

Since the beginning of 1996, however, the number of persons covered by standard plans and the total number of persons covered by all plans have been declining. By the end of the third quarter of 1996, the number of persons covered by all plans had decreased to 197,886 -- a loss of 22,498 persons from the market since January of 1996, representing a 10.2% decline. This substantial and continuing decline is a strong indication that the deterioration of the market economists

warned about is beginning to occur. As the price of coverage has risen, more and more individuals appear to be dropping their insurance.

Table 2

New Jersey Individual Insurance Market -- Number of Persons Covered at End of Quarter (Q4 1994 - Q3 1996)

Quarter	Persons Covered by Nonstandard Plans (plans issued before 8/93)	Persons Covered by Standard Plans	Total
Q4 1994	97,889	112,964	210,853
Q1 1995	69,444	136,949	206,393
Q2 1995	60,496	146,038	206,393
Q3 1995	42,764	168,180	210,944
Q4 1995	34,254	186,130	220,384
Q1 1996	28,568	184,729	213,297
Q2 1996	21,575	182,977	204,552
Q3 1996	18,391	179,495	197,886

Source: Data compiled from New Jersey Individual Health Coverage Program Board quarterly enrollment reports.

- *As one might expect, families, whose budgets ordinarily have the least amount of flexibility, have been hit hardest by the increases in insurance costs and responded earliest to the excessive inflation in prices by dropping coverage.*

Table 3 on page 7 illustrates the decline in family coverage. At the end of the fourth quarter of 1994, the number of family contracts in the individual market (both standard and nonstandard) reached a high of 28,602 contracts. Since that time, the number of contracts has declined without stop to a total of 20,062 at the end of the third quarter in 1996 -- a 29.9% decrease in the number of families covered.

- *Of even greater concern, the decline in individual coverage is accelerating.* The net decrease in the number of individual health plans in force at the end of each of the first three quarters of 1996 has grown larger and larger in each quarter.

Table 4 shows the accelerating decrease in the number of contracts for health plans in force in the

individual market. As discussed below, this disturbing trend also is consistent with the market collapse economists and actuarial experts have warned about.

Table 3

New Jersey Individual Market -- Total Standard and Nonstandard Contracts in Force at End of Quarter by Rating Category (Q4 1994 - Q3 1996)

Quarter	Single subscriber contracts	Husband and wife contracts	Parent and child(ren) contracts	Family contracts
Q4 1994	70,065	9,770	5,975	28,602
Q1 1995	70,073	10,926	5,745	26,301
Q2 1995	71,651	11,191	5,917	25,687
Q3 1995	74,731	12,475	6,386	25,562
Q4 1995	74,987	13,272	7,030	24,876
Q1 1996	72,131	12,461	7,273	23,396
Q2 1996	69,435	11,470	7,183	21,144
Q3 1996	70,838	10,883	6,625	20,067

Source: Data compiled from New Jersey Individual Health Coverage Program Board quarterly enrollment reports.

Table 4

Individual Market -- Contracts in Force at End of Quarter (Q1 1996 - Q3 1996)

Quarter	Nonstandard plans (plans issued prior to 8/93)	Standard plans	Total plans in force	Net decline in plans in force from previous quarter
Q1 1996	18,408	100,556	118,964	2,836
Q2 1996	14,357	101,392	115,749	3,215
Q3 1996	12,360	99,022	111,382	4,367

Source: Data compiled from New Jersey Individual Health Coverage Program Board quarterly enrollment reports.

- *Equally disturbing is the fact that the accelerating decline in persons covered by individual plans has been accompanied by a sharp increase in the number of uninsured persons in the state.*

According to the most recent U.S. Census figures, the number of New Jersey residents without health insurance is now higher than ever before and is rising at a rate that is six times greater than the national average. At year end 1995 more than 1.12 million New Jersey residents -- 14.2% of the population -- were without health insurance. Remarkably. this sharp increase in the uninsured has occurred at a time of rising employment and business growth in the state. The problems evident in the individual market may not be the only cause of the growing uninsured population, but they certainly are not helping matters. A number of studies have shown that the vast majority of persons who are uninsured lack insurance because they simply cannot afford it. The excessive price inflation caused by the current system of market controls clearly is contributing to this problem.

3. The excessive cost of coverage under the current system increasingly is pushing people into plans with high deductibles and high co-payments or HMOs.

- *The lack of affordable choices for New Jersey health care consumers is especially evident in the individual market.*

The only insurance plans in the individual market that are now experiencing increased enrollment are plan A, the catastrophic coverage plan, and plans B and C, both with $1,000 deductibles (the maximum allowable deductible). Plan B requires a 40% copayment; plan C requires a 30% copayment. Enrollment is now decreasing in Plan D and Plan E at all deductible levels as well as plans B and C at all deductible levels below $1,000.

- *In addition, HMO market share in both the individual and small employer markets is rising rapidly.*

Between January 1995 and September 1996, the percentage of persons with standard plans in the individual market who were enrolled in an HMO rose from 11% to 29.2%. This same trend is evident in the market for small employer plans. Between January 1995 and June 1996, the proportion of individuals covered by standard small employer plans that are HMO plans increased from 13% to 21.4%. ***Of course, there is nothing wrong with HMO plans. But it is wrong to structure the market so that the only affordable coverage is an HMO. If that is what the General Assembly intends to do, there should be a open and honest debate on this issue.***

4. Inflated costs, a declining number of persons with coverage, and movement toward HMOs and plans offering lower levels of coverage, all of which are now evident in the individual market, are consistent with the "death spiral" scenario actuarial experts and economists have warned about.

Economists and actuarial experts testifying before the General Assembly and the Department of Insurance during 1996 warned that the current excessive controls on individual plans inevitably will lead to a crippling "death spiral" in the insurance market. According to these experts, the price increases resulting from New Jersey's combination of flat community rating with guaranteed issue and inflexible loss ratio requirements is causing younger persons, who typically have lower incomes and are less likely to use their health coverage on a regular basis, to drop their coverage (or never purchase it in the first place). These consumers either cannot afford coverage or do not see the value in paying the increased prices that younger persons must pay under a system in which age is excluded as a factor in setting rates.

As younger individuals drop their insurance, the cost of coverage rises even higher since persons remaining in the insurance pool increasingly are those who are older (age 45-65) and more likely to use their health coverage. The other remaining persons are those who, regardless of age, already are ill and cannot afford to go without coverage no matter how expensive it becomes. The result is even greater increases in costs as fewer and fewer people share greater and greater health care costs, which is accompanied by increasing declines in coverage as even more people are priced out of the system. This cycle feeds on itself and accelerates over time. Excessive price inflation, growing declines in individual coverage and movement towards HMOs and lower-cost insurance plans, all of which are now being experienced in the individual market, are closely consistent with this scenario.

Issues Facing the Alaska Comprehensive Health Insurance Association (CHIA)

Prepared by the Alaska Division of Insurance
March 1997

Background:

The Alaska Comprehensive Health Insurance Association (CHIA) was established in 1992 by the Alaska Legislature to provide access to health insurance for individuals who are considered uninsurable and are unable to get insurance in the private marketplace. By its very nature CHIA was never intended to be a self-supporting entity. If the participants in the plan were able to obtain coverage in the private market by paying a premium appropriate to the risk, there would be no need for the plan.

Participants pay a premium based on their age and choice of deductible. This premium is limited by law to 200% of the standard premiums in the marketplace. The shortfall between premiums collected and the cost of the plan is funded through pro rata assessments to health insurers transacting business in Alaska. Additional information about CHIA is in the 1995 annual report which will be provided upon request.

CHIA and state self insurance:

The State of Alaska's health insurance plan represents almost 35% of the assessable health insurance premiums written in Alaska. Utilization projections provided by the CHIA administrator to the legislature and administration last year raised concerns about large assessment increases which would be passed on to the state's health plan and adversely affect the state budget. CHIA chairperson Cecil Bykerk addressed these concerns at a joint HESS Senate and House hearing on March 7, 1996. He also described how administration of the plan was hampered and made more expensive by existing statutes.

The CHIA administrator's projections assumed that the 1993 and 1994 growth rates in participants and claims would continue. In the program's first years, rapid growth was to be expected as previously uninsurable citizens signed up for the new program. However, the growth did stabilize. At the end of 1996, there were 189 participants, an increase of only 5 people during the year. The total of claims paid in 1996 was $1,672,490. The CHIA administrator's 1996 projection had been for 253 participants and paid claims of $3,515,965. Attachment 1 compares the administrator's and the board's projections with actual results through 1996.

Recent concerns have been raised about the impact of the proposed "self insurance" of the state health plan on CHIA. As shown in Attachment 2, the projected net liability to be funded through CHIA assessments is approximately $1 million in 1997, $1.3 million in 1998 and $1.7 million in

1999. Under the current state health plan, the state share of these CHIA assessments will be approximately $327,000, $419,000 and $520,000. If the state were self insured, these expenses would no longer be required in the state budget. The result of spreading the current state assessment over other health insurers would still be less than half of one percent or approximately .35%, .42% and .49%, compared to .23%, .28%, and .34% if the state continued to have an insured plan.

The impact on insurance premiums would not be significant. For example, an individual paying $400/month for health insurance could expect their monthly premium to increase by only 48-60 cents as a result of the state's decision to self-insure.

Reducing the cost of CHIA:

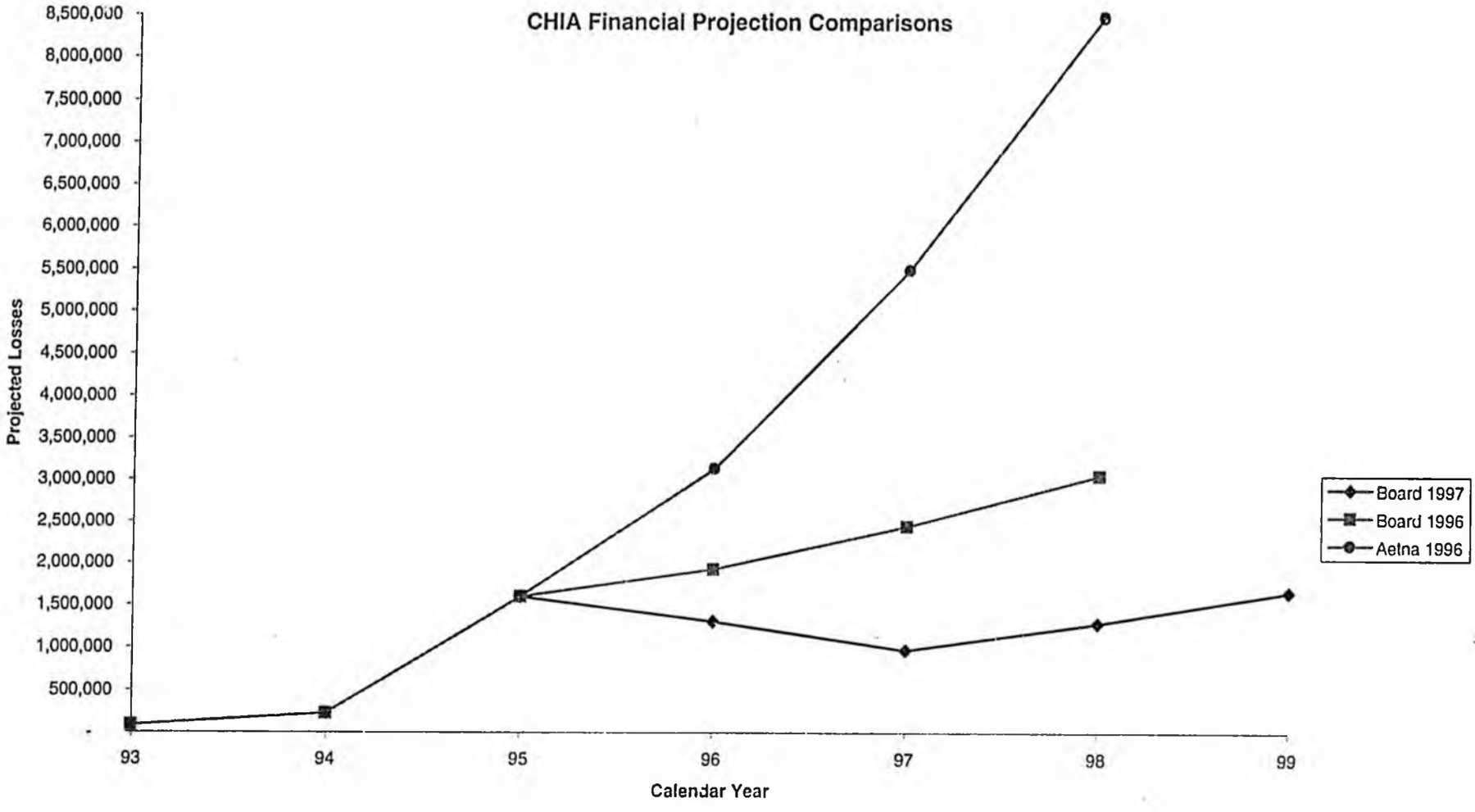
The impact of state self-insurance on CHIA could be significantly offset by statutory changes permitting the CHIA board to administer the plan in a more effective and business-like manner. For instance, Alaska's high fees could be reduced by allowing more competitive bidding for the administrative contract. (Attachment 3 compares administrative fees for similar plans in Alaska and other states.) Under current statutes, only the members of CHIA can bid on the contract.

Several legislative changes were introduced in 1996 as part of a comprehensive streamlining bill which did not pass. This year, the CHIA board has requested separate legislation to help reduce CHIA's administrative costs, resulting in lower assessments necessary to maintain the CHIA program.

This is in SB118

Since the attempt to the board Point the to keeping pool vital and operating at efficiently

ATTACHMENT 1



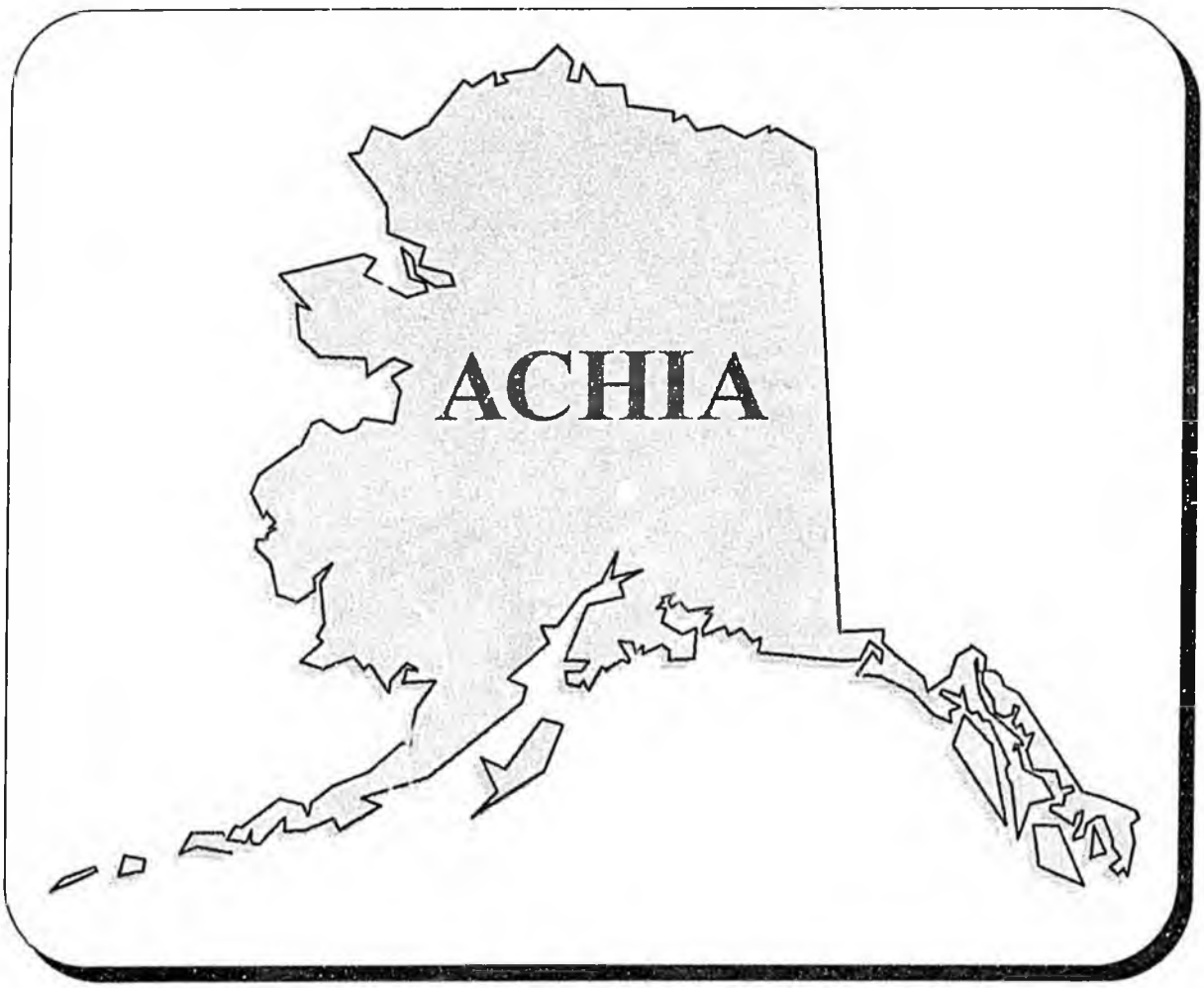
"Board 1997" shows actual numbers through 1996 and CHIA board projected numbers through 1999

"Board 1996" shows the most likely projections made in 1996 by the CHIA board

"Aetna 1996" shows the projections made in 1996 by Aetna

ANNUAL REPORT
OF
ALASKA COMPREHENSIVE
HEALTH INSURANCE ASSOCIATION

JANUARY 1, 1995 - DECEMBER 31, 1995



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.

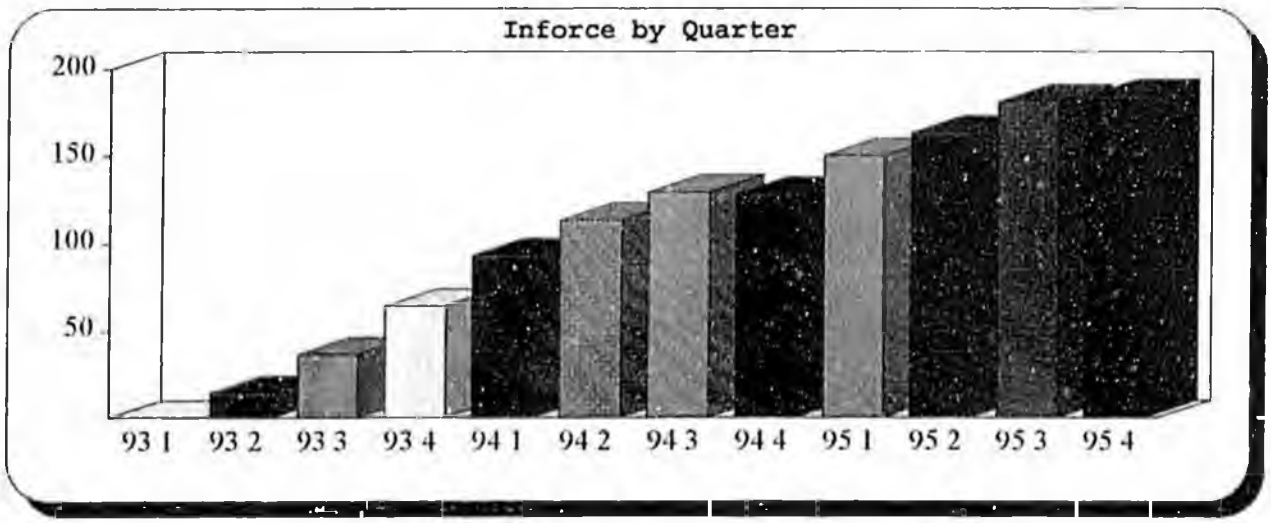
ACHIA is a nonprofit incorporated legal entity established under the provisions of Alaska Statute Title 21, Chapter 55, and is exempt from the payment of fees and taxes levied by the state or any of its political subdivisions except taxes levied on real or personal property. The Plan is governed by a 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 processes applications for coverage under the plan, collects premium, pays claims on behalf of the association and performs other administrative functions as provided in the administrative contract.

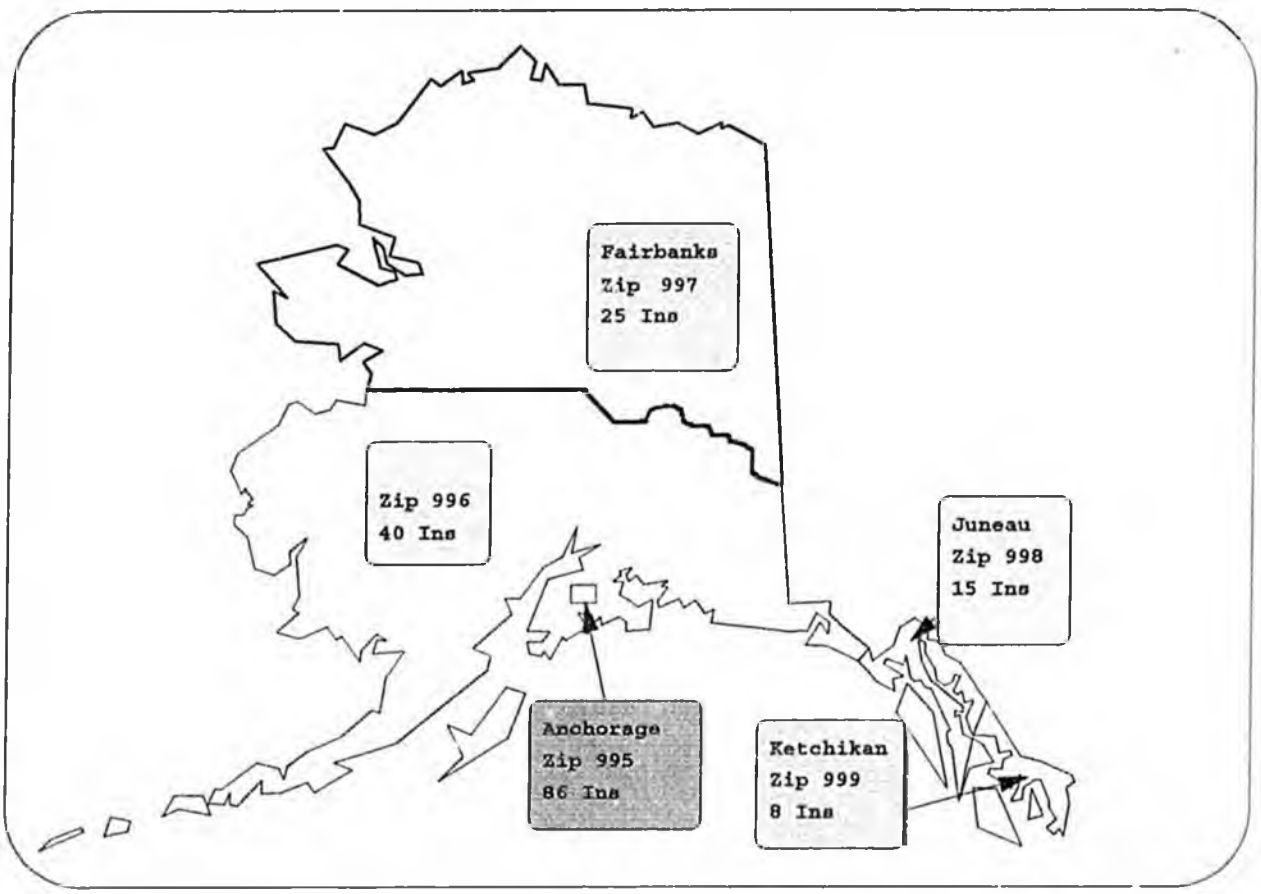
The Plan is funded through premiums collected from Insureds and assessments received from health insurers transacting business in Alaska.

At the beginning of 1995, there were 127 insureds on the plan. As of December 31, 1995, there were 179 insureds. During the year, there were 93 new issues and 41 terminations. Terminations were due to many reasons including the enactment in 1994 of Alaska Small Group Reform and insureds leaving the state.

In 1995, 93 policies were issued. 80 of these policies were still inforce and active on December 31, 1995.



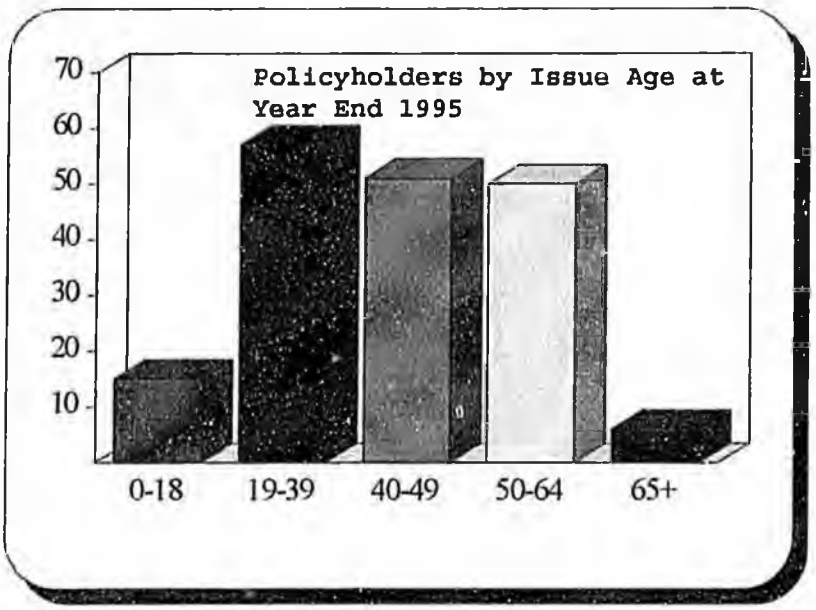
ACTIVE POLICYHOLDERS BY GEOGRAPHIC AREA



Note: Five billing addresses are outside Alaska.

Policyholders by Issue Age at Year End 1995

Age	Number
0-18	15
19-39	57
40-49	51
50-64	50
65+	6



Observations & Recommendations

During 1995, the number of policyholders covered by ACHIA continued to increase steadily ending the year with 184 individuals covered. The year ending totals from 1993 and 1994 were 64 and 128, respectively. On the other hand, incurred claim totals for the three years reflect a considerably different slope; namely, $244,758 in 1993, $805,642 in 1994, and $2,157,549 in 1995. These differing slopes/trends, which continued into early 1996, caused some considerable alarm to the ACHIA Board, ACHIA member companies, the Director of Insurance and State legislators.

While the Board had assumed that as the pool aged and matured, the claim amounts would grow, it was concerned about this differing trend. Expected reasons for increased claim levels include the expiration of pre-existing condition limits as well as the initial behavioral changes that result when someone who has not had health insurance coverage for some period of time, obtains coverage and sees physicians for long standing conditions. This is exacerbated in the case of individuals who are eligible for ACHIA coverage since they must prove that they have significant health conditions in order to participate.

As a result of this worsening experience, it was necessary for the Board to accelerate assessments against the member companies. An initial assessment of $250,000 was made in September 1993 to establish operating capital. This assessment gave credit for the seed money assessment that had been made early in 1993, but which was based solely on a set level of $5,000 per company for each of the top twenty companies. Because paid claims were so modest during 1993 and early 1994, and since the Board had little upon which to estimate or project, it was difficult to anticipate the timing and level of the next assessment following September 1993.

Additional problems complicated the process of establishing the next assessment. First, the companies to be assessed had to be determined. Many companies are licensed in Alaska to write health insurance but do not actually write health insurance and must be excluded from the assessment calculations. Second, the premium upon which each company's assessment is based is determined based on annual statement data which includes amounts that are not assessable and therefore must be excluded from the calculations. Finally, the Board and the Administrator were having difficulty in establishing the necessary reports and the timing of those reports so that timely determination of the necessary assessments could be made by the Board.

Following a discussion between the Board and the Administrator that lasted for eight months, the Board ordered that a $600,000 assessment be made in April 1995. This assessment was followed in October 1995 by an assessment for $1,200,000. Thus, by year-end 1995, the pool had a positive cash balance of $86,017. However, claims for the first two months of 1996 overwhelmed this position and on May 9, 1996, a new assessment for $1,500,000 was mailed to member companies. It is now hoped that with stabilization of the pool, assessment needs can be anticipated far enough in advance to prevent negative cash positions. It is important to note that the assessments are paid by the insurance carriers operating in Alaska based on their proportionate share of insured medical premium.

High risk pool legislation across the country was never intended to result in an insurance operation that was self sustaining and Alaska is no exception. Legislative history indicates that this fact was discussed during the deliberations of the Alaska legislation. High risk pools were developed to cover individuals who have been deemed to be essentially uninsurable by insurance carriers. If actuarially sound premiums could be developed for these individuals, insurance carriers would sell them appropriately priced coverage and a high risk pool would be unnecessary.

The rapid increase in the claim to premium ratio (loss ratio) of the pool was very distressing to everyone connected with the pool, particularly those not familiar with this type of legislation. Normally, such a result would indicate the need to raise the premiums as that is the most direct way to reduce the loss ratio. In order to prevent the premium charged by the risk pool from getting too high, the legislation provides for a maximum premium. This maximum premium is developed by obtaining the average standard risk rates of the top 5 carriers in the state and multiplying that average by 2. The Board initially set the premiums at 1.75 times this average which is less than the maximum allowed. In early 1996, the Board decided to increase the rates in order to reflect inflation in claim levels and standard risk premiums in the Alaska market. The Board chose to remain at 175% rather than 200% because it was felt that the 200% level would drive away the individuals who were healthier and result in a loss ratio that would be unimproved or worsened. This premium increase which averaged around 25% to 30% was

effective July 1, 1996. This was the first increase since the initial rates were determined in April 1993.

The Board spent a great deal of time in late 1995 and early 1996 attempting to develop some strategy for dealing with the financial situation in order to limit future assessments. However, the Board's flexibility has been, and remains, limited since (1) the policy benefits are determined by the legislation, (2) the premiums are limited by the law (and by practical affordability levels), (3) newer techniques being used elsewhere in the insurance industry, like managed care, are limited due to the legislative language and (4) legislation limits administration of the pool to a member company which may not allow for the lowest cost method of handling the administration.

Some of the approaches that the Board has taken were as follows: (1) implementation of higher deductible/out-of-pocket maximum plans that are priced at lower rates and encourage individuals to manage their costs better, (2) hiring of a case manager to help control costs while achieving better care for the individuals, (3) raising the premium levels to offset inflation, (4) requiring, in cooperation with the Administrator, better and more timely financial reports with which to monitor the plan, (5) establishment of more efficient and appropriate assessment procedures and (6) development of a PPO plan that will take advantage of hospital discounts.

On March 7, 1996, Cecil Bykerk, Chairperson, testified in Juneau before a joint Senate and House hearing concerning the status of ACHIA. Following that hearing, the Board worked with the Division of Insurance in developing some legislative language that addresses the limitations mentioned above. This language addresses the following issues: (1) Technical corrections regarding representation on the Board in order to allow proper input from consumer representatives and smaller member companies, (2) flexibility to allow development of cost containment methods as well as incentives such a PPO networks, (3) technical adjustments to the language to allow reduced complexity in the calculation of premium rates, (4) allowance for competitive bidding on the administration of the plan to allow for the lowest cost (but appropriate) provider of service and (5) additional technical corrections that have become apparent over the early years of operation of the pool.

While these legislative changes were introduced, they did not progress to enactment during 1996. The Board strongly recommends enactment of the legislation in 1997. An additional need for legislation has been created by the enactment at the Federal level of the Health Insurance Portability and Accountability Act of 1996. This Act provides for states to meet certain portability standards. The states have several options in meeting these standards. One option is met through having a pool in place much like ACHIA. However, in order for ACHIA to satisfy the necessary requirements, the law must be amended to include automatic eligibility for individuals 'who are eligible for the purchase of coverage under Section 2741(b) of the Health

Insurance Portability and Accountability Act of 1996.' Additionally, anyone who purchases coverage through this eligibility route will not be required to serve a pre-existing condition period. The Board strongly recommends enactment of these necessary changes. The changes must be completed and effective no later than July 1, 1997 (or January 1, 1998 in certain instances), in order to satisfy the Federal legislation. In addition, the Governor is required to indicate to the Health Care Financing Administration how Alaska intends to satisfy the requirements of the Act.

In summary, the Board feels that ACHIA has served a useful purpose to the citizens of Alaska. However, the need is clearly present for adjustment to the statute in order to allow the Board, with approval and input from the Director of Insurance, to better manage the overall cost of the pool. Additionally, ACHIA can provide for the requirements of Federal legislation that might otherwise cause significant disruption to the private insurance market in Alaska.

What are the Benefits?

The lifetime maximum benefit is $1,000,000 for all injuries and sicknesses combined. The Plan provides benefits which include 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 currently covered by any other health plan or health insurance policy;
- is not eligible for coverage under AS 21.56, Small Employer Health Reform;
- has been a resident for the past 12 months and continues to be a resident of Alaska; **and**
- **at least one of the following**:

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

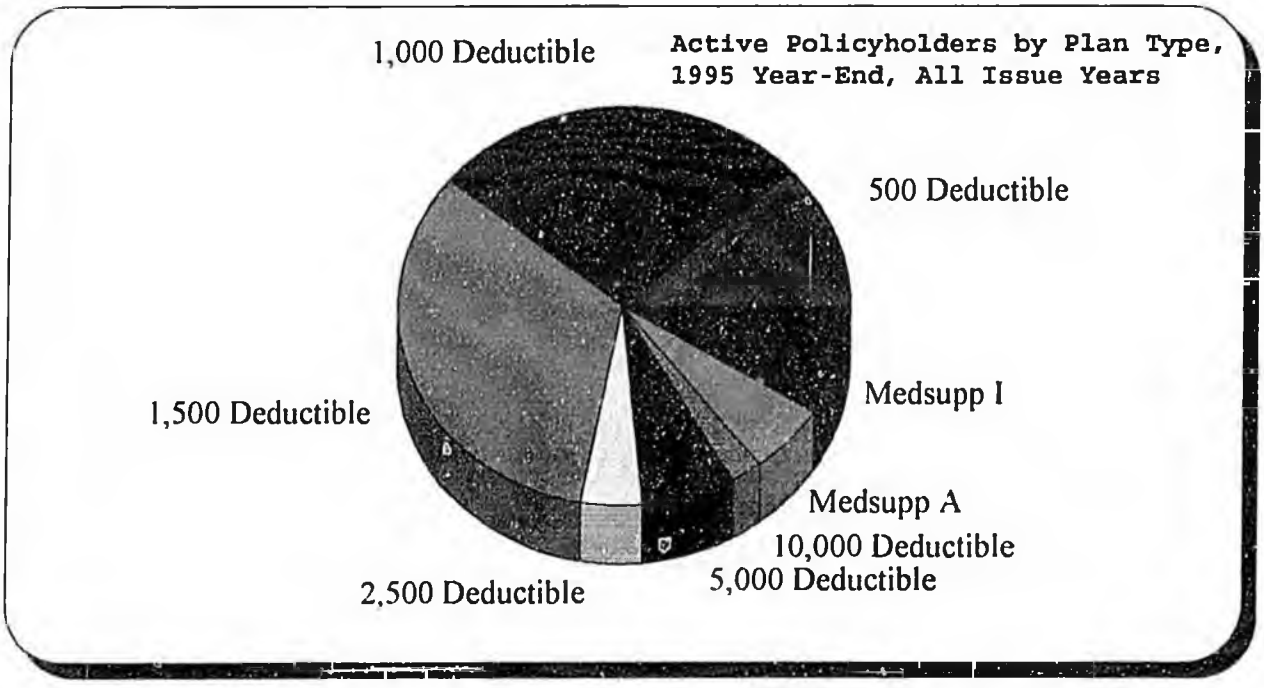
Acquired Immune Deficiency Syndrome (AIDS)
Alzheimers
Angina Pectoris
Anorexia Nervosa
Arteriosclerosis Obliteran
Articial Heart Valve
Ascites
Brain Tumors
Cardiomyopathy
Cerebral Palsy
Chronic Pancreatitis
Cirrhosis of the Liver
Coronary Insufficiency
Coronary Occlusion
Crohn's Disease
Cystic Fibrosis
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

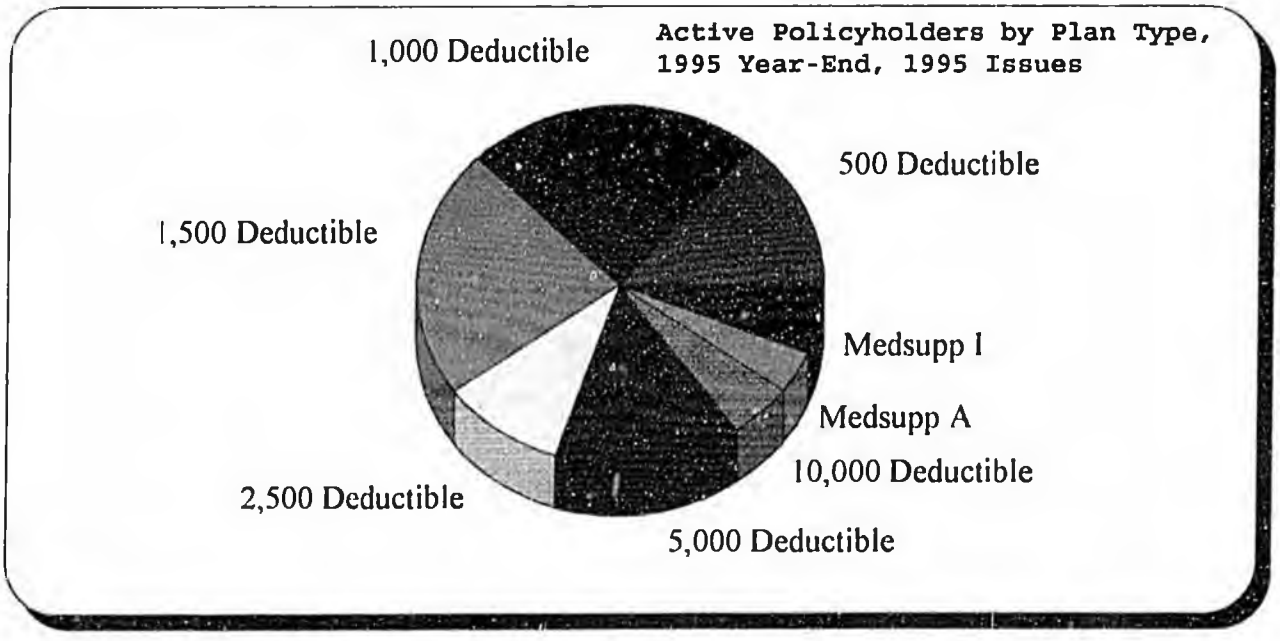
What Deductible Options are Available?

Six deductible options were available during 1995, $500, $1,000, $1,500, $2,500, $5,000, and $10,000. As of December 31, 1995, the plan insured the following:

1995 Year-End Active Policyholders by Plan Type

	Deductible						Medicare Supplement		
Issues	500	1,000	1,500	2,500	5,000	10,000	A	I	Total
All	21	49	59	8	12	4	10	16	179
1995	11	19	18	8	12	4	3	5	80





What are the Rates?

Major Medical Rates, 1993 - June 30, 1996

Deductible	$500		$1,000		$1,500	
Out of Pocket Maximum	$2,000		$2,000		$2,000	
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	616	193	579
35-39	306	918	225	675	204	612
40-44	363	1089	268	804	243	729
45-49	418	1254	308	924	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	
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	198	594

Medicare Supplement Rates, 1993 - June 30, 1996

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

What are the Rates?

Major Medical Rates, July 1, 1996

Deductible	$200		$500		$1,000		$1,500	
Out of Pocket Maximum	$2,000		$2,000		$2,000		$2,000	
Age	Mon	Qrtly	Mon	Qrtly	Mon	Qrtly	Mon	Qrtly
-18	285.25	855.75	182.00	546.00	141.75	425.25	117.25	351.75
19-24	425.25	1275.75	273.00	819.00	211.75	635.25	175.00	525.00
25-29	484.75	1454.25	309.75	929.25	243.25	729.75	201.25	603.75
30-34	540.75	1622.25	344.75	1034.25	269.50	808.50	224.00	672.00
35-39	609.00	1827.00	388.50	1165.50	306.25	918.75	253.75	761.25
40-44	705.25	2115.75	449.75	1349.25	353.50	1060.50	292.25	876.75
45-49	826.00	2478.00	526.75	1580.25	414.75	1244.25	344.75	1034.25
50-54	987.00	2961.00	630.00	1890.00	497.00	1491.00	413.00	1239.00
55-59	1172.50	3517.50	745.50	2236.50	595.00	1785.00	495.25	1485.75
60-64	1394.75	4184.25	885.50	2656.50	708.75	2126.25	595.00	1785.00

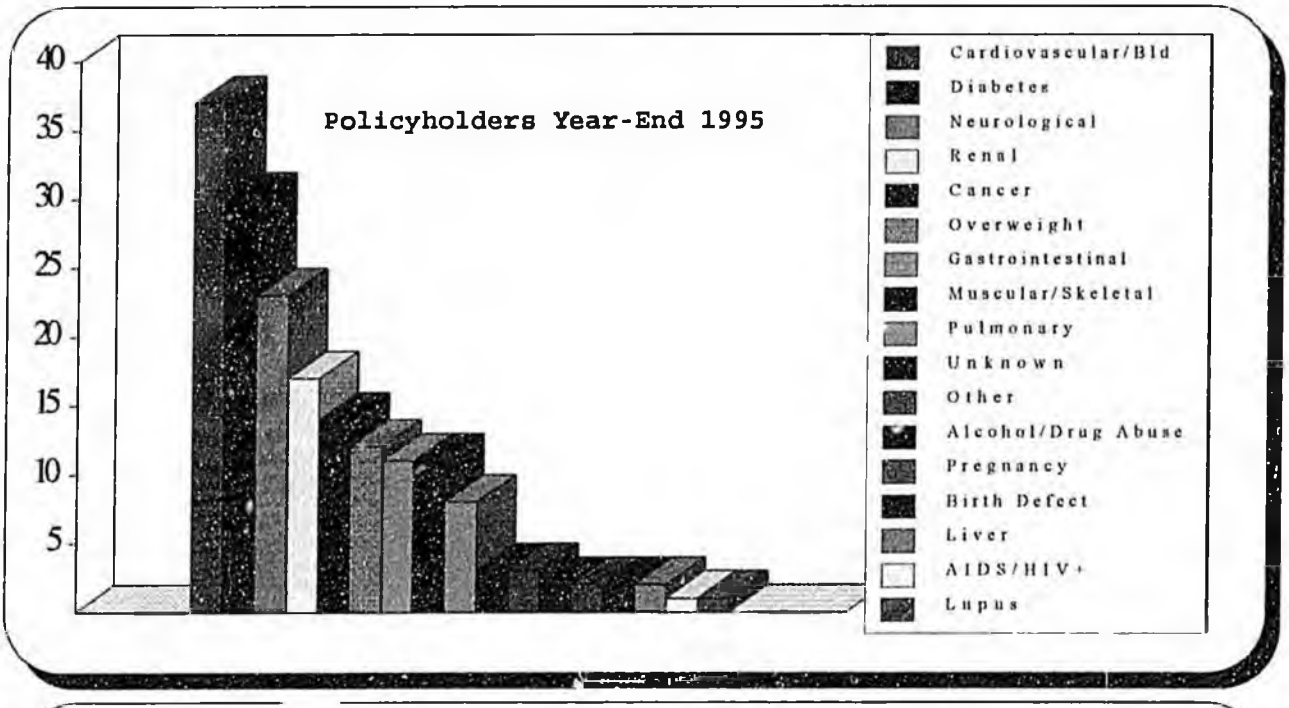
Deductible	$2,500		$5,000		$10,000	
Out of Pocket Maximum	$3,500		$7,500		$10,000	
Age	Mon	Qrtly	Mon	Qrtly	Mon	Qrtly
-18	99.75	299.25	66.50	199.50	57.75	173.25
19-24	148.75	446.25	99.75	299.25	89.25	267.75
25-29	171.50	514.50	115.50	346.50	103.25	309.75
30-34	190.75	572.25	129.50	388.50	113.75	341.25
35-39	215.25	645.75	143.50	430.50	129.50	388.50
40-44	248.50	745.50	168.00	504.00	148.75	446.25
45-49	292.25	876.75	196.00	588.00	175.00	525.00
50-54	350.00	1050.00	234.50	703.50	208.25	624.75
55-59	420.00	1260.00	283.50	850.50	250.25	750.75
60-64	502.25	1506.75	341.25	1023.75	299.25	897.75

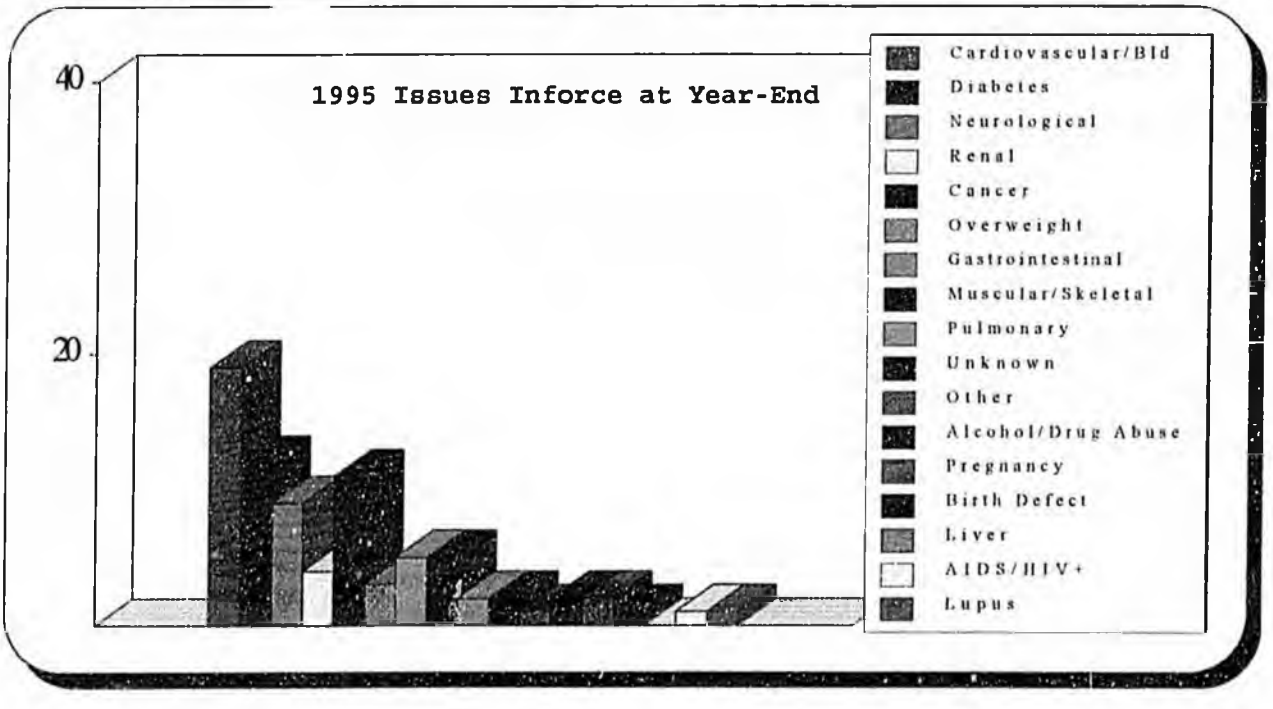
Medicare Supplement Rates, July 1, 1996

	Plan A		Plan I	
Age	Monthly	Quarterly	Monthly	Quarterly
-69	110.25	330.75	288.75	866.25
70-74	124.25	372.75	316.75	950.25
75-79	136.50	409.50	343.00	1029.00
80+	147.00	441.00	388.50	1165.50

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 cardiovascular conditions. The next most listed categories include people with diabetes, neurological, and renal problems, followed by cancer, weight, gastrointestinal, or muscular/skeletal 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 coverage. Exhibit 1 is the ACHIA balance sheet for years ended 1994 and 1995. Exhibit 2 shows the revenues, expenses and changes in the fund balance. ACHIA began 1995 with a fund balance of $(490,982), and ended with $(570,063), based on 1995 revenues of $2,257,377, and expenses of $2,336,458. Exhibit 3 shows the cash flow for 1994 and 1995.

Board of Directors

The Board of Directors for 1995 are:

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

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

Cecil D. Bykerk, Chairman
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

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

James Tysver
Blue Cross of Washington & Alaska
7001 220th Street S.W., Bldg. 3
Mountlake Terrace, WA 98043-2124
ph: (206) 670-4553
fax: (206) 670-4900

Robert Niebrugge, Vice Chairman
Box 4187
3521 Sky Ranch Loop
Palmer, AK 99645
ph: (907) 746-3256
fax: (907) 745-3110

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

Katie Campbell
ex-officio member
State of Alaska Division of Insurance
333 Willoughby
Juneau, AK 99801
ph: (907) 465-4607
fax: (907) 465-3422

Exhibit 1
Alaska Comprehensive Health Insurance Association

Balance Sheet

December 31, 1995 and 1994

Assets

	1995	1994
Cash	$86,017	$ 29,287
Funds held by writing carrier	50,206	0
Assessments receivable	46,213	0
	182,436	29,287

Liabilities and Fund Balance

	1995	1994
Reserve for claims and claim adjustment expenses	$ 674,673	$420,871
Funds due to writing carrier	0	19,865
Unearned premiums	34,198	35,905
Assessments collected in advance	43,628	43,628
Fund balance	(570,063)	(490,982)
	182,436	29,267

Exhibit 2
STATEMENTS OF REVENUES, EXPENSES
AND CHANGES IN FUND BALANCE (DEFICIT)

Years ended December 31, 1995 and 1994

	1995	1994
Revenues:		
Member assessments	$1,775,615	$ -
Premiums earned	480,708	328,962
Interest income	1,054	5,926
	2,257,377	334,888
Expenses:		
Claims Paid	$1,903,747	474,619
Change in claims and claim adjustment expense reserves	253,802	331,023
Administrative services	156,297	97,831
Accounting services	12,720	8,775
Secretarial services	4,090	3,026
Board meetings	1,881	2,690
Telephone	1,658	869
Postage	171	129
Printing	1,038	62
Bank fees	1,054	21
	$ 2,336,458	919,045
Excess (deficiency) of revenues over expenses	(79,081)	(584,157)
Fund balance at beginning of year	(490,982)	93,175
Fund balance (deficit) at end of year	$ (570,063)	$ (490,982)

Exhibit 3
STATEMENTS OF CASH FLOWS

Years ended December 31, 1995 and 1994

	1995	1994
Cash flows from operating activities:		
Assessments collected from members	$1,729,402	$ 0
Premiums collected from insureds	479,001	348,744
Interest received	1,054	5,926
Claims and claim adjustment expenses paid	(1,903,747)	(493,961)
Cash paid to administrators and suppliers in excess of claims and other expenses paid by writing carrier	(178,909)	(95,741)
	(70,071)	217,420
Net cash provided (used) by operating activities and net increase (decrease) in cash	56,730	(17,612)
Cash at beginning of year	29,287	46,899
Cash at end of year	86,017	29,287
Reconciliation of excess (deficiency) of revenues over expenses to net cash provided (used) by operating activities:		
Excess (deficiency) of revenues over expenses	(79,081)	(584,157)
Adjustments:		
Increase in assessments receivable	(46,216)	0
Decrease (increase) in funds held by writing carrier	(70,071)	217,420
(Decrease) increase in accounts payable	0	(1,680)
Increase in reserve for claims and claim adjustment expenses	253,802	331,023
(Decrease) Increase in unearned premiums	(1,707)	19,782
Total adjustments	135,811	566,545
Net cash provided (used) by operating activities	$ 56,730	$(17,612)

PUBLIC LAW 104–191—AUG. 21, 1996

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996

Available in State Law Libraries

OVERVIEW
KASSEBAUM/KENNEDY BILL

Presented by
Marianne K. Burke, Director
Division of Insurance

I. General Points

Overview: P.L. 104-191, commonly called Kassebaum/Kennedy (K/K), creates federal standards for both the individual and group health insurance markets, but it does permit substantial state flexibility for compliance. The law requires insurers to offer coverage to **all small employers** that apply for coverage and **to individuals** meeting certain requirements **(guaranteed issue)**; to guarantee renew coverage in both the group and individual markets **(guaranteed renewal)**; and to **limit the use of preexisting condition exclusions in the group market and eliminate them in the individual market for eligible individuals.** However, the federal law does not limit the premiums that issuers can charge for any type of coverage.

Preemption: The **test for preemption** in all cases EXCEPT for provisions relating to preexisting condition exclusions is: whether the state's standards and requirements would **prevent the application of the federal law.**

The **test for preemption** for provisions affecting **preexisting condition exclusions** is: The federal law DOES "**supersede any provision of State law** which establishes, implements, or continues in effect a standard or requirement applicable to imposition of a preexisting condition exclusion specifically governed by the law (in ERISA section 701 or PHSA section 2701) which **differs** from the standards or requirements in those sections, **UNLESS** the State provision meets one of seven **specific exceptions**.

II. Group Market

K/K requires **guaranteed issue of all products in the small group market.** This is a relatively radical requirement for a number of states. The federal law is also very specific that a **small group is a group of 2 to at least 50.** States may extend the law's guaranteed issue protection to larger groups, and include groups of 1 if they cover the self-employed in the small group rather than the individual market.

The **guaranteed renewability** requirement applies to **groups of all sizes.**

The rules restricting the use of **preexisting conditions exclusions** and prohibiting the use of **health status-related factors** for purposes of issuing and renewing coverage apply to **groups of all sizes.**

NAIC 1992 Small Group Model

Alaska adopted a modified version of the NAIC's 1992 Small Group Model.

The 1992 Small Group Model only requires guaranteed issue of a basic and standard health benefit plan by all health carriers doing business in a state's

small group market. A state with this model will therefore need to expand the guaranteed issue requirement to all products offered by the insurer. K/K requires guaranteed issue of all products in the small group market.

The 1992 Small Group Model requires guaranteed renewability, subject to certain exceptions. In general these exceptions are consistent with the federal law, but need the revisions suggested by the P.L. 104-191 States Implementation Working Group.

The 1992 Small Group Model allows a preexisting condition exclusion of twelve months. This is consistent with K/K, except that the model requires certain revisions to prohibit preexisting condition exclusions based on pregnancy as a preexisting condition and to extend the permissible period for a gap in coverage to 63 days.

Another key issue is the definition of "small employer." The federal law is very specific that there is guaranteed issue for groups of 2 to at least 50, and it sets forth the method of calculating that group. The 1992 Model must be modified as suggested to conform to the federal requirements.

The 1992 Model must also be revised to ensure that its concept of "qualifying previous coverage" and "qualifying existing coverage" are consistent with the federal law's concept of "creditable coverage."

III. Individual Market

We would like to review the possible scenarios for implementing an acceptable alternative mechanism to meet the requirements of K/K for the individual market.

The law requires that an **acceptable alternative mechanism** meet **four requirements**:

1. It must provide eligible individuals with a **choice** of coverage;
2. It cannot impose any **preexisting condition exclusions** for eligible individuals;
3. The choice must include at least one policy form that is:
   (i) comparable to **comprehensive coverage** in the individual market in the state; **or**
   (ii) comparable to the **standard** plan under the state's small group or individual laws;

-AND-

4. The state must be implementing **one of three** things:

   (a) one of the **two NAIC models laws** on individual market reform;
   (b) a qualified **high risk pool** as defined in the law; or
   (c) (i) a mechanism providing for **risk adjustment, risk spreading**, or a risk spreading mechanism or otherwise provides for some **financial subsidization** of eligible individuals; or
   (ii) a mechanism allowing eligible individuals a **choice of all available** individual health insurance coverage.

Under the federal law, an eligible individual:

(1) has had, in the aggregate, at least 18 months of creditable coverage;
(2) the most recent coverage is under a group, governmental, or church plan including a self insured group;
(3) is not eligible for any other coverage, including Medicare, Medicaid, etc.;
(4) has not had coverage terminated for nonpayment of premiums or fraud;
(5) has exhausted a COBRA continuation option if one was available;
(6) has had no gap in coverage exceeding 63 days.

Given these requirements, what are a state's options?

Option 1: Guaranteed issue of all products in the individual market.

States that already have guaranteed issue of all products in the individual market will have to do little to comply with the federal law's requirements. However, even these states must ensure that any state restrictions limiting the individuals eligible for guaranteed issue do not prevent those individuals who are eligible for guaranteed issue under the federal law from obtaining coverage. The state must also ensure that its high risk pool does not impose any preexisting condition exclusions for federally defined eligible individuals.

Option 2: High risk pool.

The federal law defines a qualified high risk pool as one that:

(1) Provides coverage to all eligible individuals.
(2) Does not impose a preexisting condition on an eligible individual;
(3) Provides for premium rates and covered benefits for such coverage consistent with the NAIC's Model Health Plan for Uninsurable Individuals Model Act (i.e., premium rates do not exceed 200 percent of standard risk rates);

States that choose this option will have to make sure that their risk pool meets the requirements above. Other issues raised by the high risk pool:

(1) Can state residency requirements stand?
(2) Must the high risk pool provide a choice of more than one policy? Will one policy with a choice of deductibles suffice?
(3) What is a "comprehensive" policy with respect to a state's individual market?

Option 3: Adopt one of the two NAIC individual market models.

K/K references the two NAIC models addressing individual market reform: (1) the Small Employer and Individual Health Insurance Availability Model Act, as it relates to the individual market ("Availability" Model); and (2) the Individual Health Insurance Portability Model Act ("Portability" Model).

Adoption of one of these models will constitute an acceptable alternative mechanism, provided that the other three criteria are met: a choice of coverage for all federally defined eligible individuals, which includes a choice of a comprehensive policy, and no preexisting condition exclusions for these individuals.

These two models are being reviewed and revised by the NAIC P.L. 104-191 States Implementation Working Group to make the revisions required for compliance with K/K.

General Structure of the Availability Model

In the small group market, the Availability Model requires guaranteed issue of all products, including a standard and basic plan. In the individual market it also requires guaranteed issue of all products, including a standard and basic plan, but sets out two options: a year-round guaranteed issue requirement, or a rolling open enrollment option which guarantees an individual one-month each year in which to obtain a product. It requires adjusted community rating, with variations allowed only for geographic area, family composition, and age.

It requires guaranteed renewability for both small group and individual products, subject to standard exceptions such as fraud or misrepresentation, nonpayment of premiums, etc. In general these exceptions are consistent with the requirements of the federal law, subject to some deviations.

In general the Availability Model's provisions for preexisting condition exclusions, definition of preexisting condition, eligible individual, etc. are similar to the requirements of the federal law. However, it allows a twelve-month preexisting condition exclusion and therefore must be modified to prohibit any exclusions for federally defined eligible individuals. Also, the concept of "crediting" coverage and shortening preexisting condition exclusions accordingly differs somewhat, as do some slight elements of the phrasing of the definitions. Because of the very preemptive language of the federal law for state provisions that address preexisting condition exclusions, some revisions have been made to the language of this model.

General Structure of the Portability Model

The Portability Model addresses only the individual market. It requires guaranteed issue of a basic and a standard plan by all health carriers doing business in the state's individual market. The director establishes by regulation the form and level of coverage of the basic and standard health benefit plans. It permits rating bands, subject to certain requirements.

The Portability Model requires guaranteed renewability of individual health benefit plans.

It allows a twelve-month preexisting condition exclusion and therefore must be modified to prohibit any exclusions for federally defined eligible individuals.

Option 4: Mandatory group conversion policies.

Some states have mandatory group conversion policies. These policies will not apply to individuals covered by self-funded ERISA plans. Therefore, such laws alone will not enable a state to comply with K/K because they will not protect many individuals who are entitled to protection under the federal law. Alaska does not have mandatory group conversion policies.

Option 5: Open enrollment by one or more health insurance issuers.

States that have implemented open enrollment by one or more insurers have in place a broader protection than that afforded by the rolling open enrollment option of the NAIC Availability Model. However, the rolling open enrollment option as set forth in the revised NAIC model is sufficient for compliance with K/K's guaranteed issue requirements because it would allow federally defined eligible individuals to have 63 days to obtain coverage and would not require them to wait until the month of their birthday. Under the NAIC model, other individuals with previous coverage could obtain coverage within 31 days of the termination of the previous coverage. Not available in Alaska.

Option 6: Some combination of the 4 options above.

The federal law permits states to have some combination of permissible mechanism. (Section 2744(a)(2).) The law does not specify whether a state must offer every eligible individual the same choices, or whether it may provide different groups with different choices.

Another point is that some mechanisms already contained in state law will not protect individuals whose previous coverage was in a self-funded ERISA plan. This is a problem with mandatory conversion laws, as noted above.

Option 7: Rely on federal fallback standards instead of implementing an alternative mechanism.

Guaranteed Availability: Federal standards apply if there is No State Alternative Mechanism. (Section 2741(c)). Therefore, in states that do NOT implement an acceptable alternative mechanism under Section 2744, the following standards and exceptions apply:

A. The **health insurance issuer** may **elect** to limit coverage to eligible persons to a **choice** of only **two different policy forms** (Section 2741(c)), both of which must:

(1) be designed for, made generally available to, are actively marketed to, and enroll both eligible and other individuals; **and**

(2) Either:

(a) be the "most popular policy forms:" The forms with the largest and second largest **premium volume** in the state or applicable marketing or service area (as defined in regulation); **or**

(b) be "policy forms with representative coverage:" Be a lower level and a higher level form, each of which contains benefits substantially similar to other individual coverage offered by the issuer AND each of which is covered under some risk spreading mechanism.

(i) Lower level coverage is defined as having an actuarial value of 85--100% of the weighted average;

(ii) Higher level coverage is defined as having an actuarial value of at least 15% greater than lower level coverage and between 100--120% of the weighted average;

(iii) A risk spreading mechanism must provide for risk adjustment, risk spreading, or a risk spreading mechanism (either among issuers or among the policies of an issuer); or must otherwise provide for some financial subsidization for eligible individuals, including through assistance to participating issuers. (Sec. 2744(c)(3)(A).)

(3) For purposes of Section 2741(c), policy forms which have different cost-sharing arrangements or different riders shall be considered different policy forms.

B. Special Rules for Network Plans: (These apply if the state does not implement an alternative mechanism):

(1) A network plan may limit enrollees to those who live, reside or work in the service area;

(2) A network plan may deny coverage based on the plan's enrollment capacity limits, as long as coverage is denied uniformly without regard to health status-related factors;

(3) If coverage is denied based on service capacity, the issuer is suspended from offering new coverage in the service area for 180 days;

C. Exception for Financial Capacity: (This applies if the state does not implement an alternative mechanism.)

(1) Health insurance issuer may deny health insurance coverage in the individual market to an eligible individual if the issuer demonstrates to the director that:

(a) It lacks financial reserves necessary to underwrite additional coverage; AND

(b) Is applying this denial uniformly to all individuals in the state's individual market, consistently with state law and without regard to health status-related factors and without regard to whether individuals are eligible individuals.

(2) If an issuer denies coverage based on financial capacity, it is suspended from offering coverage in the individual market in that service area for the later of: 180 days from the date of denial; or until the issuer demonstrates to the director, if required under state law, that it has sufficient financial reserves to underwrite additional coverage.

Guaranteed Renewability

A. Federal Standards apply REGARDLESS of whether the state is implementing an alternative mechanism for guaranteed issue.

B. All individuals enjoy guaranteed renewability, not just individuals eligible for guaranteed issue.

C. Exceptions to guaranteed renewability requirement:

(1) Nonpayment of premiums;

(2) Fraud or intentional misrepresentation of a material fact by an individual;

(3) Termination of a product: Issuer must provide notice to enrollee 90 days before termination, offer option to purchase any other individual product offered by the issuer, and act uniformly without regard to health status-related factors;

(4) Discontinuance of all individual coverage: Issuer must provide notice to the director and enrollees 180 days before termination, and is prohibited from market reentry for 5 years after date of last discontinuation due to nonrenewal.

(5) Network plans: Issuer may nonrenew if the individual no longer resides, lives, or works in the service area, provided that the issuer nonrenews uniformly, without regard to health status-related factors.

(6) Association membership ceases: Issuer may nonrenew if the individual ceases to be a member of the association through which coverage is obtained, provided that the issuer nonrenews uniformly, without regard to health status-related factors.

(7) Modification of coverage: At the time of coverage renewal, issuer may modify the policy form consistent with state law and provided that modification is effective on uniform basis among all individuals having that policy form.

IV. Other Issues

Mandatory Maternity Coverage

The Newborns' and Mothers' Health Protection Act of 1996 is an amendment to the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191). It applies to health care coverage sold in both the small and large group markets and the individual market.

The Act prohibits group health plans and health insurance issuers from restricting hospital coverage in connection with childbirth to less than 48 hours for a normal vaginal delivery and less than 96 hours for a cesarean section. It also prohibits plans from requiring the provider to obtain authorization for stays of this length. However, these exceptions do not apply to any case in which the decision to discharge the mother earlier than these minimum periods is made "by an attending provider in consultation with the mother."

The law also prohibits a group health plan or health insurance issuer from denying coverage to a mother or child to avoid the law's requirements, or from offering them financial incentives to reduce the length of stay. Nor may group health plans and health insurance issuers penalize attending providers for complying with the law or create financial incentives for providers that are inconsistent with the law.

The law contains three broad exceptions to the preemption of state law addressing hospital stays for childbirth. State law is NOT preempted if: (1) the state law requires coverage for a minimum of 48 hours for normal vaginal delivery and 96 hours for cesarean section; or (2) the state law requires coverage for maternity and pediatric care in accordance with guidelines issued either by the American College of Obstetricians and Gynecologists, or the American Academy of Pediatrics, "or other established professional medical associations"; or (3) the state law requires that, in connection with coverage for maternity care, the decision about the hospital length of stay is left to (or required to be made by) the attending provider in consultation with the mother.

The law also directs the Secretary of the U.S. Department of Health and Human Services to appoint an advisory panel to review studies that the Act requires the Secretary to undertake and to develop a consensus about the appropriateness of the Act's requirements. The advisory panel is to include representation from number of specified entities, including states and entities having expertise in consumer issues.

Because this Act is an amendment to P.L. 104-191 (Kassenbaum-Kennedy), the enforcement provisions of that act also apply to this law. States will enforce the maternity provisions against insurance carriers and entities under state jurisdiction unless the HHS Secretary determines that a state has failed to substantially enforce a provision, in which case the HHS Secretary will enforce the law. The Secretary of the U.S. Department of Labor will enforce the law with respect to ERISA plans.

The Act is effective January 1, 1998.

Mental Health Parity

The Mental Health Parity Act of 1996 is an amendment to the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191). It applies only to health care coverage sold through the large group market (groups of 51 or more).

The law provides that if a group plan does **not impose** an **aggregate lifetime limit** on **medical and surgical benefits**, it may **not impose such a limit on mental health benefits**. If the plan does impose an aggregate lifetime limit, the Act requires the plan to include mental health benefits with medical/surgical benefits in the aggregate limit and not distinguish between the two; or in the alternative, to offer an aggregate limit for mental health benefits that is not less than the aggregate limit for medical/surgical benefits. For plans that categorize among different types of medical and surgical benefits for the purpose of applying limits, the Secretary of the U.S. Department of Health and Human Services (or, for self-funded ERISA plans, the Secretary of the U.S. Department of Labor) is authorized to promulgate regulations for determining the aggregate lifetime limit. The law specifies the method for computing this limit.

The Act imposes **identical rules for annual limits**. If a plan does not include an annual limit on medical and surgical benefits, it may not impose such a limit on mental health benefits. If the plan does impose an annual limit, it must either include mental health benefits in the aggregate and not distinguish between medical/surgical and mental health benefits, or in the alternative, not impose any limit on mental health benefits that is less than the medical/surgical benefits limit. Again, for plans that categorize medical/surgical benefits and apply different limits per category, the HHS Secretary (or Labor Secretary) is required

to promulgate regulations for computing the aggregate annual limit as specified in the Act.

The Act does not require a group health plan to offer any mental health benefit, and does not affect the terms and conditions relating to the scope of any mental health benefit that is provided, except as described above with respect to limits.

The scope of this Act is limited by four of its provisions. First, as noted above, there is an exemption for small employers, defined as those having two to fifty employees. Second, there is an exemption if a group health plan experiences "an increase in the cost under the plan (or for such coverage) of at least 1 percent." The law does not make clear how this provision would be determined or enforced. Third, mental health benefits as defined in the law do not include substance abuse or chemical dependency services. Fourth, there is a sunset provision.

Without additional Congressional action, this law is only in effect from Jan. 1, 1998 through Sept. 30, 2001.

Because this Act is an amendment to P.L. 104-191 (Kassenbaum-Kennedy), the enforcement provisions of that act also apply to this law. States will enforce the mental health parity provisions against insurance carriers and entities under state jurisdiction unless the HHS Secretary determines that a state has failed to substantially enforce a provision, in which case the HHS Secretary will enforce the law. The Secretary of the U.S. Department of Labor will enforce the law with respect to ERISA plans.

SB104 - HIPAA Bulletin

This bulletin outlines the major health insurance updates to the Alaska Insurance Code that respond to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Alaska's approach to the federal requirements in HIPAA are in AS 21.54, Article 2, AS 21.55, and AS 21.56 Article 2. Although Interim federal regulations have been issued, final federal regulations will not be promulgated for several months and may materially change from the interim regulations. The Division of Insurance will issue future informational bulletins to address important state or federal regulatory or legislative developments.

Applicability and Scope

All health care insurers are subject to federal and state HIPAA provisions. Health care insurers include insurance companies, hospital and medical service corporations, fraternals, HMOs, and MEWAs (see AS 21.54.500(27)).

The group market for health insurance is defined to include employers with two or more employees. The group market provisions are in AS 21.54 Article 2, AS 21.56 Article 2, and AS 21.86. Note in particular the definitions in AS 21.12.050, AS 21.54.500(15)- (17), (19), and (28).

The individual market for health insurance includes all coverage offered to an individual outside of the group market. The individual market reforms are in AS 21.55. Guaranteed renewability provisions are in 42 U.S.C. 300gg-42 of the federal law and are not Alaska law.

The HIPAA provisions for the individual and group markets do not apply to excepted benefit plans - generally supplemental or limited benefit plans (see AS 21.54.160 for the complete description).

Effective Dates

With the limited exception in regard to mental health parity, the group market provisions summarized below become effective for plan years beginning on or after July 1, 1997. A plan year is defined in the federal interim regulations as the plan year designated in the policy. If the policy does not define a plan year, the plan year is the deductible or limit year used under the policy. If the policy does not impose deductibles or limits on a yearly basis and either the plan is not insured or the policy is not renewed on an yearly basis, the plan year is the employer's tax year. In all other cases the plan year is the calendar year. In most cases this means that the group provisions become effective for an existing group plan upon renewal after June 30, 1997.

The individual market provisions summarized below become effective after June 30, 1997.

As required under AS 21.54.120, health care insurers must provide a certification of coverage upon cessation of coverage or upon request by the individual. These certifications are intended to enable an individual to satisfy all or a portion of preexisting condition exclusions by receiving credit for previous coverage. The certifications must comply with federal regulations, including form, content, and delivery.

Filing Requirements

Individual Policies

All form filings for individual health insurance [illegible] must incorporate the guaranteed renewability provisions as required under 42 U.S.C. 300gg-42 of the federal law. These provisions apply to all in force policies as well as to new issues after June 30, 1997. Existing policies must be administered according to these provisions after June 30, 1997 regardless of whether or not the provisions have been incorporated into the policies as of July 1, 1997. If a policy form is no longer being issued then the contract must be amended to conform the guaranteed renewability provisions and filed with the division for approval before January 1, 1998. Also all currently issued policy forms must be amended and filed for approval before January 1, 1998.

Also as noted above since ov[illegible]insurance and eligibility for Medicare can no longer be used to terminate or non-renew a policy, the insurer may want to add a provision that reduces benefits to the extent they are provided under Medicare or otherwise. Should an insurer choose to add such a provision, the revised contract must be filed for approval with the division in conjunction with the amendments to conform to guaranteed renewability provisions as stated above.

Group Insurance

All form filings for group health insurance coverage must incorporate the required HIPAA provisions as outlined above and prescribed in AS 21.54, 55, and 86. As stated above the "actively at work" provisions in most group policies will no longer be allowed.

Existing contracts must be administered in accordance with these group provisions regardless of whether or not the provisions have been incorporated into the existing contracts as of July 1, 1997. Existing contracts must be amended to conform with the HIPAA provisions and filed for approval with the division before January 1, 1998.

Outline of Major Legislative Changes

Summary of Small Employer Changes

Definition of a Small Employer
A small employer is now defined as an employer with an average of at least two but not more than 50 employees on business days during the year that employs at least two employees on the first day of a health benefit plan year (see AS 21.54.500). Note that there is no longer a requirement that the majority of the employees be employed in Alaska.

Pre-existing Condition Provision
Pregnancy and genetic information in the absence of the condition are no longer to be considered pre-existing conditions. Also, a pregnant person requirement is no longer allowed.

Credit for Prior Coverage
For small employer health insurance coverage, qualifying previous coverage and rules for reducing the a preexisting condition waiting period for such coverage have been significantly modified. Qualifying previous coverage is now termed creditable coverage and is defined in AS [illegible]. Please note that although the definition of creditable coverage in AS 21.[illegible] does not include individual health care insurance plans, federal law requires that they be considered creditable coverage and this definition will be enforced in Alaska. The rules for determining the period of creditable coverage are provided in AS 21.54.120. The rules for reducing the preexisting condition waiting period are provided in AS 21.54.110. The most significant change for small employer health care insurance plans is in the rules for crediting a period of creditable coverage which must now use the federally defined standards method or an allowed alternative method as clarified in final regulations.

Guarantee Issue
AS 21.56.140 requires that small employer insurers guarantee issue all products they actively market to small employers in the state and must also continue to offer the Basic and Standard plans. Note that insurers are not required to offer a plan that is sold only to association plans to all small employers and that the exemption for an employer/employee that is out of the insurer's geographic service area has changed and is specific to network plans as defined in AS 21.54.500. Also, to clarify, in AS 21.56.140(a) the phrase "all health care insurance plans the small employer actively markets" should be "all health care insurance plans the small employer insurer actively markets".

Guaranteed Renewability
All health care insurance plans offered in the group market are guaranteed renewable except for nonpayment of premiums, fraud, termination of the plan,

movement outside the insurer's service area, or cessation of association membership.

There are now specific rules for discontinuing offer of particular health plans and for discontinuing offer of all health plans offered to small employers. The law specifically allows for an insurer to modify a small (not large) employer's plan at renewal on a uniform basis for all small employers with the same plan.

There are special guaranteed renewability provisions for Multiple Employer Welfare Arrangements in AS 21.54.140.

Premium Report

All health care insurers (not just small employer insurers) are required to file with the Director by March 15 each a report of total small employer premiums earned in Alaska on a form prescribed by the Director. The first report will be due by March 15, 1998. The report form is in development and will be available before 12/31/97.

Large Employer

Health care insurance plans sold to large employer groups are subject to the same preexisting condition, credit for prior coverage, guaranteed renewability provisions as described above for small employers and are provided in AS 21.54 Article 2. These are new requirements for large employer groups. Note that the guarantee issue provisions do not apply to large employer groups.

Mental Health Parity

AS 21.54.140 establishes rules for the provision of and level of mental health benefits for large employer health plans. If compliance with the rules would result in an increase in cost of more than one percent for the employer then the requirements do not apply. This provision does not become effective until 1/1/98.

Small and Large Employer

Large and small employer health plans must not establish rules for eligibility including continued eligibility and waiting periods under a health plan for an individual or dependent of an individual based on a health status factor as defined in AS 21.54.100. As a consequence of this provision "actively at work" requirements will no longer be permitted to the extent they violate this provision.

AS 21.54.100 (c) states that insurers may not require individuals as a condition of enrollment to pay a premium, contribution or policy fee greater than the premium, contribution, or policy fee for similarly situated individual enrolled in the plan on the basis of a health status factor.

Individual

In order to implement the portability provisions required by HIPAA, Alaska has modified the eligibility requirements under the Comprehensive Health Insurance Association (CHIA) to allow federally defined eligible individuals guaranteed health insurance coverage through the CHIA. A federally defined eligible individual is defined in AS 21.55.500(16) to be those individuals with at least 18 months of creditable coverage in a group plan, who is not eligible for other health care insurance coverage, whose most recent coverage was not terminated due to nonpayment of premium or fraud, and who has exhausted any available COBRA coverage. A federally defined eligible individual does not have to satisfy a preexisting condition waiting period nor do they need to meet the normal 12 month residency requirement in order to be eligible for coverage under the CHIA.

In 42 U.S.C. 300gg-42 of the federal law, all individual health insurance policies are guaranteed renewable subject to certain exceptions. These provisions are similar to the guaranteed renewability provisions in the group market as described above. Insurers may modify on a policy form basis the health care insurance coverage if modification is done on a uniform basis for all individuals with that policy form.

It is important to note that overinsurance or availability for Medicare may no longer be used as reasons for termination or nonrenewal of an individual's health insurance coverage. However, a provision in an individual health policy that reduces benefits to the extent benefits are provided under Medicare or otherwise would be permitted.