

ALASKA LEGISLATURE COMMITTEE FILES 1997-1998 00/2

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CS FOR HOUSE BILL NO. 300()
IN THE LEGISLATURE OF THE STATE OF ALASKA
TWENTIETH LEGISLATURE - SECOND SESSION

BY

Offered:
Referred:

Sponsor(s): REPRESENTATIVES BUNDE, James

A BILL

FOR AN ACT ENTITLED

1 "An Act relating to regulation of health insurance plans; relating to patients'
2 rights and prohibited practices under health insurance; relating to health care
3 review organizations; and providing for an effective date."

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

5 * Section 1. SHORT TITLE. Section 4 of this Act may be known as the Alaska Patients'
6 Bill of Rights.

7 * Sec. 2. AS 18.23.020 is amended to read:

8 Sec. 18.23.020. Liability [LIMITATION ON LIABILITY] for members of
9 review organizations. A person who is a member or employee of [, OR WHO ACTS
10 IN AN ADVISORY CAPACITY TO, OR WHO FURNISHES COUNSEL OR
11 SERVICES TO] a review organization is [NOT] liable for damages or other relief in
12 an action brought by another whose activities have been or are being scrutinized or
13 reviewed by a review organization, by reason of the performance of a duty, function,
14 or activity of the review organization, if [UNLESS] the performance of the duty,

1 function, or activity was negligent, reckless, or motivated by malice toward the
2 affected person. Except as provided in this section, a [A] person is not liable for
3 damages or other relief in an action by reason of performance of a duty, function, or
4 activity as a member of a review organization or by reason of a recommendation or
5 action of the review organization when the person acts in the reasonable belief that the
6 action or recommendation is warranted by facts known to the person or to the review
7 organization after reasonable efforts to ascertain the facts upon which the review
8 organization's action or recommendation is made.

9 * Sec. 3. AS 21 is amended by adding a new chapter to read:

10 **Chapter 07. Regulation of Health Insurance Plans.**

11 **Sec. 21.07.010. Managed care provider and patient protection.** A contract
12 between a participating health care provider and an insurer that offers a managed care
13 plan

14 (1) must state that the health care provider may not be penalized or the
15 contract terminated by the insurer because the health care provider acts as an advocate
16 for the patient in seeking appropriate, medically necessary health care services;

17 (2) may not provide financial incentives to the health care provider for
18 withholding covered health care services that are medically necessary; and

19 (3) must protect the ability of a health care provider to communicate
20 openly with a patient about all appropriate diagnostic testing and treatment options;

21 (4) must define words in a clear and concise manner; and

22 (5) must clearly identify

23 (A) all health care services to be provided;

24 (B) what health care services will be provided by contractors;

25 and

26 (C) provider compensation rates and termination procedures.

27 **Sec. 21.07.020. Required contract provisions.** A health insurance plan
28 offered to residents of the state must provide that

29 (1) coverage for a medical procedure that has been preapproved by the
30 insurer may not be denied;

31 (2) all emergency room services shall be covered if the person covered

1 reasonably believes the services are required;

2 (3) copayment requirements shall be uniform between health care
3 providers;

4 (4) pharmacy and dental services shall be located in the community in
5 which the covered person resides; and

6 ~~(5) health care services may not be denied unless the denial is reviewed~~
7 ~~and approved by a peer review committee formed by the insurer that includes~~
8 ~~appropriate representation of health care providers with knowledge of the health care~~
9 ~~services at issue.~~
*A utilization review process, to deny, reduce, or terminate
a health care benefit or deny payment for a health care service because that
service is not medically necessary, shall be made by a health care provider
having in that specialty a successful track record in providing such health
services at issue.*

10 **Sec. 21.07.030. Choice of health care provider.** (a) An insurer that offers
11 a managed care plan shall offer to every contract holder a point-of-service plan option
12 that would allow a covered person to receive covered services from an out-of-network
13 health care provider without obtaining a ~~r~~ ^rtal or prior authorization from the insurer.
14 The point-of-service plan option may require that a subscriber pay a higher deductible
15 or copayment and higher premium for the plan if the higher deductible, copayment, or
16 premium results from increased costs caused by the use of an out-of-network provider.

17 (b) An insurer shall provide each subscriber in a plan whose contract holder
18 elects the point-of-service plan option with the opportunity at the time of enrollment
19 and during the annual open enrollment period to enroll in the point-of-service plan
20 option. The insurer shall provide written notice of the point-of-service plan option to
21 each subscriber in a plan whose contract holder elects the point-of-service plan option
22 and shall include in that notice a detailed explanation of the financial costs to be
23 incurred by a subscriber who selects that ~~on~~ option.

24 (c) The requirements of this section do not apply to an insurer contract that
25 offers a managed care plan that provides health care services to Medicaid recipients
26 or to a federally qualified, nonprofit health maintenance organization.

27 **Sec. 21.07.250. Definitions.** In this chapter,

28 (1) "health care provider" means a person licensed in this state to
29 provide health care services;

30 (2) "health care services" means treatment of an individual for an
31 injury, illness, or disability and includes preventative treatment of an injury or illness;

1 (3) "health insurance" has the meaning given in AS 21.12.050;

2 (4) "managed care contractor" means a contractor who establishes,
3 operates, or maintains a network of participating health care providers, conducts or
4 arranges for utilization review activities, and contracts with an insurer, a hospital or
5 medical service plan, an employer or employee health care organization, or another
6 entity providing coverage for health care services to operate a managed care plan;

7 (5) "managed care entity" includes an insurer, hospital or medical
8 service plan, health maintenance organization, an employer or employee health care
9 organization, or a managed care contractor that operates a managed care plan;

10 (6) "managed care plan" means a health care plan operated by a
11 managed care entity; "managed care plan" does not include an integrated medical
12 group contracting with a health care plan for the direct provision of health care
13 services to a health care plan enrollee;

14 (7) "participating health care provider" means a health care provider
15 who has entered into an agreement with a managed care entity to provide services or
16 supplies to a patient enrolled in a managed care plan;

17 (8) "provider" means a health care provider;

18 (9) "utilization review" means a system of reviewing the medical
19 necessity, appropriateness, or quality of health care services and supplies provided
20 under a managed care plan using specified guidelines, including preadmission
21 certification, the application of practice guidelines, continued stay review, discharge
22 planning, preauthorization of ambulatory procedures, and retrospective review.

23 * Sec. 4. AS 21.42 is amended by adding a new section to read:

24 **Sec 21.42.390. Required health insurance coverage provisions.** (a) A
25 health care insurer may not include in the health care insurance plan or contract a
26 provision that

27 (1) prohibits a covered person from obtaining health care services from
28 a health care provider of the person's choice, including a specialist;

29 (2) restricts a covered person's right to receive full information from
30 the person's health care provider regarding the care or treatment options that the health
31 care provider believes are in the best interests of the person.

1 (b) A health care insurer may not deny, reduce, or terminate health care
2 benefits for a covered person unless the denial, reduction, or termination is approved
3 by a physician who is licensed to practice in this state.

4 (c) A health care insurer may not

5 (1) directly or indirectly reimburse a covered person at a different rate
6 because of the person's choice of provider;

7 (2) deny coverage, cancel a health care insurance plan or subscriber
8 contract, or otherwise take action against a covered person or a health care provider
9 because the person has asserted a right described under this section.

10 (d) A covered person may bring a civil action against a health care insurer to
11 enforce the person's rights under this section.

12 (e) In this section,

13 (1) "health care provider" means a person licensed in this state to
14 provide health care services;

15 (2) "health care services" means treatment of an individual for an
16 injury, illness, or disability and includes preventative treatment of an injury or illness.

17 * Sec. 5. This Act takes effect July 1, 1998.

03/23/98 15:16:40 LEGISLATIVE TELECONFERENCE NETWORK SYSTEM LTN1120
MESSAGE FROM: LIOCJEN IN ANCHORAGE JNU

RE TCN: 80538 SCHEDULED FOR:03/23/98 15:15 TO 17:15
SPONSOR: HOUSE LABOR & COMMERCE PURPOSE: PUBLIC HEARING

MESSAGE TEXT: JIM JORDAN, ANCH, OF MEDICAL ASSOC. IS
ON LINE TO ANSWER ?S

03/23/98 15:17:10 LEGISLATIVE TELECONFERENCE NETWORK SYSTEM LTN1120
MESSAGE FROM: LIOCJEN IN ANCHORAGE JNU

RE TCN: 80538 SCHEDULED FOR:03/23/98 15:15 TO 17:15
SPONSOR: HOUSE LABOR & COMMERCE PURPOSE: PUBLIC HEARING

MESSAGE TEXT: JACK MCRAE OF BLUE CROSS IN SEATTLE IS
ON LINE TO TESTIFY "IF NEEDED"

Jeff Davis - AK MGR -

03/23/98 LEGISLATIVE TELECONFERENCE NETWORK SYSTEM LTN1150
15:19:25 PARTICIPANT LIST (ALL PARTICIPANTS) BY:ANC
TCN:80538 SCHEDULED FOR:03/23/98 15:15 TO 17:15 FOR:ANC
PUBLIC HEARING HOUSE LABOR & COMMERCE

LOCATION: ANCHORAGE

HB 300	MARIANNE	BURKE	<i>Questions only</i>	TESTIFY
HB 300	ED	BURGAN		TESTIFY
HB 300	ROSE	KALAMARIDES		TESTIFY

03/23/98 LEGISLATIVE TELECONFERENCE NETWORK SYSTEM LTN1150
15:22:12 PARTICIPANT LIST (ALL PARTICIPANTS) BY:ANC
TCN:80538 SCHEDULED FOR:03/23/98 15:15 TO 17:15 FOR:ANC
PUBLIC HEARING HOUSE LABOR & COMMERCE

LOCATION: ANCHORAGE

HB 300	MARIANNE	BURKE	ANS ?S	TESTIFY
HB 300	ED	BURGAN		TESTIFY
HB 300	ROSE	KALAMARIDES		TESTIFY
HB 300	QUINN	MCKENNA	ANS ?S PHSA	TESTIFY



Alaska Insurance Consumer Guide

Tony Knowles, Governor

Marianne K. Burke, Director

State of Alaska • Department of Commerce and Economic Development • Division of Insurance

OCTOBER 1997

Dear Alaska Insurance Consumers:

We at the Division of Insurance are proud to provide you with this Alaska Insurance Consumer's Guide. The guide represents the combined experience and expertise of many people. We have put this guide together for several reasons. Our Consumer Services Specialists receive many questions about insurance. We believe that there are other people out there who also have questions. In order to help the citizens of our state be more knowledgeable purchasers of insurance and to understand their rights and responsibilities under their policies, we have developed this resource.

The guide is written in sections that cover different types of insurance. Insurance is a part of our lives. Whether it is the insurance policy we buy for our first car, the homeowner's policy we get when we purchase our first home, or the life insurance policy we purchase to provide for our children. All of us purchase, or are covered by, insurance of one form or another. The Consumer Federation of America, a consumer advocacy group, estimates that insurance is the fourth largest non-housing purchase we make in our lifetime. We spend many dollars on insurance. Frankly though, few of us fully understand what we are purchasing. We believe this guide will help you by answering some of the more frequently asked questions about insurance.

Insurance can be a very personal cost. Some insurance is mandated by statute such as auto insurance. Other insurance is a matter of personal choice i.e. life insurance. Purchasing insurance is like purchasing any other product or service. The more you know the better prepared you are to ask the right questions and make the right choices. We all need to maximize the benefits of our insurance dollars or to reduce those costs. One way to do this is to buy only the type and amount of insurance you need.

Your local licensed insurance producers and other insurance company representatives can provide you with information to help you make your insurance decisions. The Division also has a number of publications which are listed in this guide which are available to you at no cost. The Division is also here to help you if you experience problems with the handling of your insurance affairs. We will try our best to help you.

Sincerely,

Marianne K. Burke
Director

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How to Reach Us!

State of Alaska
Department of Commerce
and Economic Development

Division of Insurance

State Office Building
333 Willoughby Ave., 9th Floor
P.O. Box 110805
Juneau, AK 99811-0805
(907) 465-2515
Fax: (907) 465-3422

or

Frontier Building
3601 C Street, Suite 1324
Anchorage, AK 99503-5948
(907) 269-7900
Fax: (907) 269-7910

1-800-467-8725
(Within Alaska Only)

Internet

[www.state.ak.us/local/akpages/
COMMERCE/ins.htm](http://www.state.ak.us/local/akpages/COMMERCE/ins.htm)

E-mail

insurance@commerce.state.ak.us



Other Publications

In addition to this consumer guide, there are several other publications you may find helpful. The publications listed below are available, free of charge, by contacting our Juneau or Anchorage office:

- ▶ Annual Insurance Report
- ▶ Consumer Guide to Choosing an Insurance Company
- ▶ Shopper's Guide to Long-Term Care Insurance
- ▶ Guide to Health Insurance for People with Medicare
- ▶ Homeowners Insurance Rating Examples
- ▶ Medicare Supplement Rate Guide

- ▶ Private Passenger Auto Insurance Rating Examples
- ▶ Workers' Compensation Rating Guide
- ▶ When Disaster Strikes

Information presented in this guide should not be considered an endorsement by the Alaska Division of Insurance for any product or service offered by a particular person or organization. Before following any tips in this guide, make sure that they are right for you and your financial circumstances.



About the Division

The Alaska Division of Insurance is a state agency headed by the Director of Insurance. There are two offices. One is located on the 9th floor of the State Office Building in Juneau. The other office is on the 13th floor of the Frontier Building in Anchorage.

The most important function of the division is consumer protection, which includes oversight of the financial conditions of insurance companies. As insurance needs have grown, the need to assist Alaska consumers has also grown.

The division consists of several sections: Actuarial, Administration, Consumer Service, Financial, Form and Rate Filing Review, Investigation, Legal, Market Examination, and Producer Licensing.

- ▶ The **Actuarial Section** provides technical support to other sections in the division. This includes assisting the Form and Rate Filing Review section with the review of complex filings, assisting the Financial section in monitoring the solvency of the insurers operating within

the State of Alaska, and assisting the Market Examination section in monitoring compliance with Alaska laws and participating in insurer examinations. This section also collects and analyzes data to aid in developing more effective regulation of insurance in Alaska and participates extensively in drafting insurance laws and regulations.

- ▶ The **Administrative Section** directs, manages, supervises, establishes policies and procedures and provides support services to the division.
- ▶ The **Consumer Service Section** investigates consumer inquiries and complaints against insurance companies and producers in order to help ensure fair treatment to policyholders. Examples of complaints this section responds to include improper cancellation of insurance policies, misrepresentation of policy terms, improper claim denials, inappropriate delays in the claim settlement process, and other unfair marketing practices.
- ▶ The **Financial Section** reviews insurance companies to help assure that the company has enough money to pay claims, and licenses the insurance companies to sell business in Alaska.
- ▶ The **Form and Rate Filing Review Section** reviews most policy forms to ensure that policy language is not deceptive or misleading and properly reflects the benefits under the policy. This section also evaluates premium rates for most property and casualty insurance policies to help assure that premiums are not excessive, inadequate or unfairly discriminatory.

- ▶ **The Investigation Section** investigates cases of insurance fraud such as misappropriation of premiums received by Alaska licensed insurance producers, fraudulent insurance claims, and allegations of individuals or companies transacting insurance without a license.
- ▶ **The Legal Section** advises division staff regarding the implementation of the policies of the Division of Insurance, assists in the legal education of division staff, and recommends solutions to statutory and regulatory problems.
- ▶ **The Market Examination Section** performs examinations on insurers and producers to assure that they are in compliance with Alaska's insurance laws and regulations.
- ▶ **The Producer Licensing Section** oversees the licensing of all insurance producers who are required to be licensed with the division in order to conduct business in the state. As of 1997, there were more than 7,000 insurance producers licensed with the division.



Insurance is a mechanism to transfer risk from a person, business, or organization to an insurance company. Insurance policies cover events that may or may not occur and that could result in a financial loss.

The insurance company (insurer) pays on behalf of, or indemnifies,

the person, business, or organization (policyholder) for covered losses. By transferring risk to an insurance company, the policyholder exchanges the possibility of large unforeseen losses for small, predetermined premiums.

Insurance companies have discovered that although individual losses are hard to predict, the total losses of a large number of people are predictable. Insurance premiums are developed by estimating losses that are expected to happen in the future for a group of people. Companies pool your premiums with premiums from other policyholders to pay claims.



General Information

HOW IS INSURANCE SOLD?

The term producer is used to refer to the person who sells an insurance policy. There are several different kinds of producers, and not all insurance companies use the same types of producers to sell their products. Insurance companies generally use one of four methods to market their products: direct marketers, independent agents, exclusive agents or brokers.

- ▶ **Direct Marketers** sell insurance through the mail and by telephone. Insurance purchased from direct marketers may be less expensive because this method of selling insurance costs less to the insurance company and the insurance company may be able to pass some of the savings on to you.

- ▶ **Independent Agents** often represent many different insurance companies offering different types of insurance policies and premium rates. Since the companies are in competition with one another for business, cost differences may result.
- ▶ **Exclusive Agents** represent a single insurance company and provide premium estimates only for the policies offered by that company.
- ▶ **Brokers** represent the policyholder rather than the insurance company. The broker may work for a fee, which is negotiated with the consumer, work on a commission-only basis, or a combination of the two.

All producers must be licensed by the Division of Insurance. To verify that the company and producer you have selected are licensed to do business in the state, and have not had disciplinary action taken against their license, you may call the division.

TIPS ON BUYING INSURANCE

Before shopping for an insurance policy

- ▶ determine what type of insurance policy you need
- ▶ determine how much insurance you need
- ▶ determine what you are willing to pay or can afford to pay for the insurance
- ▶ determine how much insurance you already have
- ▶ consider what insurance may be available through other sources such as your employer, spouse, professional association membership, and credit card companies

- ▶ become familiar with insurance terminology

After you have considered the above, you may want to consider the following guidelines in shopping for an insurance policy.

SEEK OBJECTIVE INFORMATION

Information is available to you from a number of objective sources. These sources include public libraries, consumer groups, consumer publications, and the Division of Insurance. On page 20 of this guide is the section titled "Where to Go for More Information," which includes a list of companies for researching information which you may find helpful.

Check the yellow pages of your telephone book for insurance companies and producers in your area. You may also want to contact your relatives, friends, and coworkers for recommendations on insurance companies and producers. Ask them about the price of their insurance and the service they have received. Also, you may want to contact our Anchorage office at 269-7900 to find out if we have any complaints on record about your chosen insurance company.

COMPARE PREMIUMS FOR SIMILAR POLICIES

Companies may charge different premium rates for similar coverage, and the division suggests that you compare the prices of several insurance companies' policies before actually purchasing a policy.

You may want to consider the following when comparing premiums:

- ▶ Consult the Rating Examples booklets produced by the

Division of Insurance to help you find a policy. A comparison in 1996 of Alaska automobile premium rates documented that rates for nearly identical products can vary by more than 1000% depending on a driver's age, driving record, and other factors.

- ▶ Contact several insurance companies or producers and provide the same information to each producer or insurance company. Ask them to provide estimates of the premiums for the insurance coverage you are interested in purchasing. If a particular company provides a premium estimate for a similar policy that is much lower than the estimates provided by other companies, be wary. You may want to obtain additional information about the company before purchasing the coverage to assure that the company provides the level of service you want and is properly licensed by the Division of Insurance.
- ▶ Price should be only one consideration in purchasing insurance. It is also important to consider the quality and level of service, as well as the coverage provided in the policy. Some consumers may be happy to pay a little more to stay with a company that has provided good service.
- ▶ Many insurance companies let you pay on a monthly basis or have a payment plan that allows you to pay your premium over a period of time for a small service fee. In some cases, an entity called a **premium finance company** will lend you the money to pay the premium. If you finance the premiums, the total amount you pay for your coverage will be larger due to the interest charged on your loan.
- ▶ Factor any policy fees the insurance company may

charge for preparing and maintaining an insurance policy into the total cost of the policy. Producers must disclose any policy fee when you apply for coverage. However, once your coverage becomes effective, the policy fee is generally fully earned by the company. This means no portion of the policy fee will be refunded to you if the policy is canceled.

- ▶ Remember that premiums are only one component of the cost of permanent life insurance. Interest rates and methodology as well as mortality and expense charges are important components of the true cost of the policy.

COMPLETION OF THE APPLICATION FORM

- ▶ Fill out your application completely and honestly. Omissions or untruths may allow the insurance company to turn down a claim or, depending on the consumer's intent, may constitute a criminal act.
- ▶ Read the application before you sign it. If your producer helped you complete the application, be sure nothing was overlooked. Your signature on the application certifies that the information contained in your application is accurate and that you know of the contents.
- ▶ It is a good idea to keep proof of your payment for insurance premiums. Ask for a receipt and if mailing a payment, use check or money order. Never mail cash. Make sure that all receipts and checks show your policy number and the name of the insurance company providing coverage. All receipts should be signed and dated by the producer or insurance company representative

receiving the payment from you. As evidence of payment, keep all your receipts and canceled checks in a safe place for the duration of the policy.

INSURANCE BINDERS

In property/casualty insurance, some producers are given the authority to issue binders. A binder is a temporary contract of property/casualty insurance that remains in effect until the policy applied for is issued by the insurance company. Binders are not generally issued in life and health insurance.

AN INSURANCE POLICY IS A LEGAL CONTRACT

Your insurance policy is made up of two general parts. The first part of the policy (which is often the first page) is the declarations page. The declarations page lists your name and address, the name and address of the insurance company, and specific information about the policy you purchased showing what is being insured. It will list the liability or policy limits that were purchased, any deductibles, and each endorsement that is attached to the policy. The second part of the policy includes the actual contract language, which clearly describes both the insurance company's rights and responsibilities as well as the policyholder's. Certain general provisions are required by law, but policies can be very different. It is important to read any policy issued to you as soon as you receive it. If you have questions, contact your producer or the insurance company for clarification.

Some insurance companies allow a 10-45 day period in which to review the insurance policy and decide whether or not it is the

policy you need or want (often called a free-look period). If you are replacing your policy, don't cancel the old one until the new one is in effect.



UNFAIR DISCRIMINATION

Alaska law prohibits insurers from unfairly discriminating between policyholders. There is an important difference between unfair discrimination and fair discrimination. Insurers frequently divide policyholders into different classes for rating purposes or choose to issue insurance coverage only to certain types of individuals. It is important, however, that any discrimination is done fairly. Unfair discrimination is generally defined to mean treating applicants or policyholders with similar characteristics differently. For example, it is not unfair discrimination for an insurer to refuse to issue insurance coverage to all drivers with a history of driving while intoxicated. However, it is unfair discrimination for an insurer to issue policies to some drivers who have been convicted of driving while intoxicated and not to others with the same history.

CANCELLATION OR NONRENEWAL OF YOUR INSURANCE POLICY

Alaska laws forbid cancellation of your insurance policy except under certain circumstances. Insurance companies may not cancel or fail to renew a health insurance policy after it has been

issued, and may not cancel an automobile or homeowners insurance policy after it has been in effect for more than 60 days, except for:

- ▶ Nonpayment of premium
- ▶ Discovery of fraud or material misrepresentation made by you or your representative in obtaining your insurance, or by your pursuit of a fraudulent claim under your policy

Additional reasons an insurance company may cancel or fail to renew a personal auto or homeowners insurance policy are:

- ▶ Conviction of any member of your household of a crime or a grossly negligent act or omission which increases the risk insured against,
- ▶ Significant changes in your property or in its insuring characteristics which may result in your property becoming uninsurable,
- ▶ Suspension or revocation of your driver's license or that of a member of your household.

Note that your insurer may cancel your personal auto or homeowners insurance policy for any reason during the first 60 days.

PREMIUM REFUNDS

If the insurance company cancels your property/casualty policy, you may be entitled to a refund of all the premium you have paid that was intended to pay for coverage in the remainder of the policy period. If you cancel your property/casualty insurance policy, the insurance company may, by law, retain a cancellation fee of up to 7.5% of the amount that they would otherwise have to return to you. This cancellation fee (if any)

must be clearly disclosed in your insurance policy. If you have agreed to pay a minimum earned premium or a fully earned policy fee (which is shown on your application), your company will not refund these amounts to you.

APPRAISAL

Alaska law requires that disputes with your insurance company about the value of a property loss you suffer be settled using an appraisal process.

In an appraisal, you and your insurance company each select an appraiser to represent you. The two appraisers then select an impartial umpire. The two appraisers separately state the value they place on your loss. If the appraisers agree on the amount of your loss, the agreed upon amount will be binding on you and your insurance company. If the two appraisers fail to agree on the amount of your loss, then they are required to promptly submit their differences to the umpire. A decision agreed to by one of the appraisers and the umpire will be binding on you and your insurance company.

You and your insurance company each pay the expenses for your own appraiser. The umpire determines who is responsible for paying all other expenses.

The appraisal clause in your insurance policy provides a means to arbitrate the value of your damages. It does not address the question of whether or not the insurance company is responsible for paying the claim.

UNFAIR CLAIMS SETTLEMENT PRACTICES

Alaska law sets out a strict timetable for insurers to promptly settle claims. An insurer that fails to meet the requirements under the Unfair Claim Settlement Acts and Practices faces disciplinary action including the possibility of fines or revocation of the insurer's license to sell insurance in Alaska.

If you suffer a loss, immediately contact your local producer or company representative. The division recommends that you keep a record of your contact with your producer throughout the claims process. Make certain that you keep track of the specific information (whom you talked to, when, what was discussed, etc.). Follow your verbal claim notification up with written notice. Your insurer must acknowledge your claim notification within 10 working days.

Your company may acknowledge your claim by paying the claim, requesting additional information, or providing you information identifying the person responsible for handling your claim and information on how to contact that person.

Alaska law requires your insurance company to respond to your initial claim notification within 10 days and to each communication from you regarding your claim within 15 days of their receipt of your communication. Your insurer is expected to complete investigation of your claim within 30 working days. If the investigation cannot be completed within the time period (and the matter is not in litigation), your insurer must advise you in writing, explaining why, and the anticipated time to complete. Your insurer must update you every 45 days of any additional extensions required until the investigation of your claim is completed.

REBATING

The practice of rebating is prohibited in Alaska because it is considered unfair discrimination. Rebating occurs when an insurer or producer agrees to accept a lower commission or provide an applicant something of value in exchange for the applicant purchasing an insurance policy. Rebating is prohibited so that all policyholders are treated similarly, and none receive special benefits.

CIVIL RULE 82

Alaska is unique in that the legislature has provided by statute for an award of partial attorney's fees to a prevailing party in a lawsuit. This statute is implemented under Alaska Rules of Civil Procedures, Rule 82. The amount of attorney's fees awarded are set out in a schedule in the rule.

If you are sued and an injured third party obtains a judgment against you in an amount that exceeds the limit of liability of your policy, you may be responsible for paying part of the Alaska Civil Rule 82 attorney's fees and costs that are awarded by the court. The amount of Civil Rule 82 costs and fees you may be responsible for paying is calculated based upon the amount of the judgment in excess of the stated limit of liability in your policy. Simply put, your insurance company may not pay all Alaska Civil Rule 82 attorney's fees in a lawsuit filed against you.



Personal Auto Insurance

COVERAGES IN AN AUTO POLICY

Liability Coverage

Auto insurance policies purchased by the owner of a vehicle provide two forms of liability coverage: **bodily injury liability** and **property damage liability**. If you are responsible for an accident that injures other people, bodily injury liability insurance protects you against their claims for damages, such as medical expenses, lost wages, and pain and suffering.

Property damage liability pays for damage you are legally responsible for to the property of others, such as a dented fender, broken glass, or a damaged wall or fence. Both bodily injury and property damage liability insurance will pay if an accident is caused by a member of your family living with you unless the family member is specifically excluded from coverage through a **named driver exclusion**. Coverage is also provided for any person using your car with your permission. The insurance company will also cover you and any family member living with you when you are driving a vehicle owned by someone else.

Bodily injury and property damage liability insurance are sold with specific policy limits. Bodily injury liability coverage may be purchased with **multiple (or split) limit**, or with a single limit. Split limit policies pay a certain amount to each

person in an accident. The total amount paid out is subject to a maximum for each accident. If you purchase a policy with a bodily injury split limit of \$100,000 per person and \$300,000 per accident, and caused an accident resulting in injuries to one person of \$200,000, the policy would pay \$100,000 to that person. If four people suffered injury in a single accident, each with damages of \$100,000, the policy would only pay up to the maximum limit of \$300,000 for all damages. In this case a separate limit would apply for property damage.

A **single limit policy** pays one amount per accident, no matter how many people are injured or how much property is damaged. If you carried \$300,000 single limit coverage and injured one person, your policy would pay up to the \$300,000 limit of the policy for that one person.

Alaska law requires you to carry policy limits at least as high as the legal financial responsibility limits of \$50,000 for bodily injury to one person with a maximum of \$100,000 for bodily injury to two or more persons, and \$25,000 toward damages to others' property. This is commonly referred to as 50/100/25 limits. If you choose to increase the amount of coverage you carry, you will be charged an additional premium to pay for the increased risk of a higher claim that your insurance company assumes. The additional premium charged for this coverage is usually relatively low. With the high prices of today's medical and vehicle repair bills, many Alaskans recognize the wisdom of carrying higher liability limits.

Physical Damage Coverage

Physical Damage Coverage pays for damage to your vehicle, and is separated into **collision** and

comprehensive (sometimes referred to as other than collision) coverages. Both collision and comprehensive coverage are optional and are not required by Alaska law. However, if you finance your vehicle, the lender may require that both of these coverages be purchased.

Collision insurance pays for physical damage to your vehicle caused by your vehicle colliding with another object or overturning. In the event of an accident, collision coverage will pay to repair your vehicle up to an amount equal to the value of the vehicle before the accident. In an accident involving an older vehicle, the cost of repairs usually exceeds your vehicle's value. If repairs to your vehicle approach or exceed the value of your vehicle, your insurance company will declare your vehicle to be a total loss. In this case, the company will compensate you for the actual cash value of your vehicle before the accident. They are entitled to keep the damaged vehicle unless they have reduced the payment by the value of the salvage.

Comprehensive insurance pays for damage to your vehicle resulting from fire, severe weather, vandalism, broken glass, and theft. Comprehensive coverage will also pay if your car is damaged in a collision with a bird or animal.

If you finance a vehicle, the financial institution that issues the loan may require you to buy collision and comprehensive coverage. This is because the lender considers your vehicle to be collateral for the loan. The lender wants to make sure your vehicle is covered by insurance that will pay repair costs if you have an accident. The lender also wants a vehicle to repossess in the event you fail to meet your payments.

Uninsured/Underinsured Motorists Coverage (UM/UIM)

Uninsured and underinsured motorists coverage is sold together as a single package. UM/UIM insurance is sold in single or split limits similar to liability insurance.

Uninsured Motorists coverage pays for your injuries and damages to your car if you are legally entitled to recover damages from a hit-and-run driver or a driver who does not have auto insurance. **Under-insured Motorists** insurance provides coverage for you when another driver is legally liable for your damages and does not have enough insurance to cover your claim.

Alaska law does not require that you purchase uninsured motorists coverage, but your insurance company is required to offer you, in writing, a variety of policy limits. Regardless of your liability limits, you may purchase UM/UIM in amounts up to \$1,000,000/\$2,000,000 for bodily injury and \$25,000 for property damage. If you do not want this coverage or if you want less coverage than your liability limits, you must state this in writing. If you do not refuse uninsured motorist coverage in writing, it will automatically be added to your policy at the limits of your liability coverage. If you reject this coverage in writing, keep in mind your insurer does not have to offer it to you on any renewal policy unless you request it.

Other Coverages

In addition to the types of insurance coverage we have discussed, there are other additional coverages you may be interested in. Use caution when buying optional coverages.

Review the coverages you already have through other policies to avoid duplication.

► **Medical payments insurance** is an optional coverage that pays all reasonable hospital, medical, and funeral expenses for you or others injured or killed in an accident while riding in or driving your vehicle. Unlike UM/UIM, it pays without regard to fault. It will also cover you and your family if you are struck by a vehicle while walking or riding in another vehicle. The limits generally offered for this coverage are \$1,000, \$2,000, or \$5,000, although higher amounts are available. Alaska law does not require you to purchase medical payments insurance.

Even if you have a good health insurance policy for yourself and your family, you might want to consider purchasing medical payments coverage through your auto policy to cover nonfamily members who may be injured while in your car. Their medical bills can then be paid immediately by your insurer. Without this coverage, injured passengers may have to sue the responsible party to collect against the negligent driver that caused the accident.

► **Rental reimbursement coverage** usually pays a specified amount per day for you to rent a vehicle for a reasonable time while your vehicle is being repaired.

► **Towing and labor coverage** pays the cost to tow your vehicle to a repair shop. Sometimes the insurer will pay only for the cost to tow your vehicle to the nearest repair shop. Your policy will sometimes state a flat amount as the limit of coverage. If you belong to an auto club that provides this service in

the locations where you drive, you may not want to purchase duplicate protection in your auto policy.

► If you have ever rented a vehicle, you almost certainly have had a rental agent ask you whether or not you wanted **Collision Damage Waiver (CDW)** coverage. A CDW agreement essentially states that the car rental company will not collect repair costs from you if the car you rent is damaged.

All automobile insurance policies in Alaska are required by law to extend your collision and comprehensive coverages from your vehicle to a rental vehicle under a provision sometimes titled "nonowned vehicles" or "temporary or substitute vehicles." Some policies put restrictions on the amount of time a vehicle is rented for or the purpose of the rental, but usually they extend the collision and/or comprehensive coverages to a vehicle you rent for an out-of-town trip. If you do not carry physical damage coverages on your policy, then the law requires that your insurance company must at least offer you separate coverage to provide physical damage coverage to rented vehicles.

If you rely on your own coverage, the same deductible that applies to your vehicle in case of an accident will also apply to a vehicle you rent. You would have to submit a claim to your insurance company to approve repairs made to the rental vehicle. Some credit cards also provide CDW coverage. If you are uncertain as to whether your credit card offers this coverage, call your credit card company before you travel.

THINGS TO BE AWARE OF REGARDING AUTO INSURANCE

Deductibles

A deductible is the amount of money you pay as part of any loss you suffer. When shopping for collision and comprehensive coverage, you should consider your deductible. For example, if you carry collision coverage with a \$200 deductible and you suffer a \$500 covered loss, you would receive \$300 from your insurance company and you would be responsible for the remaining \$200 of the claim.

If you choose a higher deductible on your comprehensive or collision coverage, your premium will be lower. However, you will need to pay more in the event of a claim.

The Assigned Risk Plan

The assigned risk plan is an arrangement requiring all companies writing auto insurance to share the risk of insuring drivers who are unable to find an insurance company willing to write them. The assigned risk plan is administered by the Western Association of Insurance Plans (WAIP). For more information, call WAIP directly at their toll-free number: 1-800-227-4659 (inside Alaska).

Your Alaska assigned risk plan application will automatically be assigned to either State Farm or Allstate Insurance Company. Insurance purchased through the Assigned Risk Plan costs more than insurance purchased from most insurance companies. While you are in the assigned risk plan, you should keep trying to obtain insurance from an insurance company outside the plan.

Motor Vehicle Reports

For automobile and boat insurance, most insurance companies order a Motor Vehicle Report (MVR) from the Division of Motor Vehicles for all drivers listed on your insurance application. The MVR will be used to verify any traffic violations, license suspensions, or revocations. Many auto insurers require you to name all licensed drivers in your household even if you do not intend to allow them to drive your vehicle. Your company may contact your previous insurance carrier and/or commercial reporting agencies. These organizations might contact you, your family members, neighbors, or employer.

Named Driver Exclusions

Before a company decides to insure you, it must consider the driving records of all members of your household. If one family member has a poor driving record, it could affect the auto insurance premiums for the whole family. Effective July 1, 1997, Alaska law gives the named insured the right to specifically exclude a family member from coverage under the insurance policy. This is referred to as a named driver exclusion.

While it may be tempting to exclude a driver with a poor driving record from your insurance policy in order to reduce the premium (for example, if the driver is a student away at college for a large portion of the year), it is important that you be aware of the risks associated with the exclusion. Once a driver is specifically excluded from the insurance policy, any damages caused by that driver will not be covered by the insurance company. In the example above where a young driver is away at college, excluding the student from the parents'

insurance policy means that the student could not drive the parents' car while home on vacation without becoming an uninsured driver. Similarly, the student would run the risk of being uninsured while driving any other car, such as one belonging to a friend. If an excluded driver drives without insurance, they would not only be in violation of the law, they would be exposing themselves and the named insured to a large, uninsured, liability.

WHAT AFFECTS THE PRICE OF AUTO INSURANCE?

Classification

When determining the rate for an auto insurance policy, insurers separate drivers into categories called classifications. Drivers are classified based on a number of different characteristics, including but not limited to age, sex, driving record, type of vehicle, and annual miles driven. History has shown that drivers with certain characteristics, such as a poor driving record, have a greater chance of being involved in an accident, and the drivers in those classifications must pay higher rates. While some of the classification criteria (such as age and sex) are out of your control, others, such as driving record and type of vehicle driven, are within your control.

Insurers have the right to decide what types of drivers they wish to insure, as long as they apply their criteria consistently and fairly. The eligibility criteria an insurer uses to select the drivers it is willing to insure are referred to as underwriting criteria. Some insurers specialize in adult drivers with clean driving records, and will turn down an application from a teen-aged driver, or an adult who has had several serious violations. Other insurance companies specialize

in high-risk drivers and may accept individuals who have had several accidents or violations. The rates offered by the different insurance companies will vary, based at least partially on their choice of drivers to insure. If you are turned down by one insurance company, you should apply with another, since the two insurers may have different underwriting criteria. If you had a poor driving record in the past but it has improved over the last few years, it may be worth shopping around for another insurance company that has lower rates.

If you have trouble finding any insurer willing to sell you a policy, you should contact the assigned risk plan at the number given previously.

Discounts

Discounts are awarded because the insurance company sees certain types of drivers as "better risks." Before purchasing auto insurance, be aware of discounts you may qualify for that are offered by your company. Here are some discounts to look for:

- ▶ **Multiple Vehicles**—Most insurance companies offer a discount to customers who insure more than one vehicle with their company. Industry statistics show that individuals and families insuring more than one vehicle have better than average claims experience.
- ▶ **Driver Education Courses**—Discounts for driver education courses are targeted primarily at younger and older drivers. Individuals may be able to lower their auto insurance rates by voluntarily participating in a state-approved course.

Alaska law requires companies to give a discount to any primary driver who is over age 55 and who voluntarily completes a motor vehicle accident prevention course approved by the Division of Motor Vehicles. The discount must be applied for the three years following the successful completion of the course.

For further information on driver education programs, contact the Division of Motor Vehicles Driver Improvement Bureau at (907) 273-2223.

- ▶ **Good Student**—Many insurance companies have found that students who earn a B average or better tend to have fewer accidents. For this reason, many companies offer a good student discount.
- ▶ **Safety Devices**—Automobile safety devices can lower insurance costs by preventing accidents or limiting their severity. These savings are passed along to the policyholder through discounts for safety equipment such as air bags, automatic seat belts, and anti-lock brakes.
- ▶ **Anti-Theft Devices**—Devices or systems that deter theft or vandalism may also lower claim costs. Many companies offer discounts for anti-theft devices such as security alarms, combination door locks, etc.
- ▶ **Low Mileage**—Driving fewer miles lessen your chances of having an accident. Insurance companies recognize this and generally offer discounts to drivers who drive fewer miles.
- ▶ **Auto/Home Package**—Insurance companies may offer a discount if they insure both your vehicle and home.

AUTO INSURANCE CLAIMS

Be familiar with your automobile insurance policy before you need it. Read the policy thoroughly so you know what is covered, how much is covered, and what is excluded. Knowing in advance what to do in the event of an accident can help you avoid expensive mistakes.

Before You Have a Claim

- ▶ Carefully review your policy so you know how much liability coverage you have. This is the coverage that pays for damage you cause to other vehicles or injuries to other people.
- ▶ Know if you have collision and/or comprehensive coverage. Know what your deductible is.

There are several steps you should take after an accident to help you avoid expensive, time-consuming mistakes. Be aware that Alaska law requires you to report to the police any accident that results in death, injury, or damages of \$2,000 or more.

Filing a Claim

There are several steps to follow when filing a claim if your car is involved in an accident, damaged by fire, flood, vandalism, or stolen:

- ▶ Telephone your producer or company as soon as possible, even if you're away from home or if someone else caused the accident. Ask your producer what forms or documents will be needed to support your claim. Your company may require a proof of loss form, as well as documents relating to your claim, such as medical receipts, auto repair bills, and a copy of the police report.

- ▶ Supply any information your producer or company needs promptly. Cooperate with your insurance company in its investigation, settlement, or defense of any claim.
- ▶ Keep records of all your expenses. Emergency expenses you incur as the result of an automobile accident may be covered under your policy.
- ▶ Keep copies of all your paperwork. Store copies of all your accident-related paperwork with your other important papers.



Homeowner's Insurance

The largest single investment most people make is the home in which they live. Most homeowners insuring their residence purchase a policy called a homeowners policy. There are other policies available that generally are not as extensive in scope of coverage, but do provide some protection for the property. This section focuses on the homeowners policy. If you are not eligible for homeowners coverage, you may be eligible for another form of coverage such as a standard fire policy or a dwelling fire policy. For additional information on these coverages, contact the division or your producer.

Homeowners insurance is a package policy that combines property and liability coverages. If you own your home, you buy

homeowners insurance to protect your residence and your personal property. If you rent, you buy renters insurance to protect your furniture and other personal belongings. A very important reason to buy homeowners insurance is personal liability protection for accidents that injure other people or damage their property.

COVERAGES IN A HOMEOWNERS POLICY

Most homeowners policies cover your home, garage, fence, or other structures, and include some degree of personal property, medical payments, and personal liability coverage. Homeowners insurance policies are used for most single family homes and are slightly modified for apartments and condominiums.

Property

The property coverage on a homeowners policy applies when your home or belongings suffer damage as the result of a covered peril, such as fire, windstorm, lightning, and theft. Perils that are commonly excluded are flood, earthquake, war, nuclear attack, termites, rot, general wear and tear, and building code upgrades. However, coverage differs from insurer to insurer.

Homeowners insurance policies may provide limited coverage for small boats; however, most policies do not cover motor vehicles unless they are unlicensed and used only at your home. Appropriate coverage for your car, boat, snowmobile, or other recreational equipment can be obtained under different types of policies.

Personal property includes the contents of your home and other personal belongings owned by

you or family members who live with you. Some personal property, such as artwork, jewelry, antiques, computers, guns, money and silverware have limited coverage. Check your policy and consider whether the limits are sufficient to cover your valuable items if you suffer a loss. If not, you may purchase special insurance for these items with a Scheduled Personal Property Floater.

Most homeowners policies cover the home for its replacement cost. Because of that, most insurance companies will require that the amount of insurance you purchase is at least equal to 80% of the replacement cost of your home. If you insure your home for its actual cash value, payments for damage to your home may be adjusted for depreciation. If you insure your home for replacement cost, any damaged items will be replaced without an adjustment for depreciation.

Liability

The personal liability coverage in a homeowners policy protects you against a claim or lawsuit resulting from a bodily injury or property damage to others caused by your negligence and/or the negligence of any family member living with you. We urge you to review your policy to determine if the amount of personal liability coverage in your policy is sufficient. This liability coverage does not protect you from lawsuits arising from the use of your auto or your personal business.

Medical Payments

The medical payments coverage provided by your policy will pay the medical expenses for a person accidentally injured on your property no matter who is at fault. Unlike the medical payments coverage in a personal

auto insurance policy, homeowners medical payments coverage does not apply to you or family members who live with you, or to activities related to your home business. Medical payments coverage also covers accidents occurring on your property if caused by you, members of your family, or your pets. The limit of coverage included in a homeowners policy is generally quite low (usually \$1,000 per person), though higher limits are often available for an additional premium.

Additional Living Expenses

Most homeowners insurance policies provide living expenses if you cannot live in your home while it is being repaired or due to a government order to evacuate your home following a covered loss. Examples of the types of covered additional expenses are the costs of hotels (as limited by the policy), meals, and laundry facilities for a reasonable period of time.

Optional Coverages

► **Earthquake coverage** is almost always excluded from your homeowners policy. It is available with an additional deductible and additional premium from most insurers. Earthquake coverage comes with a deductible that is a percentage of the policy limit. Generally, the deductible is 10% of the property damage liability limit. If your property damage liability limit is \$100,000, the deductible would be \$10,000. Contact your producer about obtaining this coverage so that you are protected from the financial loss an earthquake often causes. Most of Alaska is subject to earthquake damage, and the division encourages you to consider

purchasing earthquake insurance to protect your home.

Many people don't think about buying earthquake coverage until there is a small, nearby earthquake. Insurance companies usually suspend sales following the initial occurrence of a small earthquake. Because earthquakes are difficult to predict, it is necessary to consider purchasing earthquake coverage before an earthquake occurs.

- Standard home insurance policies do not cover **flood damage** caused by rising water. Your lender will usually require flood insurance if your home is located in a flood plain. Depending on where your home is located, you may qualify for flood insurance through the Federal Flood Insurance Program. Contact the National Flood Insurance Program at (800) 638-6620 for more information.
- **Guaranteed Replacement Cost Coverage** is the most complete coverage for your home and generally says that in the event of a total loss, the insurer will replace your home regardless of the cost. Some policies limit the replacement cost to 120% of the policy limits. Generally, to obtain this type of coverage, you must meet specific underwriting standards. Your insurer can require you to increase the amount of your insurance on a monthly, quarterly, or yearly basis to keep up with the inflation rate. Ask your producer about this coverage, what exclusions or conditions apply and how much additional premium you will be required to pay.
- For an additional premium, many insurers offer you the option to insure your

belongings at **replacement cost**. Most standard homeowners insurance policies cover the contents of your home on an actual cash value basis. This means that, in the event an item was stolen or destroyed, the insurance company would pay an amount equal to what the property was worth immediately before it was destroyed (or stolen). This may be significantly less than what it would cost to replace the item.

The guaranteed replacement cost and replacement cost on contents endorsements are frequently confused since their names are similar. The important distinction is that the guaranteed replacement cost endorsement effectively raises your policy limits in the event that a total loss exceeds your policy limits. The replacement cost on contents endorsement increases the amount you will be repaid for each stolen or destroyed item.

- A **personal property floater** endorsement provides additional coverage for your furs, jewelry, stamps, coins, antiques, computers, guns, and other items that exceed the normal low limits in your homeowners policy. A personal property floater endorsement lists each item along with a description of the item insured and lists the excluded perils.
- To help maintain an adequate level of insurance, many insurance companies offer an **inflation guard endorsement**. This endorsement allows your insurer to increase your policy limit automatically based upon the insurance company's estimate of changes in building construction and repair costs. The insurance company may make adjustments either during the policy period or at the

policy's renewal. Premium charges are usually made for the changes in policy limits.

Even if you have an inflation guard endorsement, you should still check the limits of your coverage periodically to make certain you are adequately, but not excessively, insured.

TYPES OF HOMEOWNERS POLICIES

Homeowners insurance policies vary, depending on the number of different perils the dwelling, detached outbuildings, and contents are insured against. There are two approaches that can be used when writing a homeowners policy: a named perils basis, which insures against damage from a list of specific perils, and an all risks basis, which insures against damage from all perils except for those specifically excluded. The more perils your policy covers, the higher your premium will be. Some policies cover the dwelling and detached structures on a different basis than the contents. A policy sold on a named perils basis will cover the perils listed as basic coverage perils or broad coverage perils. These perils are listed below:

Basic Coverage Perils

Fire; Lightning; Windstorm; Hail; Explosion; Riot or Civil Commotion; Aircraft; Vehicles; Smoke; Vandalism; Theft; Volcanic Eruption; Falling Objects; Weight of Ice, Snow, or Sleet

Broad Coverage Perils

All of the Basic Coverage Perils, and Accidental Discharge of Water or Steam; Sudden or Accidental Tearing Apart, Cracking, Burning, or Bulging; Freezing; or Sudden or Accidental Damage from Artificially Generated Electrical Currents

Policies for Single Family Homes

The most commonly sold types of policies sold to owners of single family homes are described below. Note that not all insurers use the same terms to describe their forms of homeowners insurance, but the coverage provided will be similar.

- ▶ A basic policy (also referred to as an HO-1 policy) insures your dwelling, detached structures, and personal property against loss or damage caused by one of the basic perils listed above.
- ▶ A broad policy (also referred to as an HO-2 policy) insures your dwelling, detached structures, and personal property against loss or damage caused by one of the broad perils listed above.
- ▶ A special policy (also referred to as an HO-3 policy) insures your dwelling and detached structures against loss or damage from any peril except for the ones specifically listed in the policy as being excluded. This policy insures your personal property against loss or damage caused by one of the broad coverage perils listed previously. HO-3 policies are the most commonly sold type of homeowners policy in Alaska.
- ▶ A comprehensive policy (also referred to as an HO-3/ HO-15 policy) insures your dwelling, detached structures, and personal property against loss or damage from any peril except for the ones specifically listed in the policy as being excluded. This form of policy provides the broadest coverage available, but is not offered by all companies and is usually more expensive.
- ▶ A modified coverage policy (also referred to as an HO-8

policy) provides insurance for dwellings that are older or do not meet all the underwriting standards applicable to other forms of homeowners policies. It insures your dwelling, detached structures, and personal property against loss or damage caused by one of the basic perils listed previously. The coverage provided by an HO-8 policy is intended to restore a dwelling to a livable condition, not necessarily the same condition that it was in prior to the damage. An HO-8 policy may be suitable for homes that have suffered significant depreciation or have a replacement cost that is significantly higher than their market value.

Tenants' Policies

If you are renting an apartment or home, your landlord's property insurance policy does not cover your furniture or other personal property, nor will it protect you if you are sued. You will need to obtain insurance to cover your liability and personal possessions. The owner of the dwelling or building you rent is responsible for insuring the structure and obtaining liability coverage to cover the owner's acts of negligence.

A tenant's policy (also referred to as an HO-4 policy), insures your personal property against the broad perils listed above. Like all homeowners policies, tenant's policies also provide coverage for additional living expenses and include liability coverage.

Condominium Owner's Policies

Your condominium association should purchase an insurance policy that includes property damage coverage for the building and all common walls or

grounds, and coverage for liability associated with common properties. It is in your best interest to examine a copy of the association's policy.

A condominium owner's policy (also referred to as an HO-6 policy) insures your personal property; wall, floor and ceiling coverings; and any accessories not originally in the unit when it was purchased. The HO-6 policy will also provide coverage for additional living expenses in the event of a loss and includes liability coverage.

THINGS TO BE AWARE OF REGARDING HOMEOWNERS INSURANCE

How much insurance do you need?

When determining the amount of insurance to purchase, there are several different limits to consider. The policy limit that is generally selected first is the amount of insurance on your house. This amount should equal the cost of rebuilding your home in the event that it was destroyed, and may be less than the market value of your home, since the market value includes the value of the land. Your producer may be able to help you determine the amount of insurance that is appropriate for your home. If you have a mortgage on your home, the lender will probably require that you carry an amount of insurance that it at least as high as your mortgage.

The limits of insurance on other structures and on the contents of your home are generally expressed as a percentage of the limit on your house. You should check with your producer as to what those amounts are. If you have a particularly expensive detached garage or if you have a house full of antiques, you may want to raise the limits on the

other structures or contents coverages.

The other significant policy limit to consider is the liability limit. This limit should be high enough to protect you from lawsuits resulting from your negligence. If you carry an umbrella policy, that policy probably specifies minimum liability limits for your homeowners policy.

Flood and Earthquake Damage Not Covered

It is important to be aware that a standard homeowners policy does not provide coverage for damage due to floods or earthquakes. Insurance for these two perils may be purchased separately and as discussed earlier in this section.

WHAT AFFECTS THE PRICE OF HOMEOWNERS INSURANCE?

Classification

There are a number of things that affect the price of a homeowners insurance policy. These include:

- ▶ **The Type of Construction**—Frame houses usually cost more to insure than brick houses because they are subject to more extensive damage in the event of a fire. Earthquake insurance is much more expensive for brick homes than frame houses because brick houses are more susceptible to extensive damage from earthquakes.
- ▶ **The Age of Your Home**—Some insurance companies may not be willing to insure older homes or may offer limited coverage. Having a new home may qualify you for a discount on your insurance.

- ▶ **Available Fire Protection**—The quality of your fire department and your home's distance from a fire hydrant determine the fire protection class of your home and in turn affects the rate.
- ▶ **The Amount of Coverage**—The amount of coverage you decide to buy for your home, personal belongings, and personal property liability will affect the price of your insurance.

Discounts

Insurers often offer discounts on homeowners insurance. Some commonly found discounts are:

- ▶ **Dead Bolt Locks or Safety Alarms**—Insurers frequently offer a discount if you have dead bolt locks or fire and burglar alarms in your home.
- ▶ **Fire Resistant Material**—A home constructed of fire resistant material reduces the risk of a significant fire loss and may qualify you for a discount.
- ▶ **Multi-Policy**—If you buy your automobile, home, and umbrella insurance policies from the same company, you may be entitled to receive a larger discount. Check with your producer.
- ▶ **Senior Citizen**—If you are retired, you may qualify for a discount. Some insurance companies believe that retired persons are around the home more and can prevent potential losses.
- ▶ **Nonsmoker's**—Some insurance companies believe that there is more of a chance smokers will have a fire than nonsmokers, and offer nonsmokers a discount.

Deductibles

The higher your deductible, the lower the price of your insurance. Deductibles reduce your premiums because you agree to pay a part of each claim that your insurance company would otherwise have to pay. Insurance companies offer deductibles because deductibles reduce the number of small, covered claims that are costly for insurers to handle. Most insurers sell policies with \$250 deductibles, but the higher the deductible you choose, the lower your cost will be. For example, a policy you buy with a \$250 deductible will cost more than one you buy with a \$500 deductible. Determine how much you can reasonably afford to pay out of pocket if a loss occurs. Your deductible applies only to the coverage you have for your personal property (known as contents coverage) and your home. You are not required to pay a deductible for your liability coverage.

HOMEOWNERS CLAIMS

Be familiar with your homeowners insurance policy before you need it. Read the policy thoroughly so you know what is covered, how much is covered, and what is excluded.

Before You Have a Claim

Use a video recorder or camera to document your belongings in a room-by-room inventory, with all closet doors open. Visual proof of your belongings will verify the items were actually on your premises and ensures you won't forget anything in the event of a claim. Providing you with this kind of documentation will also help determine how much personal property insurance you need. If you can't make visual images of the inside and outside of your home, keep

a written inventory of the contents, including the date purchased, where it was purchased, the cost, and a receipt. Obtain appraisals of your special valuables such as antiques, jewelry, stamp, coin, and other collections. You may want additional coverage if the value of these items exceeds the limited coverage in your policy. You may want to maintain this information on a computer disk that can be easily updated. Store your records in a safe deposit box, at a relative or friend's home, or at your office.

Contact your producer for a home inventory form to complete or request one from the Insurance Information Institute at the address on page 20.

After a Loss

As soon as possible after the loss, you need to notify your producer or insurance company. Follow up any conversation in writing. Losses that involve theft, or which cause you to suspect arson, should also be reported to the police. If your home is damaged and it is safe to do so, make temporary repairs to protect the house and your belongings from further damage. For example, if the windows are broken due to a burglary, you should cover them with plywood or other material to protect your home from weather damage and further vandalism. Expenses for temporary repairs are covered under your policy; be sure to save receipts or bills.

It is important that the repairs be temporary and not permanent. If you make permanent repairs before the insurance company inspects the damage, your claim may be denied. In addition, you should preserve all evidence of the loss, including the damaged property, so that it can be inspected by your insur-

ance company. If you have any doubts about whether the repairs will be considered permanent, check with your insurance company before work begins.

Soon after you report your loss to the insurance company, an adjuster will be sent to inspect your property. Insist on being present during the inspection, so that you can assure that the adjuster does not fail to notice any damage. During the inspection, the adjuster will assess the damage to your home and estimate the costs of repairs. The adjuster will also determine whether the damage is covered under the terms of your policy. You may want to bring your own contractor to inspect the loss and act as your representative during the inspection.

Replacement cost payments for small building damage claims will be made whether or not actual repair or replacement is complete. For large losses, insurance companies will only pay the difference between actual cash value and replacement cost when the property has actually been repaired or replaced.

If, at the time of loss, the amount of insurance purchased does not equal the specified percentage, usually 80%, of the full replacement cost of the building before the loss, the insurance company will pay less than the replacement cost. The amount the insurance company will pay is the greater of the actual cash value or the replacement cost less a penalty specified in the policy. The policy will never pay more than the stated policy limits.

Complete a Proof of Loss Statement. In some instances, your insurer will request a signed, sworn statement called a Proof of Loss. Your company will provide you with a standardized

form to use. You must file a Proof of Loss if the company requests you to as it is the basis for determining the value of your claim.

In most cases, you will be asked to estimate the actual cash value of the household items you have lost and the cost to repair your home. You must provide the company with evidence if you have purchased a replacement item. Contractors, catalogs, and local stores are good sources of current cost information. Be sure to find out from your insurer if you should include sales tax in your cost estimates, and whether you should use exact costs or round numbers to the nearest dollar. Don't forget to include small items such as kitchen utensils or clothing accessories, as the replacement cost of these items can add up.

Negotiate the Final Settlement. After the adjuster has reviewed the damage to your property, the adjuster will prepare or obtain an estimate of the cost to repair or replace your home and personal belongings. If you disagree with the adjuster's estimate, explain your reasoning to your company. It's possible your company has overlooked something and is willing to make adjustments. If you continue to disagree with the company's valuation of your loss, you are entitled to resolution of your dispute through a process called appraisal. See page 4 for an explanation of the appraisal process.



Personal Umbrella Insurance

WHAT IS COVERED?

Although homeowners policies provide liability coverage for injuries or property damage for which you are legally liable, this coverage is limited. You can buy additional liability protection through a separate umbrella policy. Umbrella policies provide higher insurance limits (frequently of \$1 million and higher) as well as expanded protection for a variety of losses. The coverage on an umbrella policy becomes effective if you are sued for an amount greater than the limits of your auto or homeowners policy. Umbrella policies are surprisingly inexpensive. For \$1 million of coverage, you may pay as little as \$150.

In addition to protection for bodily injury and property damage claims against you or a family member, coverage may be provided if you are sued for false arrest, wrongful eviction, libel, slander, etc. Policy provisions vary so be certain you receive a full explanation of coverage. The cost of personal umbrella insurance is relatively low.

THINGS TO BE AWARE OF REGARDING UMBRELLA INSURANCE POLICIES

Umbrella policies generally carry requirements that you purchase specific policy limits on your auto and/or homeowners policies. Be sure to check with your producer to verify that you have purchased adequate underlying limits.



Life Insurance

The primary purpose of life insurance is to provide financial security for your family. Life insurance provides cash that can help to ensure that, when you die, your family will have the financial resources necessary to protect their home, assets, and to provide additional income.

In choosing a life insurance policy, the division recommends that you consider the following:

- ▶ the type of insurance product that best suits your needs
- ▶ the length of time you need insurance
- ▶ how much insurance you need, considering current and future debt, income, and expense requirements such as burial, hospital, taxes, college tuition, and any others
- ▶ what you can afford to pay

After you have purchased a life insurance policy, the division recommends that you

- ▶ periodically review your policies and the selection of your beneficiaries, keeping in mind that your financial situation and family needs change
- ▶ be aware that revising your will does not revise your life insurance policy and death benefits will be distributed according to the provisions in your insurance policy and not according to the provisions in your will

- ▶ request any change of beneficiary in writing and keep a copy of the request until the requested change has been made

TYPES OF LIFE INSURANCE POLICIES

Described below are some of the most common types of life insurance policies. It is important to keep in mind that the life insurance policies offered by an insurer frequently change. Policy terms can vary significantly from one insurer to the next.

Term Life

Term life insurance pays a predetermined death benefit if the insured dies during the period of time the policy is in effect. The term can range from a single year to a period ending at a specific age, such as 65 or 70. If the insured does not die during the term of the policy, the policy expires with no payment. The amount of death benefit can be a level, decreasing or increasing amount to match your insurance needs. For example, a decreasing term policy may provide a death benefit that matches the decrease in your mortgage loan balance.

Term life insurance is generally less expensive than other forms of life insurance, since a benefit is provided only upon death and only for a limited period of time. Also, unlike many other life insurance policies, no penalties are assessed if you decide to terminate the policy before the end of the term. Since term life policies provide no accumulation of cash values or dividends, they can generally be compared to one another on the basis of their premium.

Term insurance allows a higher death benefit to be purchased for less money than other types

of life insurance policies. This may be particularly important for young families with limited income and a higher need for insurance. Term insurance is also useful for protecting the family members in the event of the death of a wage earner during periods of high debt, such as during the terms of a mortgage or car loan.

You may want to consider the following when shopping for a term life insurance policy:

- ▶ Most shorter term policies offer an option to continue or renew the policy for an additional period of time. One advantage of this option is that the insured does not have to show evidence of insurability in order to maintain the policy for additional periods of time. The premium charged each renewal will be based on the insured's age at the time of the renewal.
- ▶ Most term policies also offer an option to exchange or convert the term policy for a cash value or whole life insurance policy without providing evidence of insurability. This option provides flexibility to those who may have preferred a policy with cash value accumulation, but could not afford it at the time of purchase. This option becomes valuable if an insured develops a medical condition during the policy term which renders them uninsurable or insurable but only at a higher premium rate.
- ▶ Credit life insurance is a type of term insurance that pays the balance due on a loan or debt if you die. In Alaska, the death benefit on a credit life insurance policy is required to match the remaining balance of the loan. Credit insurance is usually sold through a bank, store, or auto dealer at the time of a loan transaction.

If you purchase credit life insurance and decide to pay off your debt early, the insurer is required to give you a refund of unearned premium. Note that a standard term life policy can be used for the same purpose as a credit life policy, but often at a much lower cost.

Permanent Life

Permanent life insurance provides insurance protection for the entire life of the insured, unlike term policies that expire after a predetermined period of time. As long as you make the premium payments, the policy will pay a death benefit. Most permanent life insurance policies build cash value which can

- ▶ provide a lump sum of money, if you cancel your policy
- ▶ pay premiums, if you need to stop paying premiums on the policy
- ▶ be used as collateral for a loan from the insurance company.

Cash values develop from the premiums that you pay for the insurance policy. The premiums you pay are generally higher than the amount needed to cover the risk of your death and the insurance company's expenses for acquiring and maintaining your policy. The amount of this excess premium is accumulated with interest. Generally interest earnings are based on your insurance company's investment experience. Most policies will have little or no cash value in the first few years due to the large expenses involved in acquiring and setting up your policy.

Permanent life insurance policies are intended to be kept for a long period of time. Premiums for

permanent life insurance policies are higher than term insurance policies in the early years of the policy. Therefore, if you do not intend to keep the policy for a long period (at least 15 years), term insurance may be a better choice.

Permanent life insurance takes on many different forms with a variety of features. Following is a brief description of the most common forms.

► **Whole life insurance policies** have fixed level premiums and level death benefits for the life of the insured. This type of policy generally provides no flexibility for adjusting the premiums or the amount of death benefit. If premiums are not paid, the policy terminates. Cash values are predetermined and will not vary over the life of the policy based on the insurance company's experience. Whole life is often referred to as ordinary life or straight life.

► **Participating whole life insurance policies** have the fixed level premiums, level death benefit and predetermined cash values of a whole life policy. However, participating whole life provides a return of some portion of the premium, called a dividend, if the insurance company's investment, mortality or expense experience is better than expected. These dividends provide flexibility to the policy, since they can be used for a number of purposes. Dividends could be used to purchase additional insurance, pay premiums, or just accumulate with interest. Note that there is no guarantee that you will actually receive a dividend.

► **Variable life insurance policies** have a fixed level premium with a death benefit that varies based on the experience of a selected set of

investments. You may specify which investments your cash value is to be invested in. Most insurance companies offer several investment options including money market funds, common stock funds, and bond funds. A higher rate of return on the selected fund will cause the cash value and death benefit to increase, while a low or negative rate will cause the cash value and death benefit to decrease. These policies provide a guaranteed minimum death benefit, but no guarantee of cash value. Therefore, variable life is more risky than other permanent life insurance policies because it is an investment-type product. Variable life policies are subject to federal securities laws.

► **Universal life or flexible premium life insurance policies** allow you to pay premiums at any time, in any amount, subject to certain maximums and minimums. These policies also allow you to adjust the death benefit. With a universal life policy you will be able to actually see the interaction of premiums, death benefit, interest credits, mortality charges, expenses, and cash values. A presentation will generally be given to you at the time you purchase the policy and at least annually showing how the cash values and death benefits develop. In general, a universal life policy will develop cash values as follows:

The limits specified by your insurance policy:

Deductible	\$ 500
Coinsurance	80%
Out-of-pocket maximum	\$1,000

Amount Insurer Owes:

Charges billed by provider	\$4,200
Amount greater than the UCR for the procedure	-\$ 550
Amount you owe for your deductible	-\$ 500
Charges eligible for reimbursement by insurer	\$3,150
Insurer's coinsurance	80%
Amount insurer owes before out-of-pocket limit applied	\$2,520
Amount that is greater than your out-of-pocket limit	\$ 130
Total amount insurer owes after out-of-pocket limit applied	\$2,650

Amount You Owe:

Deductible	\$ 500
Coinsurance amount (20% of \$3,150)	\$ 630
Amount of eligible charges before out-of-pocket limit applied	\$1,130
Amount greater than your out-of-pocket limit	-\$ 130
Amount of eligible charges after out-of-pocket limit applied	\$1,000
Amount greater than the UCR for the procedure	\$ 550
Total amount you owe	\$1,550

Cash value = cash value from prior period + premiums paid - expense charges - mortality charges + interest

In a universal life policy, the insurance company generally guarantees that it will not charge you more than the stated maximum mortality charges. Most insurance companies charge less than the stated maximum mortality charges. Universal life policies provide a guarantee that not less than a stated minimum interest rate will be credited. These rates are low and insurance companies generally credit a higher rate based on their investment experience or sometimes based on the performance of a stock market index such as the S&P 500. It is important to remember that in most cases the higher interest rate is not guaranteed to be credited in the future.

As long as the cash value is large enough to cover the mortality charges and expenses, no premium payment is required. However, you may still make premium payments which will be added to the cash value. Federal law includes some restrictions on how high your cash value may be in relation to the death benefit before your policy will become subject to certain federal taxes. Your insurance company will generally verify that your cash value is within the federal standards and if it is not they will adjust the death benefit automatically.

Under a universal life policy you are able to choose between two primary death benefit options. One option is a level death benefit and the other is a death benefit that increases with the increase in cash value. Regardless of the death benefit chosen, you will be allowed to adjust the death benefit at a later date. If you decide you want to increase the death benefit at a later date, you will likely be required to provide evidence of insurability.

If you decide to cancel (referred to as surrendering) your univer-

sal life insurance policy, your cash value may be reduced by surrender charges. Surrender charges are specified in the insurance policy and will vary significantly from one policy to the next depending on what expense charges were already assessed on your policy. Surrender charges help the insurance company offset some of the expenses of acquiring and maintaining your policy. You will generally pay for the flexibility provided by universal life policies. In order to assess the actual cost of these policies, the expense charges including surrender charges, mortality charges, and interest crediting rates should be reviewed. One of the most important considerations will be what the insurance company's historical experience has been. Do not just compare the interest crediting rates since mortality and expense charges can easily offset any additional interest credits.

► Universal Variable Life is a variable life policy but with the flexible premium structure of a universal life policy. Unlike a universal life policy that provides a guaranteed death benefit if premiums are paid, a universal variable life insurance policy pays a death benefit that varies with the experience on the selected fund. Universal variable life may be appropriate, if you are looking for a life insurance policy that treats cash values more as an investment than a savings account.

THINGS TO BE AWARE OF REGARDING LIFE INSURANCE POLICIES

Important Policy Provisions

► Most permanent life insurance policies provide that the insurance company will give you a loan of a portion of the cash value. The insurance

company will charge interest on the loan as specified in your policy. If you borrow from the insurance company and the amount exceeds the cash value over time due to interest, your life insurance policy will terminate within a specified number of days unless a payment is made. Any remaining portion of the loan unpaid at death will be deducted from the death benefit.

► Life insurance benefits can be paid in various ways called . Some of the options generally available include: a cash or lump sum payment; interest only option where the insurance company keeps the benefits and provides payment of the interest; fixed period option where benefits are paid out over a predetermined number of months or years; fixed amount option where the death benefit or cash value is paid out in a specified amount each period; life income option where the benefits are paid for the life of the beneficiary. Combinations of these options are also available.

► Cash values provided upon termination of your policy can be generally paid out in cash; as reduced paid up insurance where the cash value is used to purchase a permanent life insurance policy that is paid up (i.e., no premium payments are required); or as extended term insurance where the cash value is used to purchase a term insurance policy.

► A grace period is defined as the additional number of days beyond the due date of the policy when you can pay the premium without interest or fear that the policy will terminate (lapse). If your policy has enough cash value

and you have elected on the application to have an **Automatic Premium Loan**, then any available cash value will automatically pay for the premium. An automatic premium loan can prevent the policy from lapsing.

In the event you die during the grace period, the death benefit will be reduced by the amount of premium due.

- ▶ All life insurance policies contain an **incontestability clause**. This clause will not allow an insurance company to deny a death benefit or terminate a life insurance contract after a specified period of time, usually two years. This clause has the effect of requiring the company to thoroughly investigate the information provided in an application during the first two years.
- ▶ Most insurance policies contain a **suicide clause**. This clause allows the insurance company to refuse payment of a death claim if the insured commits suicide within the first two years of the policy. The insurance company must return premiums paid on the policy.
- ▶ In most cases, cash value and policy loan requests are granted quickly. However, all life insurance policies contain a **delay clause** that allows the insurance company the right to wait up to six months before providing a cash value or policy loan.

Multiple Life Policies Vs. Single Life Policies

- ▶ Multiple life policies insure the lives of more than one person on a single policy. There are two types of multiple life policies. A joint life policy pays a death

benefit when the first person dies. Since joint life policies are less expensive than purchasing two individual policies, they are commonly purchased by a husband and wife who are each other's beneficiary. A second-or-later-to-die policy pays a death benefit when the last person insured under the policy dies. Second-or-later-to-die policies are often purchased by married couples who want to protect their assets from federal estate taxes.

- ▶ Single life policies insure the life of only one person and pay a death benefit when that person dies.

Group Vs. Individual Policies

Life insurance is sold on both an individual and group basis.

- ▶ **Individual policies** provide coverage to a specific individual under a policy issued solely to that individual. In order to be considered for individual insurance coverage, you will be asked several medical questions and may be required to undergo a medical examination. The insurer will use the results to determine whether to sell you the policy. This is called medical underwriting.
- ▶ **Group policies** provide coverage to individuals under a single master policy issued to the group policy owner. The policy owner may be an employer, an association, a labor union, or other entity. Unless the group is small, generally ten employees or members or fewer, no individual medical underwriting is performed. Instead, insurers require employee or member minimum participation levels and minimum employer

contribution levels in order to assure that there are sufficient individuals in the group in good health to balance those in the group in poor health. One drawback to group life insurance is that it will often terminate when you leave the group unless there is a conversion option to an individual policy.

Replacement

Your insurance producer may suggest that you replace an existing life insurance policy with a new one. The suggestion to replace a policy may be made because your life insurance needs have changed, a new policy has some additional features that would be useful for you, or for another reason. Before you agree to replace a policy, you should understand the advantages and disadvantages of replacing your current policy.

Replacing a current policy may mean giving up certain valuable benefits and rights that may not be available on a new policy or may not be available for a number of years. Review your life insurance policy incontestability period. Before purchasing, compare your current policy with the new policy and consider the guaranteed benefits, cash values, and your rights under both policies.

Riders

A rider is a written agreement that attaches to a policy to add, subtract, or modify insurance coverage. A rider takes precedence over the original provisions in the policy.

- ▶ An **accelerated death benefit rider** is often available at no extra charge, and will allow you to take all or a portion of the death benefit early if you become terminally ill or have

a specific disease. Some of these riders also provide you with a monthly payment if you require long-term care due to a medical condition as defined in your policy. The death benefit and cash value of your policy will be reduced by the amount you have received plus incurred interest on the paid out amount. It is important to consider that the amount of death benefit taken early will likely be considered income. This means that the benefit will be subject to federal taxes and will also be included in any income calculation for purposes of determining eligibility for government programs such as Medicaid.

- ▶ A **waiver of premium rider** will pay your life insurance premiums if you become totally and permanently disabled according to the disability definition in your policy. The insurance policy continues just as if you were paying the premiums. This rider can generally be purchased for a small extra premium.
- ▶ An **accidental death benefit rider** doubles or even triples the death benefit if you die from an accident. This rider can be purchased for a small extra premium. The division recommends that before purchasing this rider you carefully consider that the amount of coverage you need does not depend on cause of death.
- ▶ A **guaranteed insurability option** allows you to purchase additional amounts of death benefit at stated periods of time without providing evidence of insurability. This rider may be of value to those with a family history of significant medical problems who currently have limited

income and cannot afford a larger death benefit.

- ▶ A **family rider** allows you to provide term insurance on all or certain members of your family under your policy.

Taxes

The division recommends that you consult with your tax advisor regarding the taxability of life insurance benefits. However, the following are some tax rules that generally apply to life insurance policies that meet the federal definition of life insurance:

- ▶ Death benefits are not subject to federal income taxes
- ▶ Dividends are considered a return of excess premium and are therefore not taxable. If dividends are left with the insurance company to accumulate interest, the interest is taxable.
- ▶ Interest credited on life insurance cash values is not included in current taxable income
- ▶ Cash value payments that exceed the sum of premiums paid, less any dividends paid, are subject to federal income taxes

LIFE INSURANCE CLAIMS

When you purchase an individual policy, your producer will be able to assist your beneficiary in filing a claim. Your producer should have a supply of claim forms and can help your beneficiaries fill in the forms and meet any necessary **proof of loss** requirements. If your beneficiaries do not know who your insurance producer was at the time the policy was purchased, then they may want to contact another producer who is licensed with the insurance com-

pany or call the insurance company directly. Most insurance companies have consumer service representatives that would be able to assist them.

Your beneficiaries will receive a settlement from your insurer upon receipt of **due proof** of your death and upon surrender of the policy. What constitutes due proof may differ from company to company. However, a death certificate from the Office of Vital Statistics, a Coroner's Report, an attending physician's statement or a hospital certificate of death is sufficient for most death claims.



Annuities

An annuity is a contract that guarantees to provide you with periodic income payments for your lifetime, for a fixed period of time, or both. Annuities may be purchased with a single lump sum of money, with fixed periodic premium payments, or with premium payments made at your discretion. Periodic income payments may begin almost immediately (called an immediate annuity) or may be deferred until a specified time (called a deferred annuity). The person who receives income payments under an annuity is called the annuitant.

TYPES OF ANNUITIES

Immediate Annuities

Immediate annuities are purchased with a single lump sum of money (premium). Income payments begin within one payment interval from the date

the premium was paid. For example, if you are to receive annual payments under the annuity contract, you will receive your first periodic income payment one year after paying the premium. The following are common types of immediate annuities:

- ▶ **Joint and last-survivor annuities** provide periodic income payments for as long as any of the people insured under the contract are alive. These annuities are commonly used in husband and wife relationships.
- ▶ **Life income annuities** are also called straight life annuities and provide periodic income payments for as long as the annuitant lives and terminate on the annuitant's death. This type of annuity provides the largest payment of all the immediate annuities, because no matter how few income payments have been made when the annuitant dies, no refund of the premium is made.
- ▶ **Installment refund annuities** provide a periodic income payment for as long as the annuitant lives and then continue payments to the annuitant's beneficiary after the annuitant's death until the total of all income payments made equals the premium.
- ▶ **Cash refund annuities** provide a periodic income payment for as long as the annuitant lives. Upon the death of the annuitant, they provide a lump sum payment to the beneficiary equal to the difference between the premium and the total of all income payments made prior to the annuitant's death.
- ▶ **Certain and life annuities** provide a periodic income payment for as long as the annuitant lives or for a

specified (certain) period of time, whichever is longer. The certain periods are usually 5, 10, 15, or 20 years. The longer the certain period, the lower the periodic income payments.

Deferred Annuities

Deferred annuities may be purchased with a single premium or with periodic or flexible premiums. Periodic income payments begin at a specified date, often age 65. The period between the purchase date and the date the income payments begin is called the **deferral period** or **accumulation period**. During this period the insurance company treats your premium payments much like deposits to a savings account. Premium payments are reduced for expenses and any withdrawals you may make and are credited at an interest rate declared by the insurance company. The balance in the account is called the **account value**. At the end of the accumulation period, the insurance company purchases an immediate annuity using the account value less any expense charges. A deferred annuity contract provides a guarantee that a minimum income payment per dollar of account value will be paid.

THINGS TO BE AWARE OF REGARDING ANNUITIES

Interest Rates

The interest rate credited during the accumulation period of a deferred annuity is subject to a stated minimum as required by state law, usually 3% per year. Insurance companies determine the actual rate of interest to be credited on a periodic basis. The method of determining this crediting rate varies among different annuity contracts and insurance companies but is generally based on the

company's investment experience and competition. More recently, insurance companies have begun to sell annuity contracts that determine the crediting rate by relating it to the return on a stock index such as the S&P 500. It is important to remember that current crediting rates are generally guaranteed only for a short period of time, often one year.

Surrenders and Withdrawals

- ▶ Upon death or cancellation (surrender) of a deferred annuity, the insurance company is required to provide you with the cash value remaining in the annuity contract. The cash value is generally the account value less the surrender charge, which is an expense charge for surrendering the contract. Surrender charges are often waived if the policy is terminated due to the death of the annuitant. Surrender charges are usually a percentage of the account value and decrease with time. State law establishes minimum cash values. Immediate annuities do not develop cash values.
- ▶ Most deferred annuity contracts allow you to withdraw a portion, usually 10%, of the account value without a surrender charge. This is called a **free partial withdrawal**. The amount that is withdrawn is deducted from the account value.
- ▶ Many single premium deferred annuity contracts have **bailout provisions**. This is a provision that allows you to withdraw the account value without a surrender charge, if the interest rate credited falls below a set rate.

Market Value Adjusted Annuities

Market value adjusted annuities guarantee a crediting rate over a specified period above the state minimum guaranteed rate, but if you decide to surrender the annuity, the account value is subject to both surrender charges and an adjustment based on current interest rates. This adjustment is intended to protect the insurance company from the tendency of annuitants to surrender during periods of increasing interest rates.

Variable Annuities

Unlike the annuities described above, a variable annuity contract does not guarantee a minimum interest crediting rate, nor does it guarantee the amount of income payments per dollar of cash value. A variable annuity generally offers you the option to invest your premium payments in many different investment funds such as money market funds, common stock funds, bond funds, and others. During the accumulation period of the variable annuity, premium payments less expense charges are used to purchase units in a selected fund. The number of units purchased depends on the value of a unit in that fund, much like purchasing shares in a mutual fund. Cash values and income payments then depend on the number of units purchased and the value of each unit at the time the payments are made. Variable annuities are more appropriate for people looking for an investment product without the long-term guarantees provided by other annuity products.

Taxes

Annuity contracts contain an important tax benefit. Federal income taxes on interest earnings that accumulate during the

deferral period are deferred until the annuity is paid out. This can result in a significant saving over a long period of time relative to other methods of saving. If a deferred annuity is surrendered before age 59 1/2, the amount of the cash value that is larger than the total premiums paid is subject to a 10% federal tax penalty in addition to the required income taxes. The tax penalty generally does not apply if the annuity is surrendered due to death or disability, nor to equal periodic payments made over the lifetime of the annuitant. Consult a tax advisor before you purchase or surrender an annuity in order to thoroughly understand the tax consequences.



Health Insurance

Everyone runs the risk of becoming ill or suffering an accident that results in doctor or hospital bills, and sometimes in loss of income. Most Alaskans need protection from unexpected and sometimes devastating expenses associated with an illness or accident.

How do you choose from the hundreds of medical plans available? To wisely purchase medical care protection you must:

- ▶ Determine your family's needs
- ▶ Know the different types of protection available
- ▶ Choose a plan on the basis of coverage, costs, and services

Before buying a health insurance policy, know what insurance or other benefits you already have. This will help prevent duplicating coverage and will help you determine if you have enough coverage, inadequate coverage, or no coverage at all. Make sure you have up-to-date information on medical insurance, disability benefits, and sick leave benefits provided by your employer. Your first priority should be assuring that you have either a comprehensive major medical insurance policy or both basic medical insurance and supplemental major medical insurance.

HOW HEALTH INSURANCE POLICIES ARE SOLD

Individual Insurance

An individual insurance policy provides coverage to a specific individual or to an individual and their family under a policy issued to that individual. In order to be considered for individual insurance coverage, you will be asked to provide evidence of insurability that may require you to undergo a medical examination. This is called medical underwriting. The same requirements would apply to any dependents you may insure under the policy.

Group Insurance

A group insurance policy provides coverage to individuals under a single master policy issued to the group policy owner. Certificates of insurance are provided to the individuals. The policy owner may be an employer, an association, a labor union, or other entity. Unless the group is small, no individual medical underwriting is performed. Instead, insurers require minimum employee or member participation levels and minimum employer contribution

levels in order to assure that there are sufficient individuals in the group in good health to balance those in the group in poor health.

CONSIDERATIONS IN PURCHASING HEALTH INSURANCE

Whether you have individual or group health insurance coverage, it is important to understand what your coverage is and what charges you may be responsible for paying. Read your policy or certificate thoroughly and consider the following:

- ▶ What services and supplies are covered?
- ▶ What limits are set on the benefits for these services and supplies?
- ▶ What are the deductible, coinsurance and other charges you will be responsible for paying?
- ▶ How are benefit payments coordinated with other health coverage you may have?
- ▶ What are the managed care features and requirements of the plan?
- ▶ What level, type, and quality of service can be expected from the insurer?

TYPES OF HEALTH INSURANCE PLANS

Following is a summary of several types of health insurance plans sold as group and individual health insurance. The actual health insurance benefits will vary from policy to policy. Therefore, it is important to read and understand your insurance contract. The term **provider** is commonly used in health insurance and in this guide to refer to

physicians and other providers of medical care.

Basic Medical

A basic medical insurance policy provides coverage for basic hospital, provider and other services. There are limits placed on the benefits for covered services such as a limited number of hospital days, a maximum payment for each day of hospital confinement, or a surgical schedule where a specific payment maximum is established for each procedure. These benefits are provided without deductibles or coinsurance.

Supplemental Major Medical

Under a supplemental major medical policy, benefits are structured to supplement a basic medical insurance policy. The policy would pay for any covered services and supplies not covered by the basic medical insurance policy after the required deductible has been paid and subject to the coinsurance requirements. A basic medical policy in combination with a supplemental major medical policy results in coverage similar to a comprehensive major medical policy.

Comprehensive Major Medical

A comprehensive major medical policy provides coverage for almost all types of medical care services and supplies and has high benefit limits. These policies cover hospital, provider, and other services subject only to the required deductible, coinsurance, and benefit maximums. Unlike basic medical, individuals are required to share in the cost of their medical expenses. These policies have replaced most of the basic medical insurance policies.

Limited Benefit

Limited benefit plans are offered as independent, noncoordinated benefits provided under a separate policy and paid without regard to any other insurance plan. Examples of these types of plans include **hospital indemnity policies** that pay a fixed amount for each day of hospital confinement, and **specified or dread disease policies** that only pay for medical expenses associated with a specified disease (such as cancer or heart disease).

Long-Term Care

Long-term care insurance policies provide nursing home or home health care benefits for individuals with a prolonged physical illness, disability or mental disorder, medical condition, or a deficiency affecting activities of daily living or lifestyle. Benefits are provided as a reimbursement for services, but subject to a fixed dollar maximum per day. Usually a waiting period called an **elimination period** of 0, 30, 90, 180, or 360 days is required before the plan will pay benefits. Long-term care insurance may be available as a rider to a life insurance or annuity policy, as well as a separate health insurance policy.

Medicare Supplement

Medicare supplement (also called Medigap) insurance is sold to people age 65 and older and helps pay for medical costs that Medicare Parts A & B do not pay, such as the deductible and coinsurance amounts. Medicare supplement insurance is regulated by both state and federal laws. This coverage can only be provided through **non-standard health plans** that vary in the amount and type of coverage provided. Coverage is available to individuals without medical underwriting for six

months following the date the individual first becomes eligible for Medicare Part B. The Division of Insurance produces, on an annual basis, a rate comparison guide that outlines the basic characteristics of Medicare supplement insurance, describes the ten standard health insurance plans, and shows the current premium rates charged by the insurers selling this insurance in Alaska. There is also a pamphlet entitled "Health Insurance for People with Medicare" produced by the 50 states and the federal government that summarizes the Medicare and Medicare supplement programs. Both publications are available from the Division of Senior Services, 3601 C Street, Suite 310, Anchorage, Alaska 99503, telephone number (907) 269-3680 or (800) 478-6065.

Dental Insurance

Dental insurance covers costs associated with the care of teeth. Benefits for preventive services, such as cleanings and exams are generally limited to once every six months. Most plans contain coinsurance and deductible cost-sharing requirements. The coinsurance provisions will vary based on the type of procedure.

Vision Coverage

Vision coverage provides benefits for glasses, contact lenses, and eye examinations up to a specified amount per year. Vision benefits are often subject to a set schedule of benefits and limits on the frequency of services. A typical vision plan covers the cost for one examination per year, with coverage for glasses and contact lenses limited to once every two years.

THINGS TO BE AWARE OF REGARDING HEALTH INSURANCE POLICIES

Benefit Limits

- ▶ Most health insurance plans set a maximum benefit amount that will be provided for all covered services and supplies over the lifetime of the covered individual. This is called a **lifetime maximum**. This maximum is often set at \$1,000,000.
- ▶ Most health insurance plans set a maximum benefit amount that provides for particular services and supplies, such as a maximum benefit of \$250,000 for organ transplants.
- ▶ Some health insurance plans limit the benefit that will be provided per day for a covered service. This is called a **daily maximum**. They may also limit the number of days that a service will be covered. These types of limits are generally used for services including mental and nervous disorders, skilled nursing facilities, and home health care.
- ▶ Many health insurance plans limit the total benefit that will be provided per year for covered services. This is called an **annual maximum**. These limits are generally used for those services where it is difficult to assess whether the service is medically necessary.
- ▶ Most health insurance plans exclude or limit coverage for a period of time for medical conditions that existed within a certain period, commonly six months, prior to the date coverage began for which medical advice, diagnosis, care or treatment was recommended or received.

This is called a **preexisting condition waiting period**. The waiting period is commonly 12 months. In most cases, insurance companies must reduce this waiting period by the number of days you were covered under prior health insurance plans, as long as you had no more than a 90-day break in your health insurance coverage.

Deductibles, Coinsurance, and Other Charges

- ▶ A **deductible** is a specified dollar amount an individual must pay in each policy period before reimbursement for expenses begin. The primary purpose of the deductible is to encourage individuals to use health care services only when necessary. A separate deductible may be required for specified services such as hospital admissions or prescription drugs. Some health plans may include a provision that allows any claims incurred in the last quarter of the policy period to be carried over and applied to meet the deductible in the next quarter.
- ▶ **Coinsurance** is that percentage of covered services and supplies the insurer will pay for after the individual pays the deductible. The individual is responsible for the amount the insurer does not pay. A common coinsurance arrangement is for the insurer to pay 80% of charges for covered services and the individual 20%.
- ▶ **Out-of-pocket maximum** is the maximum dollar amount the individual pays for covered services and supplies during a specified period, generally a calendar year. This maximum may be defined to include or exclude the deductible. Once

the out-of-pocket maximum is paid, benefits are paid at 100% of the costs incurred at that time.

- ▶ A **copayment** is the fixed dollar amount that the individual is required to pay at the time each covered service takes place. Copayments vary by type of service. They are commonly used with emergency services and prescription drugs.
- ▶ A **usual, customary and reasonable (UCR)** charge is an established maximum amount that an insurance company will reimburse for a medical expense covered under your health insurance policy. UCR charges are generally determined based on charges that are actually billed by providers for each medical procedure or service in a geographical area. In order to determine a reasonable charge, UCR charges are commonly calculated as a percentile of the charges billed by providers. The percentile is generally set so that a large percentage, such as 80% or 90%, of charges actually billed by providers are reimbursable in full. Note that UCR charges are determined by each insurer and will vary.

Under most health insurance plans, you will be responsible for paying any amount billed by a hospital or physician that is larger than the insurer's established UCR charges for the service or procedure. However, service corporations, such as Blue Cross, contract with various hospitals and providers who agree to accept the service corporation's payment as payment in full. Therefore you would not be responsible for paying any amount that exceeds their UCR charges, unless you chose to use a hospital or provider that does not have a

contract with the service corporation.

- ▶ The following is an example of how the various charges described above impact the amount you may be responsible for paying for medical services:

Covered Services and Supplies

There are two basic categories of services and supplies covered by health insurance policies.

- ▶ **Hospital Benefits** include expenses associated with stays at hospitals and other covered facilities, such as skilled nursing facilities, nursing homes and outpatient surgery centers. Benefits for hospital services often require that the individual or their physician contact the insurer or the employer to obtain prior approval for the number of days of hospital stay. Without this approval the benefits may be reduced.
- ▶ **Physician or Provider Benefits** include services provided by licensed physicians and other medical providers.

There are a number of other charges and services generally excluded from coverage under most health insurance plans. Following are examples of common exclusions:

- ▶ Services determined by the insurer to be medically unnecessary
- ▶ Services considered experimental by an accepted medical authority
- ▶ Services related to cosmetic surgery
- ▶ Services for mental or nervous disorders, vision, hearing

- ▶ Services that are provided without charge
- ▶ Services provided due to war
- ▶ Services provided as a result of a work-related injury
- ▶ Services provided by a relative
- ▶ Services related to normal pregnancy and routine well-baby care (these are generally excluded from individual policies and included in group policies).

Alaska law mandates that the following specific charges or services be covered in health insurance plans sold in Alaska. These requirements do not apply to employers with self-insured health plans.

- ▶ Coverage for newly born or adopted children for at least 30 days, if coverage includes dependents
- ▶ Coverage for treatment of alcoholism or drug abuse
- ▶ Low-dose mammography screening if the contract covers mastectomies and prosthetic devices and reconstructive surgery
- ▶ Treatment of phenylketonuria
- ▶ Coverage for not less than 48 hours after vaginal birth and 96 hours after a cesarean birth, if the contract covers the costs of childbirth
- ▶ Coverage for prostate cancer screening and cervical cancer screening

Coordination of Benefits

This provision applies to the situation where an individual is covered under two different health insurance plans. It is included in almost all group insurance plans. It requires that

payments made under the two plans be coordinated so that the individual does not receive duplicate payments for a service, thereby being reimbursed more than what was spent. Duplicate coverage frequently occurs when an individual is covered under both their own and their spouse's insurance plans. Most coordination of benefits provisions require that the individual's own plan pay first on a claim, and the other plan only pay the amounts not covered by the first plan. It is important that this provision be reviewed so that misunderstandings can be avoided regarding the benefit payments each insurer will make.

MANAGED CARE

This is a common term today and there is no one generally accepted definition. For insurance companies, the term is often used to describe the many cost and care management features of health insurance plans. The most significant managed care feature of health insurance plans is **utilization review programs** that evaluate the appropriateness, necessity, and quality of health care provided to the policyholders. These programs include requirements (as described below) for hospital preadmission authorization, second surgical opinions, hospital stay reviews and planning, and case management. Utilization review is provided by nurses or physicians employed by or contracted with the insurer. Other examples of managed care features are centers of excellence, preferred provider arrangements, and prescription drug copayment plans.

Hospital Preadmission Authorization

Hospital preadmission authorization requires that the insured individual receive authorization

to be admitted to a hospital in nonemergency cases. If the individual fails to receive prior authorization, benefits will be reduced.

Second Surgical Opinion

Second surgical opinion requirements provide that a second opinion by a different physician be given before certain surgeries are performed. The cost of the second opinion is covered at 100%. Requiring second surgical opinions is intended to eliminate unnecessary surgery and to encourage better use of health care services by individuals.

Case Management

Case management is used for individuals with high-cost illnesses such as cancer, heart disease, and diabetes. Usually a nurse employed by the insurer monitors the individual's treatment and helps develop a treatment plan to achieve the best outcome and the most cost effective use of health care services for the patient.

Concurrent Hospital Review and Discharge Planning Reviews

Concurrent hospital review and discharge planning reviews take place for any hospitalization, not just high cost illnesses, and involves monitoring the necessity of continued hospitalization. They are intended to ensure the individual stays in the hospital only as long as medically necessary and when discharged, receives appropriate care.

Centers of Excellence

Centers of excellence are specific providers selected by the insurer that provide fairly low volume, high risk procedures such as transplants and heart surgery at

reduced costs. These providers have an expertise in the procedure, and therefore provide high quality care, with fewer complications and shorter hospital stays.

Preferred provider arrangements occur when insurers contract with hospitals and/or providers to provide services for a reduced cost. When policyholders are encouraged to use preferred providers, the providers gain from the additional patients directed to them. The policyholders and insurer gain because the providers will usually agree to a lower fee schedule for services rendered. Policyholders have the choice whether or not to use these preferred providers. It is often to the policyholder's advantage to utilize the preferred providers, since lower deductibles and coinsurance payments will exist. In Alaska, insurers are prohibited from refusing to pay benefits for the use of nonpreferred providers.

Prescription Drug Copayment Plans

Prescription drug copayment plans encourage the use of generic drugs, which can be as much as 50% less expensive than brand-name drugs. The individual will generally be required to make a higher copayment if they choose to use a brand-name drug when a generic version is available.

ALASKA HEALTH INSURANCE LAWS

Small Employer Health Insurance

Alaska Statute requires insurers who offer health insurance coverage to small employers in the state to offer each small employer (defined as those with 2-50 employees) all the health insurance plans that they offer to

other small employers in the state regardless of the health or claims experience of the group. They must offer coverage to all eligible employees and not deny coverage to an employee. This law does not require an employer to purchase coverage for their employees. Alaska law also requires that insurance companies providing coverage to small employers adhere to certain rating restrictions including a maximum annual rate increase of 15% for poor group claims experience.

Large and Small Employer Health Insurance

According to Alaska law, insurance companies that offer health insurance coverage to large and small employer groups:

- ▶ May not base eligibility for coverage on health status, claims experience, medical history or condition, disability, receipt of health care, genetic information or any evidence of insurability.
- ▶ Must continue to renew the coverage, except in certain specified circumstances such as a failure to pay premiums
- ▶ May not require a preexisting condition waiting period that is longer than 12 months for a health condition that existed prior to the effective date of coverage which is called a preexisting condition waiting period. Pregnancy and genetic information cannot be considered preexisting conditions and therefore no waiting period may be applied.
- ▶ Must reduce any preexisting condition waiting period by the amount of time an individual was covered under prior health insurance coverage. However, the insurer is not required to

reduce such a waiting period by any periods of health insurance coverage before a 90 day or more break in health insurance coverage. For example:

An individual is covered under employer A's health insurance plan for 6 months before terminating coverage. The individual then terminates employment and is not covered under any health insurance plan for 100 days. The individual then becomes covered under employer B's health plan and remains covered for 5 months. The individual terminates employment and is not covered under any health insurance plan for 45 days. The individual then enrolls in employer C's health insurance plan which has a 12 month preexisting condition waiting period. Since the individual had a break in coverage of more than 90 days between employer A and employer B, the 6 months covered under employer A's health insurance plan are not used to reduce the 12 month preexisting condition waiting period. Therefore, only 5 months of coverage with employer B will be used to reduce the 12 month preexisting condition waiting period. Employer C's health insurance plan may only apply a 7-month waiting period (12 months - 5 months).

Comprehensive Health Insurance Association (CHIA)

In 1992, the Alaska legislature established a health insurance program for high-risk individuals. This law allows all individuals who have been refused coverage by at least two insurers, who have a specified medical condition, or who meet certain other criteria, to purchase coverage through the CHIA.

Individuals who meet the state definition of a federally defined eligible individual can receive coverage through the CHIA without a waiting period. A federally defined eligible individual is an individual whose most recent coverage was under a group health plan; who had at least 18 months of health insurance coverage; who has exhausted any available COBRA coverage; whose most recent coverage was not terminated due to nonpayment of premiums or fraud; who does not have other health insurance coverage; and who is not eligible for other coverage.

The premium rates for the program are set at 175% of the average standard risk rate for health insurance plans sold in Alaska with similar benefits.

For information on this program, contact the Division of Insurance in Anchorage at 1-800-467-8725 (in Alaska only) or 907-269-7900.

FEDERAL LAWS AFFECTING HEALTH INSURANCE

COBRA

COBRA is the federal law that requires employers to continue to provide their health insurance coverage to employees who have been laid off or terminated. The coverage may extend from 18 to 36 months. To obtain coverage under COBRA, the employee or their dependent must apply to the employer within 60 days of termination of their employment. The U.S. Department of Labor handles all inquiries regarding COBRA coverage. Inquiries should be sent to:

Office of Program Services
Pension and Welfare
Benefits Administration
U.S. Department of Labor
200 Constitution Ave., N.W.
Washington, DC 20210
(202) 219-8776

ERISA (Employee Retirement Income Security Act)

Many people who believe that they have a health insurance policy through their employer are actually covered under what is called a self-insured health plan. A self-insured health plan exists when an employer chooses to pay for medical bills directly, instead of purchasing insurance for that purpose. Most self-insured plans are regulated by the federal government through the Department of Labor under the authority of ERISA and are exempt from state regulation. Most large employers have self-insured health plans. The State of Alaska changed to a self-insured health plan for employees and retirees effective July 1, 1997.

Employers choosing to self-insure their health plans are not subject to state insurance laws such as benefit mandates, state premium taxes, capital and surplus requirements, and reserve requirements. They are also able to gain more control over their cash flow and have more freedom in determining benefits to be provided to their employees. Most employers with self-insured health plans purchase stop-loss insurance from insurance companies to protect themselves against large losses.

Employees who receive health coverage under a self-insured plan are not afforded the protections of state insurance laws and regulations. These protections include financial solvency requirements as well as requirements applying to the payment of claims. If a self-insured plan fails, Alaska benefits and managed care protections, such as standards for grievance procedures, fair disclosure of plan provisions, fair claims settlement practices and consumer services, are not available to employees. The federal laws governing these self-insured plans limit damages to actual costs and may not even

cover attorney fees. Individuals covered under a self-insured plan must assume responsibility for all claims if the plan fails. Also, individual employees are required to obtain their own legal counsel to settle disputes, since the U.S. Department of Labor will not become involved in individual disputes over coverage. One other important consideration is that a self-insured employer may make material changes to the health plan (such as reducing or eliminating benefits) without providing advance notice.

HIPAA (Health Insurance Portability and Accountability Act of 1996)

This Act establishes federal standards for group and individual health insurance plans. The Act sets minimum standards for guaranteed renewability, preexisting condition waiting periods, and crediting for prior health insurance coverage. Alaska has enacted into law these federal standards which are discussed in the health insurance sections of this guide.

Medical Savings Accounts

Under this federal law a bank, insurance company, or other federally approved entity may set up an individual savings account called a Medical Savings Account (MSA) where you can set money aside to pay for qualified medical expenses. The deposits (called contributions) in the account are tax deductible. Qualified medical expenses are those expenses paid by you for medical care including any deductible and coinsurance payments. Medical Savings Accounts are regulated by the federal government, not the Alaska Division of Insurance. One advantage to establishing an MSA is that contributions are not subject to tax and qualified

medical expenses paid out of the account are not included in gross income for federal income tax purposes.

In order for a savings account to qualify as an MSA, you must be covered by a high deductible health plan offered by a small employer (2-50 employees) or be self-employed and have purchased a high deductible health plan. A high deductible health plan is an individual health insurance policy with deductibles between \$1,500 and \$2,250 and out-of-pocket limit of \$3,000, or a family health insurance policy with deductibles between \$3,000 and \$4,500 and out-of-pocket limit of \$5,500. These high deductible health plans are regulated by the Division of Insurance in the same manner as other health insurance policies.

If you are seeking information on setting up an MSA account, the best place to start is by contacting your financial advisor or producers selling health insurance in Alaska. Producers should have knowledge of the high deductible plans that are available in Alaska and any MSAs that may be offered in conjunction with those plans.

DISABILITY INCOME INSURANCE

Disability income insurance provides a weekly or monthly income benefit if you are disabled due to a covered injury or sickness. This type of insurance can provide an income to partially replace the wages lost when a person is unable to work for an extended time. Policies are available to cover disability due to an accident only, or due to either accident or illness.

Disability income insurance is an extremely important kind of insurance coverage that is often overlooked. Statistically, people

are three times more likely to become disabled for a period of time during their working years than they are to die during those same years, yet many people who buy life insurance fail to buy disability income insurance.

Disability income policies have waiting periods before benefits become payable. The waiting period starts after you have become disabled for a covered disability. The longer the waiting period, the lower the premium will be. The period of time for which benefits are payable can also vary considerably. Benefit periods may depend on whether the disability was caused by accident or illness. A long-term policy may provide for lifetime accident benefits and illness benefits to the age of 65. The longer the benefit period, the higher the premium will be.

What it Covers

The amount of monthly benefit provided by a disability income policy may be stated as a percentage of income or as a set dollar amount. The amount of benefit for which you can qualify is usually based on a percentage of your gross earnings, normally around 60%. A partial disability benefit may be provided, or may be available, on an optional basis.

Some policies may reduce your benefit by the amount you receive from social security or workers' compensation so your disability benefit and social security or workers' compensation benefits together will provide a specified income. Some companies will consider possible social security benefits when they decide the amount of benefits for which you qualify.

Occupational therapy and vocational rehabilitation benefits may also be provided by a disability income policy.

Things to Be Aware of Regarding Disability Insurance

A disability income policy generally requires that you be totally disabled before benefits are paid. The definitions of total disability vary from policy to policy. There are two different definitions used in disability policies. One definition is that you are unable to perform your own occupation. The other definition is much more comprehensive requiring that you are unable to perform any occupation (for which you are suited by education or experience). This distinction can be important for jobs that require very specialized physical skills such as surgeons or loggers.

Relationship with Other Forms of Disability Insurance

If you are hurt on the job, or in a job-related activity, you probably qualify for workers' compensation benefits. Employers, with certain exceptions, must have this insurance to pay your medical bills and pay a weekly benefit to replace some of your wages if you are injured at work.

You can contact your employer or the Alaska Division of Workers' Compensation about claims. The telephone numbers are: Anchorage: (907) 269-2424, Fairbanks: (907) 452-1509, and Juneau: (907) 465-2790.

Social security benefits include disability benefits for long term or permanent total disability. Contact your local social security office for more information. You should consider what benefits would be available to you from social security when you are buying disability income insurance.



Where to Go for More Information

CONSUMER ORGANIZATIONS

There are a number of organizations that provide information about insurance to consumers. These consumer organizations include:

The National Insurance Consumer Help Line
(800) 942-4242

Consumer Coalition for Quality Health Care
1275 K Street, N.W., Suite 602
Washington, DC 20005
(202) 789-2389

Insurance Information Institute
110 William St.
New York, NY 10038
(800) 331-9146
<http://www.iii.org/CONSUMER.HTM>

Consumer Federation of America
1424 16th Street, N.W., Ste. 604
Washington, DC 20036
(202) 387-6121

Council for Responsible Genetics
5 Upland Road, Suite 3
Cambridge, MA 02140
(617) 868-0870

Center for Insurance Research
Ste. 302
1130 Massachusetts Ave.
Cambridge, MA 02138

Medicare Rights Center
1460 Broadway 8th Floor
New York, NY 10036
(617) 441-2900
(212) 869-3850

RATING AGENCIES

Several rating agencies review the financial information of each insurer and issue them a grade based on their financial strength. Looking at these grades allows you to compare the solvency of different companies and aid in your selection of an insurance company. Keep in mind the information you receive is for a specific point in time; the financial condition of companies can change quickly. To find out more about an insurance company before you purchase insurance, you may want to contact one of the listed rating agencies. Be sure to ask about the rating scale used and how the rating agency assigns its highest rating so that you will be able to put the rating of any company into context. It is also a good idea to see if an insurance company's grade or rating has changed over the last couple of years.

Rating guides prepared by one or more of these rating agencies are available at most public libraries, or you can call the numbers listed below. If you call, ask the company for their fee schedule.

A.M. Best Company
(908) 439-2200
Internet: www.ambest.com

Telephone ratings are available for a per-minute charge. You can also buy booklet-form rating summaries and reports on individual insurers.

Demotech, Inc.
(614) 761-8602
Internet: www.demotech/inc.com

There is no charge for telephone ratings.

Duff & Phelps, Inc.
(312) 368-3157
Internet: www.insure.com/ratings/dcr/duff.html

There is no charge for telephone ratings.

Fitch Investors Service, Inc.
(212) 908-0500
Internet: www.fitchinv.com

There is no charge for telephone ratings.

Moody's Investors Service
(212) 553-1653
Internet: www.moody.com

No charge for up to three ratings.

Standard & Poor's
(212) 208-1527
Internet: www.insure.com/ratings/sandp.html

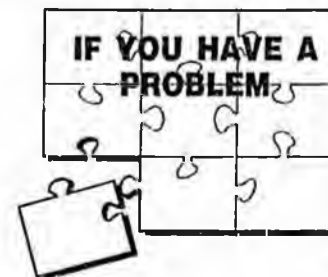
Up to five ratings, free of charge, with a brief explanation of the ratings.

Weiss Research, Inc.
(800) 289-9222
Internet: www.weissinc.com

Charge for brief telephone ratings, one page ratings, or 18-page in-depth ratings.

DIVISION OF INSURANCE CONSUMER SERVICES SECTION

The Division's Consumer Services Section is located in our Anchorage office and staffed by consumer service specialists. They can help by providing information on Alaska insurance laws and regulations. If you believe someone has committed an unfair claims settlement practice, the consumer service specialists want to know. Although they cannot represent you in making a claim against an insurance company or adjuster, they do make appropriate investigations into the potential violations of insurance law or regulations based upon written complaints received from the public. Violators are subject to fines and/or suspension or revocation of their license and sometimes criminal prosecution.



If you have a problem with your insurance policy, the first thing you should do is contact your insurance producer or insurance company and explain your concern. For example, if you believe your insurance company has improperly denied you coverage, refused to continue your policy, or has refused to pay all or part of a valid claim, you can question the action taken. Even though your concern may be resolved after contacting your insurance producer or insurance company, it is important to write down whom you talked to, the date, time, and what was said. This information may be helpful if the issue comes up again.

If you do not receive a prompt, courteous, and satisfactory response from your insurance producer or insurance company, you may need the division's assistance. Follow the instructions on the Insurance Inquiry/Complaint Form on page and send it to us with legible copies of your documents.

Even though we cannot provide the legal services that are sometimes required to settle complicated problems, the Division of Insurance is able to resolve most complaints before you hire an attorney. However, if you need legal advice, you may call the Lawyer Referral Service in Anchorage at 907-272-0352 or outside Anchorage at 1-800-770-9999.

FILING AN INQUIRY OR COMPLAINT

If you need to request our assistance, please clip out and complete our Insurance Inquiry/Complaint Form found on this page.

What we can do for you

- ▶ We can answer your questions directly, or get answers to your questions from the insurance producers involved.
- ▶ We can determine if your company or producer has complied with Alaska insurance laws.
- ▶ We can assist in obtaining any refund due.
- ▶ We can explain basic policy language.

What we cannot do

- ▶ We cannot act as your attorney, give you legal counsel, or refer you to a specific attorney.
- ▶ We cannot recommend or rank insurance companies.
- ▶ We cannot decide a dispute between you and an insurance company when the only evidence is your word against the company.
- ▶ We cannot resolve disputes involving issues of negligence in an accident.

- ▶ We cannot resolve disputes of medical necessity.
- ▶ We cannot enter negotiations for settlement amounts.

COMPLETING THE INQUIRY/ COMPLAINT FORM

Your completed inquiry/complaint form gives us authorization to review your concern and provides the information necessary to pursue our investigation. Briefly explain your inquiry or complaint by providing written details as to what happened, who was involved, and why you feel the company's position in the matter is wrong. Tell us what you have done to work with the company (written letters, called the company, whom you spoke with, on what date, etc.). If someone else's insurance company is involved, provide us with the company's name, insured's name, policy number, and claim number. Tell us what you want from the insurance company or the producer involved (payment of a claim, a refund, etc.).

If you need additional space, please attach a separate piece of paper and sign each page. Along with your completed form, provide us copies (never originals) of any correspondence,

policies, or material relating to your insurance concern. Once we have received your inquiry/complaint, we will assign a specialist to assist you.

We will request that your producer and/or company explain their position with respect to your concern. Once we receive their response, we will review and determine whether Alaska laws have been complied with and decide whether further action by our office will be required. As soon as the producer or company involved agrees to resolve your concern, we will send you a short verification letter indicating what action will be taken and within what time frame.

If your inquiry or complaint exceeds our regulatory authority, we will let you know. We will also indicate in our written response who may be able to help you. If Alaska law is not violated, we will let you know in writing and explain why. Keep in mind we are restricted from making determinations regarding disputed facts or contested questions of law.

See next page for complaint form.

DIVISION OF INSURANCE
CONSUMER SERVICES SECTION

3601 C Street, Suite 1324, Anchorage, AK 99503-5948
Telephone: (907) 269-7900
Fax: (907) 269-7910

INSURANCE INQUIRY/COMPLAINT FORM

YOUR NAME: _____

DAYTIME TELEPHONE NO.: _____

ALTERNATE TELEPHONE NO.: _____

ADDRESS: _____
Street City ZIP Code

INSURED'S NAME AND ADDRESS (If different from above): _____

YOUR AGE Under 25 25 to 49 50 to 64 65+

INSURANCE COMPANY: _____
(Give name exactly as shown on policy)

EFFECTIVE DATE: _____

POLICY TYPE: _____

POLICY NUMBER(s): _____
(Auto, Health, Life, etc.)

NAME OF AGENT OR ADJUSTER _____

DATE OF LOSS: _____

DATE CLAIM SUBMITTED: _____
(If applicable)

GROUP INSURANCE MEMBERSHIP OR CERT. NO.: _____

EMPLOYER: _____

Please give a **FACTUAL STATEMENT OF THE PROBLEM**. Enclose a copy of your policy and any related material in this guide. If more space is required, use reverse side or an additional sheet of paper and sign each page.

Signature: _____

Date: _____

Definitions of Insurance Terms

A

Actual Cash Value

In automobile insurance, actual cash value is equivalent to a vehicle's pre-loss market value. In homeowners insurance, actual cash value represents the actual cost to replace a damaged item less depreciation.

Agent

A person or firm authorized to sell insurance as a representative of the insurance company (also see producer).

Adjuster

A person or firm who is employed by the insurance company (or contracted by the company) and is responsible for investigating and determining the value of your loss.

Annuitant

A person who receives income payments from an annuity.

Application

The form on which you provide the information required by the insurer for their use determining whether to sell you an insurance policy. The information provided on this form is also used to determine the premium rate you will be charged for the insurance policy.

Arbitration

A process of resolving disputes in a nonjudicial setting to determine the rights or obligations under a contract.

Assigned Risk Plan

An entity established to provide automobile insurance to people who are unable to find a licensed insurance company willing to sell them a policy.

B

Beneficiary

A person named by the owner of a life or annuity to receive benefits under an insurance policy.

Binder

A temporary evidence of a contract of property/casualty insurance that remains in effect until the actual insurance policy applied for is issued by the insurance company. Binders are not issued in life and health insurance.

Broker

A producer who represents you, not the insurance company, and who helps you find an insurance policy. Brokers cannot bind your coverage.

C

Cancellation

The termination of your insurance coverage at any time other than at a policy anniversary date.

Cash Value

The amount of money you are entitled to receive from the insurance company when you terminate a life insurance or annuity policy. The amount of cash value will be determined as stated in the policy.

Claim

A request for benefits for a loss made against you or your insurance company.

Commission

The amount paid by the insurance company to the producer as compensation for selling and servicing an insurance policy.

Covered Loss

Any claim that is covered under the provisions of your insurance policy.

D

Declaration Page

The part of your insurance policy that shows the policy period, who and what is insured, the basic amounts and general types of coverage being provided. The declaration page also lists all the documents or policy forms, endorsements and riders which make up the insurance policy.

Deductible

The amount you pay when you have a claim before your insurance company begins payment.

E

Endorsement

Written agreement attached to a policy to add or subtract insurance coverages. An endorsement modifies the original provisions in a policy.

Evidence of Insurability

Statement or proof of a person's medical history, occupation, age, lifestyle, and physical condition upon which acceptance for coverage will be made.

I

Incontestability Clause

Section in a life insurance policy stating that after the policy is in force for a period of time (usually two years), the company cannot terminate the policy because of misrepresentation or concealment by the insured in obtaining the policy.

Inflation Guard Endorsement

An endorsement to a homeowners policy that adjusts the policy limits based on the insurer's estimates of increases in building costs.

Insurance Policy

The entire written legal contract of insurance that describes you and your insurance company's rights and responsibilities.

Insured

The person covered by an insurance policy. The insured is often the policyholder.

Insurer

The insurance company

Definitions of Insurance Terms



Lapse

For property/casualty insurance, termination of your policy for failure to pay your premium. For life insurance, termination of your policy for failure to pay premium and lack of enough cash value to pay the premium.

Lienholder

The person or entity that holds a security interest in a property until debt on the property is paid off.

Limits of Liability

The maximum amount a policy will pay, either overall or under a particular coverage.



Misrepresentation

When a policyholder or applicant makes an oral or written false statement of any fact.



Nonrenewal

The insurance company's failure to continue coverage at a policy anniversary.



Personal Property

Property that belongs to the insured and family members living in the insured's home other than real estate

Policyholder

The person who purchases or owns an insurance policy.

Premium

The amount of money that you are charged to purchase or maintain your insurance coverage.

Producer

The person who sells you an insurance policy.

Proof of Loss

A formal statement made by the insured to the insurance company providing sufficient information concerning the loss that the company uses to determine its liability under the policy.

Provider

Physicians and other individuals or entities that provide medical care.



Rating Agency

An independent organization that reviews the financial condition of insurance companies and provides a grade based on their review.

Rebate

When an insurer or producer agrees to accept a lower commission or provides something of value not stated in the insurance policy to an applicant or the insurance company in exchange for the applicant's agreement to purchase an insurance policy.

Renewal

The continuation of your insurance coverage at the end of the original policy period with the same insurance company.

Replacement Cost

The cost to repair or replace an insured item without adjustment for depreciation.



Stop-Loss Insurance

Insurance coverage purchased by employers, associations, labor unions and other entities that choose to self-

insure. Stop-loss insurance pays for claims that exceed a preset limit often called the retention amount.

Subrogation

In property/casualty insurance, the transfer to an insurance company of an insured's rights to recover from a third party.



Twisting

Misrepresentation by an insurer or producer that is intended to cause you to terminate an existing insurance policy and purchase a new policy.



Underwrite

The process of examining, accepting or rejecting an individual or group for insurance coverage and classifying those accepted into categories based on their risk in order to charge an appropriate premium

Unearned Premium

That portion of a premium payment that has not yet been used for coverage. For example, if you pay an annual premium, at the end of the first month of the premium period, 11/12 of the premium would still be unearned.



Waiting Period

The period of time indicated in a policy that must pass before you are covered.

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H.R.1415

Patient Access to Responsible Care Act of 1997 (Introduced in the House)

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H.R.1415

SPONSOR: [Rep Norwood](#) (introduced 04/23/97)

RELATED BILLS: [S.644](#)

A bill to amend the Public Health Service Act and the Employee Retirement Income Security Act of 1974 to establish standards for relationships between group health plans and health insurance issuers with enrollees, health professionals, and providers.

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SPONSOR: [Rep Norwood](#) (introduced 04/23/97)

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TITLE(S):

- **SHORT TITLE(S) AS INTRODUCED:**
Patient Access to Responsible Care Act of 1997
 - **OFFICIAL TITLE AS INTRODUCED:**
A bill to amend the Public Health Service Act and the Employee Retirement Income Security Act of 1974 to establish standards for relationships between group health plans and health insurance issuers with enrollees, health professionals, and providers.
-

STATUS: Floor Actions

NONE

STATUS: Detailed Legislative Status

House Actions

Apr 23, 97:

Referred to the Committee on Commerce, and in addition to the Committee on Education and the Workforce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

May 9, 97:

Referred to the Subcommittee on Employer-Employee Relations.

Oct 23, 97:

Subcommittee Hearings Held.

Apr 23, 97:

Referred to the Committee on Commerce, and in addition to the Committee on Education and the Workforce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

May 2, 97:

Referred to the Subcommittee on Health and Environment.

Oct 28, 97:

Subcommittee Hearings Held.

STATUS: Congressional Record Page References

NONE

COMMITTEE(S):

- **COMMITTEE(S) OF REFERRAL:**
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House Education and the Workforce

- SUBCOMMITTEE(S):
Hsc Health and the Environment
Hsc Employer-Employee Relations

AMENDMENT(S):

NONE

219 COSPONSORS:

<u>Rep Bachus</u> - 04/23/97	<u>Rep Baker, R.</u> - 04/23/97
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Rep Carson - 01/27/98
Rep Norton - 01/27/98
Rep Jackson-Lee - 01/27/98

SUMMARY:

(AS INTRODUCED)

Patient Access to Responsible Care Act of 1997 - Amends the Public Health Service Act to require a health insurance issuer to: (1) assure that covered items and services are available and accessible to each

enrollee; (2) assure the availability and accessibility of emergency services and urgent care 24 hours a day, 7 days a week; (3) not require prior authorization for emergency services; and (4) cover emergency and urgent (and related ancillary) services.

Requires an issuer offering network coverage to show that enrollees have access to specialized treatment. Regulates network incentive plans.

Requires an issuer to: (1) permit each network enrollee to select a personal health professional from participating professionals; (2) cover nonparticipating providers, regulating premiums and cost sharing; (3) avoid undue enrollee burden from care coordination and cost control processes; (4) ensure direct specialist access; (5) provide for continuity of care for those with special needs or a chronic condition; and (6) provide for continued coverage in certain circumstances.

Prohibits issuer discrimination on the basis of specified factors against individuals or providers.

Prohibits any issuer-professional agreement from restricting the professional from engaging in medical communications with the professional's patient.

Sets forth requirements regarding utilization review, an appeals process, and the process by which health professionals and providers become participants.

Requires issuers to: (1) disclose certain information to enrollees and prospective enrollees; (2) comply with Federal and State confidentiality laws; (3) meet State solvency-related requirements; and (4) establish a quality improvement program.

Requires issuers to comply with this Act regarding group and individual coverage. Declares that the requirements of this Act do not preempt any State law providing equivalent or stricter protections for individuals.

Amends the Employee Retirement Income Security Act of 1974 to require a group health plan and an issuer offering coverage under such a plan to comply with the requirements of this Act. Declares that this Act does not preempt any State: (1) law providing equivalent or stricter protections for individuals; or (2) cause of action for personal injury or wrongful death damages that provides insurance or administrative services to or for an employee welfare benefit plan maintained to provide health benefits.

HR 1415 IH

105th CONGRESS

1st Session

H. R. 1415

To amend the Public Health Service Act and the Employee Retirement Income Security Act of 1974 to establish standards for relationships between group health plans and health insurance issuers with enrollees, health professionals, and providers.

IN THE HOUSE OF REPRESENTATIVES

April 23, 1997

Mr. NORWOOD (for himself, Mr. BACHUS, Mr. BAKER, Mr. BARCIA, Mr. BARR of Georgia, Mr. BARRETT of Wisconsin, Mr. BISHOP, Mr. BROWN of Ohio, Mr. CANADY of Florida, Mr. CHAMBLISS, Mr. COBLE, Mr. COBURN, Mr. COMBEST, Mr. COOKSEY, Mr. CRAMER, Mr. DAVIS of Illinois, Mr. DAVIS of Virginia, Mr. DEAL of Georgia, Mr. DEFAZIO, Mr. DICKEY, Mr. DUNCAN, Mr. FILNER, Mr. FOLEY, Mr. FOX of Pennsylvania, Mr. FROST, Mr. GILMAN, Mr. GRAHAM, Mr. HALL of Ohio, Mr. HILLEARY, Mr. HILLIARD, Mr. HINCHEY, Mr. JENKINS, Mrs. KELLY, Mr. KENNEDY of Rhode Island, Mr. KIND, Mr. LAHOOD, Mr. LEWIS of Kentucky, Mr. LINDER, Mr. LIVINGSTON, Mrs. MALONEY of New York, Mr. MCHALE, Mr. MCHUGH, Mrs. MORELLA, Mrs. MYRICK, Mr. NETHERCUTT, Mr. PALLONE, Mr. PICKERING, Mr. RANGEL, Mr. RIGGS, Mrs. ROUKEMA, Mr. SANDERS, Mr. SCARBOROUGH, Mr. SENSENBRENNER, Mr. SHADEGG, Mr. SOLOMON, Mr. SPENCE, Mr. STRICKLAND, Mr. TOWNS, Mr. WALSH, Mr. WICKER, Mr. WISE, Ms. WOOLSEY, Mr. WEYGAND, Mr. CHRISTENSEN, Mr. COLLINS, and Mr. WAMP) introduced the following bill; which was referred to the Committee on Commerce, and in addition to the Committee on Education and the Workforce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To amend the Public Health Service Act and the Employee Retirement Income Security Act of 1974 to establish standards for relationships between group health plans and health insurance issuers with enrollees, health professionals, and providers.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE- This Act may be cited as the 'Patient Access to Responsible Care Act of 1997'.

(b) TABLE OF CONTENTS- The table of contents of this Act is as follows:

Sec. 1. Short title; table of contents.

Sec. 2. Patient protection standards under the Public Health Service Act.

'Part C--Patient Protection Standards

`Sec. 2770. Notice; additional definitions; construction.

`Sec. 2771. Enrollee access to care.

`Sec. 2772. Enrollee choice of health professionals and providers.

`Sec. 2773. Nondiscrimination against enrollees and in the selection of health professionals; equitable access to networks.

`Sec. 2774. Prohibition of interference with certain medical communications.

`Sec. 2775. Development of plan policies.

`Sec. 2776. Due process for enrollees.

`Sec. 2777. Due process for health professionals and providers.

`Sec. 2778. Information reporting and disclosure.

`Sec. 2779. Confidentiality; adequate reserves.

`Sec. 2780. Quality improvement program.

Sec. 3. Patient protection standards under the Employee Retirement Income Security Act of 1974.

Sec. 4. Non-preemption of State law respecting liability of group health plans.

SEC. 2. PATIENT PROTECTION STANDARDS UNDER THE PUBLIC HEALTH SERVICE ACT.

(a) PATIENT PROTECTION STANDARDS- Title XXVII of the Public Health Service Act is amended--

(1) by redesignating part C as part D, and

(2) by inserting after part B the following new part:

`Part C--Patient Protection Standards

`SEC. 2770. NOTICE; ADDITIONAL DEFINITIONS; CONSTRUCTION.

(a) NOTICE- A health insurance issuer under this part shall comply with the notice requirement under section 711(d) of the Employee Retirement Income Security Act of 1974 with respect to the requirements of this part as if such section applied to such issuer and such issuer were a group health plan.

(b) ADDITIONAL DEFINITIONS- For purposes of this part:

(1) ENROLLEE- The term 'enrollee' means, with respect to health insurance coverage offered by a health insurance issuer, an individual enrolled with the issuer to receive such coverage.

(2) HEALTH PROFESSIONAL- The term 'health professional' means a physician or other health care practitioner licensed, accredited, or certified to perform specified health services consistent with State law.

'(3) NETWORK- The term 'network' means, with respect to a health insurance issuer offering health insurance coverage, the participating health professionals and providers through whom the plan or issuer provides health care items and services to enrollees.

'(4) NETWORK COVERAGE- The term 'network coverage' means health insurance coverage offered by a health insurance issuer that provides or arranges for the provision of health care items and services to enrollees through participating health professionals and providers.

'(5) PARTICIPATING- The term 'participating' means, with respect to a health professional or provider, a health professional or provider that provides health care items and services to enrollees under network coverage under an agreement with the health insurance issuer offering the coverage.

'(6) PRIOR AUTHORIZATION- The term 'prior authorization' means the process of obtaining prior approval from a health insurance issuer as to the necessity or appropriateness of receiving medical or clinical services for treatment of a medical or clinical condition.

'(7) PROVIDER- The term 'provider' means a health organization, health facility, or health agency that is licensed, accredited, or certified to provide health care items and services under applicable State law.

'(8) SERVICE AREA- The term 'service area' means, with respect to a health insurance issuer with respect to health insurance coverage, the geographic area served by the issuer with respect to the coverage.

'(9) UTILIZATION REVIEW- The term 'utilization review' means prospective, concurrent, or retrospective review of health care items and services for medical necessity, appropriateness, or quality of care that includes prior authorization requirements for coverage of such items and services.

'(c) NO REQUIREMENT FOR ANY WILLING PROVIDER- Nothing in this part shall be construed as requiring a health insurance issuer that offers network coverage to include for participation every willing provider or health professional who meets the terms and conditions of the plan or issuer.

'SEC. 2771. ENROLLEE ACCESS TO CARE.

'(a) GENERAL ACCESS-

'(1) IN GENERAL- Subject to paragraphs (2), and (3), a health insurance issuer shall establish and maintain adequate arrangements, as defined by the applicable State authority, with a sufficient number, mix, and distribution of health professionals and providers to assure that covered items and services are available and accessible to each enrollee under health insurance coverage--

'(A) in the service area of the issuer;

'(B) in a variety of sites of service;

'(C) with reasonable promptness (including reasonable hours of operation and after-hours services);

'(D) with reasonable proximity to the residences and workplaces of enrollees; and

(E) in a manner that--

(i) takes into account the diverse needs of enrollees, and

(ii) reasonably assures continuity of care.

For a health insurance issuer that serves a rural or medically underserved area, the issuer shall be treated as meeting the requirement of this subsection if the issuer has arrangements with a sufficient number, mix, and distribution of health professionals and providers having a history of serving such areas. The use of telemedicine and other innovative means to provide covered items and services by a health insurance issuer that serves a rural or medically underserved area shall also be considered in determining whether the requirement of this subsection is met.

(2) RULE OF CONSTRUCTION- Nothing in this subsection shall be construed as requiring a health insurance issuer to have arrangements that conflict with its responsibilities to establish measures designed to maintain quality and control costs.

(3) DEFINITIONS- For purposes of paragraph (1):

(A) MEDICALLY UNDERSERVED AREA- The term 'medically underserved area' means an area that is designated as a health professional shortage area under section 332 of the Public Health Service Act or as a medically underserved area for purposes of section 330 or 1302(7) of such Act.

(B) RURAL AREA- The term 'rural area' means an area that is not within a Standard Metropolitan Statistical Area or a New England County Metropolitan Area (as defined by the Office of Management and Budget).

(b) EMERGENCY AND URGENT CARE-

(1) IN GENERAL- A health insurance issuer shall--

(A) assure the availability and accessibility of medically or clinically necessary emergency services and urgent care services within the service area of the issuer 24 hours a day, 7 days a week;

(B) require no prior authorization for items and services furnished in a hospital emergency department to an enrollee (without regard to whether the health professional or hospital has a contractual or other arrangement with the issuer) with symptoms that would reasonably suggest to a prudent layperson an emergency medical condition (including items and services described in subparagraph (C)(iii));

(C) cover (and make reasonable payments for)--

(i) emergency services,

(ii) services that are not emergency services but are described in subparagraph (B),

(iii) medical screening examinations and other ancillary services necessary to diagnose, treat, and stabilize an emergency medical condition, and

(iv) urgent care services, without regard to whether the health professional or provider furnishing such services has a contractual (or other) arrangement with the issuer; and

(D) make prior authorization determinations for--

'(i) services that are furnished in a hospital emergency department (other than services described in clauses (i) and (iii) of subparagraph (C)), and

'(ii) urgent care services, within the time periods specified in (or pursuant to) section 2776(a)(8).

'(2) DEFINITIONS- For purposes of this subsection:

'(A) EMERGENCY MEDICAL CONDITION- The term 'emergency medical condition' means a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention could reasonably be expected to result in--

'(i) placing the patient's health in serious jeopardy,

'(ii) serious impairment to bodily functions, or

'(iii) serious dysfunction of any bodily organ or part.

'(B) EMERGENCY SERVICES- The term 'emergency services' means health care items and services that are necessary for the diagnosis, treatment, and stabilization of an emergency medical condition.

'(C) URGENT CARE SERVICES- The term 'urgent care services' means health care items and services that are necessary for the treatment of a condition that--

'(i) is not an emergency medical condition,

'(ii) requires prompt medical or clinical treatment, and

'(iii) poses a danger to the patient if not treated in a timely manner, as defined by the applicable State authority in consultation with relevant treating health professionals or providers.

'(c) SPECIALIZED SERVICES-

'(1) IN GENERAL- A health insurance issuer offering network coverage shall demonstrate that enrollees have access to specialized treatment expertise when such treatment is medically or clinically indicated in the professional judgment of the treating health professional, in consultation with the enrollee.

'(2) DEFINITION- For purposes of paragraph (1), the term 'specialized treatment expertise' means expertise in diagnosing or treating--

'(A) unusual diseases or conditions, or

'(B) diseases and conditions that are unusually difficult to diagnose or treat.

'(d) INCENTIVE PLANS-

'(1) IN GENERAL- In the case of a health insurance issuer that offers network coverage, any health professional or provider incentive plan operated by the issuer with respect to such coverage shall meet the following requirements:

'(A) No specific payment is made directly or indirectly under the plan to a

professional or provider or group of professionals or providers as an inducement to reduce or limit medically necessary services provided with respect to a specific enrollee.

'(B) If the plan places such a professional, provider, or group at substantial financial risk (as determined by the Secretary) for services not provided by the professional, provider, or group, the issuer--

'(i) provides stop-loss protection for the professional, provider, or group that is adequate and appropriate, based on standards developed by the Secretary that take into account the number of professionals or providers placed at such substantial financial risk in the group or under the coverage and the number of individuals enrolled with the issuer who receive services from the professional, provider, or group, and

'(ii) conducts periodic surveys of both individuals enrolled and individuals previously enrolled with the issuer to determine the degree of access of such individuals to services provided by the issuer and satisfaction with the quality of such services.

'(C) The issuer provides the Secretary with descriptive information regarding the plan, sufficient to permit the Secretary to determine whether the plan is in compliance with the requirements of this paragraph.

'(2) In this subsection, the term 'health professional or provider incentive plan' means any compensation arrangement between a health insurance issuer and a health professional or provider or professional or provide group that may directly or indirectly have the effect of reducing or limiting services provided with respect to individuals enrolled with the issuer.

'SEC. 2772. ENROLLEE CHOICE OF HEALTH PROFESSIONALS AND PROVIDERS.

'(a) CHOICE OF PERSONAL HEALTH PROFESSIONAL- A health insurance issuer shall permit each enrollee under network coverage to--

'(1) select a personal health professional from among the participating health professionals of the issuer, and

'(2) change that selection as appropriate.

'(b) POINT-OF-SERVICE OPTION-

'(1) IN GENERAL- If a health insurance issuer offers to enrollees health insurance coverage which provides for coverage of services only if such services are furnished through health professionals and providers who are members of a network of health professionals and providers who have entered into a contract with the issuer to provide such services, the issuer shall also offer to such enrollees (at the time of enrollment) the option of health insurance coverage which provides for coverage of such services which are not furnished through health professionals and providers who are members of such a network.

'(2) FAIR PREMIUMS- The amount of any additional premium required for the option described in paragraph (1) may not exceed an amount that is fair and reasonable, as established by the applicable State authority, in consultation with the National Association of Insurance Commissioners, based on the nature of the additional coverage provided.

'(3) COST-SHARING- Under the option described in paragraph (1), the health insurance coverage shall provide for reimbursement rates for covered services offered by health

professionals and providers who are not participating health professionals or providers that are not less than the reimbursement rates for covered services offered by participating health professionals and providers. Nothing in this paragraph shall be construed as protecting an enrollee against balance billing by a health professional or provider that is not a participating health professional or provider.

`(c) CONTINUITY OF CARE- A health insurance issuer offering network coverage shall--

`(1) ensure that any process established by the issuer to coordinate care and control costs does not create an undue burden, as defined by the applicable State authority, for enrollees with special health care needs or chronic conditions;

`(2) ensure direct access to relevant specialists for the continued care of such enrollees when medically or clinically indicated in the judgment of the treating health professional, in consultation with the enrollee;

`(3) in the case of an enrollee with special health care needs or a chronic condition, determine whether, based on the judgment of the treating health professional, in consultation with the enrollee, it is medically or clinically necessary to use a specialist or a care coordinator from an interdisciplinary team to ensure continuity of care; and

`(4) in circumstances under which a change of health professional or provider might disrupt the continuity of care for an enrollee, such as--

 `(A) hospitalization, or

 `(B) dependency on high-technology home medical equipment,

provide for continued coverage of items and services furnished by the health professional or provider that was treating the enrollee before such change for a reasonable period of time.

For purposes of paragraph (4), a change of health professional or provider may be due to changes in the membership of an issuer's health professional and provider network, changes in the health coverage made available by an employer, or other similar circumstances.

SEC. 2773. NONDISCRIMINATION AGAINST ENROLLEES AND IN THE SELECTION OF HEALTH PROFESSIONALS; EQUITABLE ACCESS TO NETWORKS.

`(a) NONDISCRIMINATION AGAINST ENROLLEES- No health insurance issuer may discriminate (directly or through contractual arrangements) in any activity that has the effect of discriminating against an individual on the basis of race, national origin, gender, language, socioeconomic status, age, disability, health status, or anticipated need for health services.

`(b) NONDISCRIMINATION IN SELECTION OF NETWORK HEALTH PROFESSIONALS- A health insurance issuer offering network coverage shall not discriminate in selecting the members of its health professional network (or in establishing the terms and conditions for membership in such network) on the basis of--

 `(1) the race, national origin, gender, age, or disability (other than a disability that impairs the ability of an individual to provide health care services or that may threaten the health of enrollees) of the health professional; or

 `(2) the health professional's lack of affiliation with, or admitting privileges at, a hospital (unless such lack of affiliation is a result of infractions of quality standards and is not due to a health professional's type of license).

'(c) NONDISCRIMINATION IN ACCESS TO HEALTH PLANS- While nothing in this section shall be construed as an 'any willing provider' requirement (as referred to in section 2770(c)), a health insurance issuer shall not discriminate in participation, reimbursement, or indemnification against a health professional, who is acting within the scope of the health professional's license or certification under applicable State law, solely on the basis of such license or certification.

'SEC. 2774. PROHIBITION OF INTERFERENCE WITH CERTAIN MEDICAL COMMUNICATIONS.

'(a) IN GENERAL- The provisions of any contract or agreement, or the operation of any contract or agreement, between a health insurance issuer and a health professional shall not prohibit or restrict the health professional from engaging in medical communications with his or her patient.

'(b) NULLIFICATION- Any contract provision or agreement described in subsection (a) shall be null and void.

'(c) MEDICAL COMMUNICATION DEFINED- For purposes of this section, the term 'medical communication' means a communication made by a health professional with a patient of the health professional (or the guardian or legal representative of the patient) with respect to--

'(1) the patient's health status, medical care, or legal treatment options;

'(2) any utilization review requirements that may affect treatment options for the patient; or

'(3) any financial incentives that may affect the treatment of the patient.

'SEC. 2775. DEVELOPMENT OF PLAN POLICIES.

'A health insurance issuer that offers network coverage shall establish mechanisms to consider the recommendations, suggestions, and views of enrollees and participating health professionals and providers regarding--

'(1) the medical policies of the issuer (including policies relating to coverage of new technologies, treatments, and procedures);

'(2) the utilization review criteria and procedures of the issuer;

'(3) the quality and credentialing criteria of the issuer; and

'(4) the medical management procedures of the issuer.

'SEC. 2776. DUE PROCESS FOR ENROLLEES.

'(a) UTILIZATION REVIEW- The utilization review program of a health insurance issuer shall--

'(1) be developed (including any screening criteria used by such program) with the involvement of participating health professionals and providers;

'(2) to the extent consistent with the protection of proprietary business information (as defined for purposes of section 552 of title 5, United States Code) release, upon request, to affected health professionals, providers, and enrollees the screening criteria, weighting elements, and computer algorithms used in reviews and a description of the method by which they were developed;

'(3) uniformly apply review criteria that are based on sound scientific principles and the most recent medical evidence;

`(4) use licensed, accredited, or certified health professionals to make review determinations (and for services requiring specialized training for their delivery, use a health professional who is qualified through equivalent specialized training and experience);

`(5) subject to reasonable safeguards, disclose to health professionals and providers, upon request, the names and credentials of individuals conducting utilization review;

`(6) not compensate individuals conducting utilization review for denials of payment or coverage of benefits;

`(7) comply with the requirement of section 2771 that prior authorization not be required for emergency and related services furnished in a hospital emergency department;

`(8) make prior authorization determinations--

 `(A) in the case of services that are urgent care services described in section 2771(b)(2)(C), within 30 minutes of a request for such determination, and

 `(B) in the case of other services, within 24 hours after the time of a request for determination;

`(9) include in any notice of such determination an explanation of the basis of the determination and the right to an immediate appeal;

`(10) treat a favorable prior authorization review determination as a final determination for purposes of making payment for a claim submitted for the item or service involved unless such determination was based on false information knowingly supplied by the person requesting the determination;

`(11) provide timely access, as defined by the applicable State authority, to utilization review personnel and, if such personnel are not available, waives any prior authorization that would otherwise be required; and

`(12) provide notice of an initial determination on payment of a claim within 30 days after the date the claim is submitted for such item or service, and include in such notice an explanation of the reasons for such determination and of the right to an immediate appeal.

 `(b) APPEALS PROCESS- A health insurance issuer shall establish and maintain an accessible appeals process that--

 `(1) reviews an adverse prior authorization determination--

 `(A) for urgent care services, described in subsection (a)(8)(A), within 1 hour after the time of a request for such review, and

 `(B) for other services, within 24 hours after the time of a request for such review;

 `(2) reviews an initial determination on payment of claims described in subsection (a)(12) within 30 days after the date of a request for such review;

 `(3) provides for review of determinations described in paragraphs (1) and (2) by an appropriate clinical peer professional who is in the same or similar specialty as would typically provide the item or service involved (or another licensed, accredited, or certified health professional acceptable to the plan and the person requesting such review); and

 `(4) provides for review of--

 `(A) the determinations described in paragraphs (1), (2), and (3), and

'(B) enrollee complaints about inadequate access to any category or type of health professional or provider in the network of the issuer or other matters specified by this part,

by an appropriate clinical peer professional who is in the same or similar specialty as would typically provide the item or service involved (or another licensed, accredited, or certified health professional acceptable to the issuer and the person requesting such review) that is not involved in the operation of the plan or in making the determination or policy being appealed.

The procedures specified in this subsection shall not be construed as preempting or superseding any other reviews or appeals an issuer is required by law to make available.

'SEC. 2777. DUE PROCESS FOR HEALTH PROFESSIONALS AND PROVIDERS.

'(a) IN GENERAL- A health insurance issuer with respect to its offering of network coverage shall--

'(1) allow all health professionals and providers in its service area to apply to become a participating health professional or provider during at least one period in each calendar year;

'(2) provide reasonable notice to such health professionals and providers of the opportunity to apply and of the period during which applications are accepted;

'(3) provide for review of each application by a credentialing committee with appropriate representation of the category or type of health professional or provider;

'(4) select participating health professionals and providers based on objective standards of quality developed with the suggestions and advice of professional associations, health professionals, and providers;

'(5) make such selection standards available to--

'(A) those applying to become a participating provider or health professional;

'(B) health plan purchasers, and

'(C) enrollees;

'(6) when economic considerations are taken into account in selecting participating health professionals and providers, use objective criteria that are available to those applying to become a participating provider or health professional and enrollees;

'(7) adjust any economic profiling to take into account patient characteristics (such as severity of illness) that may result in atypical utilization of services;

'(8) make the results of such profiling available to insurance purchasers, enrollees, and the health professional or provider involved;

'(9) notify any health professional or provider being reviewed under the process referred to in paragraph (3) of any information indicating that the health professional or provider fails to meet the standards of the issuer;

'(10) offer a health professional or provider receiving notice pursuant to the requirement of paragraph (9) with an opportunity to--

'(A) review the information referred to in such paragraph, and

'(B) submit supplemental or corrected information;

'(11) not include in its contracts with participating health professionals and providers a provision permitting the issuer to terminate the contract 'without cause';

'(12) provide a due process appeal that conforms to the process specified in section 412 of the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11112) for all determinations that are adverse to a health professional or provider; and

'(13) unless a health professional or provider poses an imminent harm to enrollees or an adverse action by a governmental agency effectively impairs the ability to provide health care items and services, provide--

'(A) reasonable notice of any decision to terminate a health professional or provider 'for cause' (including an explanation of the reasons for the determination),

'(B) an opportunity to review and discuss all of the information on which the determination is based, and

'(C) an opportunity to enter into a corrective action plan, before the determination becomes subject to appeal under the process referred to in paragraph (12).

'(b) RULE OF CONSTRUCTION- The requirements of subsection (a) shall not be construed as preempting or superseding any other reviews and appeals a health insurance issuer is required by law to make available.

'SEC. 2778. INFORMATION REPORTING AND DISCLOSURE.

'(a) IN GENERAL- A health insurance issuer offering health insurance coverage shall provide enrollees and prospective enrollees with information about--

'(1) coverage provisions, benefits, and any exclusions--

'(A) by category of service,

'(B) by category or type of health professional or provider, and

'(C) if applicable, by specific service, including experimental treatments;

'(2) the percentage of the premium charged by the issuer that is set aside for administration and marketing of the issuer;

'(3) the percentage of the premium charged by the issuer that is expended directly for patient care;

'(4) the number, mix, and distribution of participating health professionals and providers;

'(5) the ratio of enrollees to participating health professionals and providers by category and type of health professional and provider;

'(6) the expenditures and utilization per enrollee by category and type of health professional and provider;

'(7) the financial obligations of the enrollee and the issuer, including premiums,

copayments, deductibles, and established aggregate maximums on out-of-pocket costs, for all items and services, including--

`(A) those furnished by health professionals and providers that are not participating health professionals and providers, and

`(B) those furnished to an enrollee who is outside the service area of the coverage;

`(8) utilization review requirements of the issuer (including prior authorization review, concurrent review, post-service review, post-payment review, and any other procedures that may lead to denial of coverage or payment for a service);

`(9) financial arrangements and incentives that may--

`(A) limit the items and services furnished to an enrollee,

`(B) restrict referral or treatment options, or

`(C) negatively affect the fiduciary responsibility of a health professional or provider to an enrollee;

`(10) other incentives for health professionals and providers to deny or limit needed items or services;

`(11) quality indicators for the issuer and participating health professionals and providers, including performance measures such as appropriate referrals and prevention of secondary complications following treatment;

`(12) grievance procedures and appeals rights under the coverage, and summary information about the number and disposition of grievances and appeals in the most recent period for which complete and accurate information is available; and

`(13) the percentage of utilization review determinations made by the issuer that disagree with the judgment of the treating health professional or provider and the percentage of such determinations that are reversed on appeal.

`(b) REGULATIONS- The Secretary, in collaboration with the Secretary of Labor, shall issue regulations to establish--

`(1) the styles and sizes of type to be used with respect to the appearance of the publication of the information required under subsection (a);

`(2) standards for the publication of information to ensure that such publication is--

`(A) readily accessible, and

`(B) in common language easily understood,

by individuals with little or no connection to or understanding of the language employed by health professionals and providers, health insurance issuers, or other entities involved in the payment or delivery of health care services, and

`(3) the placement and positioning of information in health plan marketing materials.

SEC. 2779. CONFIDENTIALITY; ADEQUATE RESERVES.

`(a) CONFIDENTIALITY-

'(1) IN GENERAL- A health insurance issuer shall establish mechanisms and procedures to ensure compliance with applicable Federal and State laws to protect the confidentiality of individually identifiable information held by the issuer with respect to an enrollee, health professional, or provider.

'(2) DEFINITION- For purposes of paragraph (1), the term 'individually identifiable information' means, with respect to an enrollee, a health professional, or a provider, any information, whether oral or recorded in any medium or form, that identifies or can readily be associated with the identity of the enrollee, the health professional, or the provider.

'(b) FINANCIAL RESERVES; SOLVENCY- A health insurance issuer shall--

'(1) meet such financial reserve or other solvency-related requirements as the applicable State authority may establish to assure the continued availability of (and appropriate payment for) covered items and services for enrollees; and

'(2) establish mechanisms specified by the applicable State authority to protect enrollees, health professionals, and providers in the event of failure of the issuer.

Such requirements shall not unduly impede the establishment of health insurance issuers owned and operated by health care professionals or providers or by non-profit community-based organizations.

'SEC. 2780. QUALITY IMPROVEMENT PROGRAM.

'(a) IN GENERAL- A health insurance issuer shall establish a quality improvement program (consistent with subsection (b)) that systematically and continuously assesses and improves--

'(1) enrollee health status, patient outcomes, processes of care, and enrollee satisfaction associated with health care provided by the issuer; and

'(2) the administrative and funding capacity of the issuer to support and emphasize preventive care, utilization, access and availability, cost effectiveness, acceptable treatment modalities, specialists referrals, the peer review process, and the efficiency of the administrative process.

'(b) FUNCTIONS- A quality improvement program established pursuant to subsection (a) shall--

'(1) assess the performance of the issuer and its participating health professionals and providers and report the results of such assessment to purchasers, participating health professionals and providers, and administrative personnel;

'(2) demonstrate measurable improvements in clinical outcomes and plan performance measured by identified criteria, including those specified in subsection (a)(1); and

'(3) analyze quality assessment data to determine specific interactions in the delivery system (both the design and funding of the health insurance coverage and the clinical provision of care) that have an adverse impact on the quality of care.'

(b) APPLICATION TO GROUP HEALTH INSURANCE COVERAGE-

(1) Subpart 2 of part A of title XXVII of the Public Health Service Act is amended by adding at the end the following new section:

'SEC. 2706. PATIENT PROTECTION STANDARDS.

'(a) IN GENERAL- Each health insurance issuer shall comply with patient protection requirements under part C with respect to group health insurance coverage it offers.

'(b) ASSURING COORDINATION- The Secretary of Health and Human Services and the Secretary of Labor shall ensure, through the execution of an interagency memorandum of understanding between such Secretaries, that--

'(1) regulations, rulings, and interpretations issued by such Secretaries relating to the same matter over which such Secretaries have responsibility under part C (and this section) and section 713 of the Employee Retirement Income Security Act of 1974 are administered so as to have the same effect at all times; and

'(2) coordination of policies relating to enforcing the same requirements through such Secretaries in order to have a coordinated enforcement strategy that avoids duplication of enforcement efforts and assigns priorities in enforcement.'

(2) Section 2792 of such Act (42 U.S.C. 300gg-92) is amended by inserting 'and section 2706(b)' after 'of 1996'.

(c) APPLICATION TO INDIVIDUAL HEALTH INSURANCE COVERAGE- Part B of title XXVII of the Public Health Service Act is amended by inserting after section 2751 the following new section:

'SEC. 2752. PATIENT PROTECTION STANDARDS.

'Each health insurance issuer shall comply with patient protection requirements under part C with respect to individual health insurance coverage it offers.'

(d) MODIFICATION OF PREEMPTION STANDARDS-

(1) GROUP HEALTH INSURANCE COVERAGE- Section 2723 of such Act (42 U.S.C. 300gg-23) is amended--

(A) in subsection (a)(1), by striking 'subsection (b)' and inserting 'subsections (b) and (c)';

(B) by redesignating subsections (c) and (d) as subsections (d) and (e), respectively; and

(C) by inserting after subsection (b) the following new subsection:

'(c) SPECIAL RULES IN CASE OF PATIENT PROTECTION REQUIREMENTS- Subject to subsection (a)(2), the provisions of section 2706 and part C, and part D insofar as it applies to section 2706 or part C, shall not be construed to preempt any State law, or the enactment or implementation of such a State law, that provides protections for individuals that are equivalent to or stricter than the protections provided under such provisions.'

(2) INDIVIDUAL HEALTH INSURANCE COVERAGE- Section 2762 of such Act (42 U.S.C. 300gg-62), as added by section 605(b)(3)(B) of Public Law 104-204, is amended--

(A) in subsection (a), by striking 'subsection (b), nothing in this part' and inserting 'subsections (b) and (c)', and

(B) by adding at the end the following new subsection:

'(c) SPECIAL RULES IN CASE OF PATIENT PROTECTION REQUIREMENTS- Subject to subsection (b), the provisions of section 2752 and part C, and part D insofar as it applies to section

2752 or part C, shall not be construed to preempt any State law, or the enactment or implementation of such a State law, that provides protections for individuals that are equivalent to or stricter than the protections provided under such provisions.'

(e) ADDITIONAL CONFORMING AMENDMENTS-

(1) Section 2723(a)(1) of such Act (42 U.S.C. 300gg-23(a)(1)) is amended by striking 'part C' and inserting 'parts C and D'.

(2) Section 2762(b)(1) of such Act (42 U.S.C. 300gg-62(b)(1)) is amended by striking 'part C' and inserting 'part D'.

(f) EFFECTIVE DATES- (1)(A) Subject to subparagraph (B), the amendments made by subsections (a), (b), (d)(1), and (e) shall apply with respect to group health insurance coverage for group health plan years beginning on or after July 1, 1998 (in this subsection referred to as the 'general effective date') and also shall apply to portions of plan years occurring on and after January 1, 1999.

(B) In the case of group health insurance coverage provided pursuant to a group health plan maintained pursuant to 1 or more collective bargaining agreements between employee representatives and 1 or more employers ratified before the date of enactment of this Act, the amendments made by subsections (a), (b), (d)(1), and (e) shall not apply to plan years beginning before the later of--

(i) the date on which the last collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after the date of enactment of this Act), or

(ii) the general effective date.

For purposes of clause (i), any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by subsection (a) or (b) shall not be treated as a termination of such collective bargaining agreement.

(2) The amendments made by subsections (a), (c), (d)(2), and (e) shall apply with respect to individual health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market on or after the general effective date.

SEC. 3. PATIENT PROTECTION STANDARDS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.

(a) IN GENERAL- Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended by adding at the end the following new section:

'SEC. 713. PATIENT PROTECTION STANDARDS.

'(a) IN GENERAL- Subject to subsection (b), a group health plan (and a health insurance issuer offering group health insurance coverage in connection with such a plan) shall comply with the requirements of part C of title XXVII of the Public Health Service Act.

'(b) REFERENCES IN APPLICATION- In applying subsection (a) under this part, any reference in such part C--

'(1) to a health insurance issuer and health insurance coverage offered by such an issuer is deemed to include a reference to a group health plan and coverage under such plan, respectively;

'(2) to the Secretary is deemed a reference to the Secretary of Labor;

'(3) to an applicable State authority is deemed a reference to the Secretary of Labor; and

'(4) to an enrollee with respect to health insurance coverage is deemed to include a reference to a participant or beneficiary with respect to a group health plan.

'(c) ASSURING COORDINATION- The Secretary of Health and Human Services and the Secretary of Labor shall ensure, through the execution of an interagency memorandum of understanding between such Secretaries, that--

'(1) regulations, rulings, and interpretations issued by such Secretaries relating to the same matter over which such Secretaries have responsibility under such part C (and section 2706 of the Public Health Service Act) and this section are administered so as to have the same effect at all times; and

'(2) coordination of policies relating to enforcing the same requirements through such Secretaries in order to have a coordinated enforcement strategy that avoids duplication of enforcement efforts and assigns priorities in enforcement.'

(b) MODIFICATION OF PREEMPTION STANDARDS- Section 731 of such Act (42 U.S.C. 1191) is amended--

(1) in subsection (a)(1), by striking 'subsection (b)' and inserting 'subsections (b) and (c)';

(2) by redesignating subsections (c) and (d) as subsections (d) and (e), respectively; and

(3) by inserting after subsection (b) the following new subsection:

'(c) SPECIAL RULES IN CASE OF PATIENT PROTECTION REQUIREMENTS- Subject to subsection (a)(2), the provisions of section 713 and part C of title XXVII of the Public Health Service Act, and subpart C insofar as it applies to section 713 or such part, shall not be construed to preempt any State law, or the enactment or implementation of such a State law, that provides protections for individuals that are equivalent to or stricter than the protections provided under such provisions.'

(c) CONFORMING AMENDMENTS- (1) Section 732(a) of such Act (29 U.S.C. 1185(a)) is amended by striking 'section 711' and inserting 'sections 711 and 713'.

(2) The table of contents in section 1 of such Act is amended by inserting after the item relating to section 712 the following new item:

'Sec. 713. Patient protection standards.'

(3) Section 734 of such Act (29 U.S.C. 1187) is amended by inserting 'and section 713(d)' after 'of 1996'.

(d) EFFECTIVE DATE- (1) Subject to paragraph (2), the amendments made by this section shall apply with respect to group health plans for plan years beginning on or after July 1, 1998 (in this subsection referred to as the 'general effective date') and also shall apply to portions of plan years occurring on and after January 1, 1999.

(2) In the case of a group health plan maintained pursuant to 1 or more collective bargaining agreements between employee representatives and 1 or more employers ratified before the date of enactment of this Act, the amendments made by this section shall not apply to plan years beginning before the later of--

(A) the date on which the last collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after the date of enactment of this Act), or

(B) the general effective date.

For purposes of subparagraph (A), any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by subsection (a) shall not be treated as a termination of such collective bargaining agreement.

SEC. 4. NON-PREEMPTION OF STATE LAW RESPECTING LIABILITY OF GROUP HEALTH PLANS.

(a) **IN GENERAL-** Section 514(b) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144(b)) is amended by redesignating paragraph (9) as paragraph (10) and inserting the following new paragraph:

'(9) Subsection (a) of this section shall not be construed to preclude any State cause of action to recover damages for personal injury or wrongful death against any person that provides insurance or administrative services to or for an employee welfare benefit plan maintained to provide health care benefits.'

(b) **EFFECTIVE DATE-** The amendment made by subsection (a) shall apply to causes of action arising on or after the date of the enactment of this Act.

END



STATE OF ALASKA

Department of Commerce and
Economic Development

DIVISION OF INSURANCE 59th ANNUAL REPORT

Health Insurance Pages Only

Calendar Year 1996 ◆ Fiscal Year 1997

1996 ALASKA HOSPITAL AND MEDICAL SERVICE CORPORATIONS (\$000)

PREMIUMS WRITTEN

INSURER	GROUP	NON- GROUP	MEDICARE	TOTAL
BLUE CROSS	134,651	13,032	891	148,573
ALASKA VISION	1,404	0	0	1,404

PREMIUMS EARNED

INSURER	GROUP	NON- GROUP	(Supp) MEDICARE	TOTAL
BLUE CROSS	133,564	12,884	879	147,327
ALASKA VISION	1,403	0	0	1,403

Basic One - Hospital

Traditional - Hospital + Physician

CLAIMS INCURRED

INSURER	ALL MEDICAL SURGICAL HOSPITAL	DENTAL	VISION	OTHER	TOTAL	NUMBER OF SUB- SCRIBERS*
BLUE CROSS	132,552	0	0	0	132,552	85,667
ALASKA VISION	0	0	1,033	0	1,033	8,077

*Numbers not rounded to the nearest thousand.

1996 ALASKA ACCIDENT & HEALTH MARKET SHARE

01 - GROUP (\$000)

COMPANY NAME	PERCENT OF MARKET	DIRECT PREMIUMS WRITTEN
AETNA LIFE INSURANCE CO	64.53	161,525
PRINCIPAL MUTUAL LIFE INS CO	7.73	19,340
EMPLOYERS HEALTH INS CO	3.53	8,838
GUARDIAN LIFE INS CO OF AMERICA	3.52	8,801
GREAT-WEST LIFE & ANNUITY INS CO	2.12	5,304
PRUDENTIAL INSURANCE CO OF AMERICA	1.83	4,569
UNITED OF OMAHA LIFE INS CO	1.81	4,522
NEW YORK LIFE INS CO	1.50	3,753
PFL LIFE INS CO	1.16	2,898
STANDARD INSURANCE CO	0.90	2,262
UNUM LIFE INS CO OF AMERICA	0.78	1,943
GOLDEN RULE INSURANCE CO	0.57	1,436
JC PENNEY LIFE INSURANCE CO	0.55	1,378
DELTA DENTAL INSURANCE COMPANY	0.51	1,285
PIONEER LIFE INSURANCE COMPANY	0.48	1,199
TRAVELERS INS CO (LIFE DEPT)	0.44	1,097
STATES WEST LIFE INS CO	0.41	1,017
FORTIS BENEFITS INSURANCE COMPANY	0.41	1,017
MEGA LIFE & HEALTH INS CO THE	0.39	984
CUNA MUTUAL INS SOCIETY	0.36	893
TOTAL FOR TOP 20 RANKED INSURERS	93.53	234,061
TOTAL FOR ALL 128 INSURERS WRITING THIS LINE	100.00	250,302

02 - CREDIT (\$000)

COMPANY NAME	PERCENT OF MARKET	DIRECT PREMIUMS WRITTEN
UNION FIDELITY LIFE INSURANCE CO	24.75	1,105
CUNA MUTUAL INS SOCIETY	20.99	937
AMERICAN BANKERS LIFE ASR CO OF FL	14.76	659
HERITAGE LIFE INS CO	11.24	502
SUNAMERICA LIFE INS CO	5.64	252
UNION SECURITY LIFE INS CO	5.51	246
AMERICAN HERITAGE LIFE INS CO	4.14	185
CENTURION LIFE INS CO	3.29	147
AMERICAN NATIONAL INSURANCE CO	2.40	107
PRUDENTIAL INSURANCE CO OF AMERICA	2.37	106
VISTA LIFE INS CO	1.63	73
USLIFE CREDIT LIFE INS CO	1.25	56
MINNESOTA MUTUAL LIFE INS CO	0.65	29
BALBOA LIFE INSURANCE CO	0.47	21
ALLSTATE LIFE INSURANCE CO	0.45	20
LIFE INVESTORS INS CO OF AMERICA	0.34	15
JC PENNEY LIFE INSURANCE CO	0.29	13
ASSOCIATES FINANCIAL LIFE INS CO	0.29	13
GENERAL FIDELITY LIFE INS CO	0.20	9
HOUSEHOLD LIFE INSURANCE CO	0.16	7
TOTAL FOR TOP 20 RANKED INSURERS	100.82	4,502
TOTAL FOR ALL 27 INSURERS WRITING THIS LINE	100.00	4,464

1996 ALASKA ACCIDENT & HEALTH MARKET SHARE

9 - ALL OTHER (\$000)

COMPANY NAME	DIRECT PERCENT OF MARKET	PREMIUMS WRITTEN
AMERICAN FAMILY LIFE ASR CO COLUMBUS	16.77	1,785
NEW YORK LIFE INS CO	10.45	1,112
PHYSICIANS MUTUAL INSURANCE CO	7.48	796
GOLDEN RULE INSURANCE CO	7.39	787
COLONIAL LIFE & ACCIDENT INS CO	5.98	636
MUTUAL OF OMAHA INS CO	5.82	619
PAUL REVERE LIFE INS CO	5.14	547
EQUITABLE LIFE ASR SOC OF THE US	4.53	482
UNUM LIFE INS CO OF AMERICA	4.25	452
MUTUAL LIFE INS CO OF NEW YORK	3.68	392
NORTHWESTERN MUTUAL LIFE INS CO	3.57	380
JOHN HANCOCK MUTUAL LIFE INS CO	2.14	228
MEDICO LIFE INS CO	1.55	165
MASSACHUSETTS CASUALTY INS CO	1.26	134
MASSACHUSETTS MUTUAL LIFE INS CO	1.11	118
AMERICAN TRAVELLERS LIFE INS CO	1.08	115
BANKERS LIFE & CASUALTY CO	1.01	107
LINCOLN NATIONAL LIFE INS CO	0.84	89
JC PENNEY LIFE INSURANCE CO	0.78	83
LONE STAR LIFE INS CO	0.73	78
TOTAL FOR TOP 20 RANKED INSURERS	85.56	8,832
TOTAL FOR ALL 126 INSURERS WRITING THIS LINE	100.00	10,652

10 - TOTAL (\$000)

COMPANY NAME	DIRECT PERCENT OF MARKET	PREMIUMS WRITTEN
AETNA LIFE INSURANCE CO	60.01	161,590
PRINCIPAL MUTUAL LIFE INS CO	7.20	19,392
GUARDIAN LIFE INS CO OF AMERICA	3.28	8,845
EMPLOYERS HEALTH INS CO	3.28	8,838
GREAT-WEST LIFE & ANNUITY INS CO	1.97	5,309
NEW YORK LIFE INS CO	1.81	4,865
PRUDENTIAL INSURANCE CO OF AMERICA	1.76	4,734
UNITED OF OMAHA LIFE INS CO	1.68	4,522
CONTINENTAL ASSURANCE CO	1.36	3,657
PFL LIFE INS CO	1.08	2,902
UNUM LIFE INS CO OF AMERICA	0.89	2,396
STANDARD INSURANCE CO	0.84	2,273
GOLDEN RULE INSURANCE CO	0.83	2,223
CUNA MUTUAL INS SOCIETY	0.68	1,830
AMERICAN FAMILY LIFE ASR CO COLUMBUS	0.66	1,787
JC PENNEY LIFE INSURANCE CO	0.55	1,474
UNION FIDELITY LIFE INSURANCE CO	0.50	1,357
DELTA DENTAL INSURANCE COMPANY	0.48	1,285
PIONEER LIFE INSURANCE COMPANY	0.47	1,263
TRAVELERS INS CO (LIFE DEPT)	0.43	1,168
TOTAL FOR TOP 20 RANKED INSURERS	89.76	241,710
TOTAL FOR ALL 196 INSURERS WRITING THIS LINE	100.00	269,271

1996 ALASKA ACCIDENT & HEALTH - LIFE INSURERS

GROUP - (\$000)

COMPANY NAME	DOM	DIRECT PREMIUMS WRITTEN	DIRECT PREMIUMS EARNED	DIVIDENDS PAID	DIRECT LOSSES PAID	DIRECT LOSSES INCURRED
AAA LIFE INSURANCE CO	DC	30	20	0	0	0
ACADEMY LIFE INSURANCE CO	MO	19	19	0	2	2
AETNA LIFE INSURANCE CO	CT	161,525	22,442	0	138,824	141,625
AIG LIFE INSURANCE CO	DE	582	631	0	275	294
ALEXANDER HAMILTON LIFE INS CO AMER	MI	0	0	0	0	0
ALL AMERICAN LIFE INS CO	IL	4	4	0	23	8
ALLIANZ LIFE INS CO OF NORTH AMER	MN	573	586	0	192	201
ALLSTATE LIFE INSURANCE CO	IL	443	446	0	62	60
AMERICAN BANKERS LIFE ASR CO OF FL	FL	66	66	0	7	-4
AMERICAN CHAMBERS LIFE INSURANCE CO	OH	289	289	0	119	112
AMERICAN FAMILY LIFE ASR CO COLUMBUS	GA	2	2	0	13	14
AMERICAN FIDELITY ASSURANCE CO	OK	162	209	0	16	40
AMERICAN INCOME LIFE INS CO	IN	5	5	0	2	1
AMERICAN INTERNATL LIFE ASR CO NY	NY	0	0	0	0	0
AMERICAN LIFE INS CO OF NEW YORK	NY	7	7	0	19	10
AMERICAN NATIONAL INSURANCE CO	TX	6	7	0	0	0
AMERICAN NATIONAL LIFE INS CO OF TX	TX	7	7	0	0	0
AMERICAN REPUBLIC INSURANCE CO	IA	1	1	0	0	0
AMERITAS LIFE INSURANCE CORP	NE	139	137	0	87	88
ANTHEM HEALTH & LIFE INSURANCE CO	IN	878	877	0	572	580
ANTHEM LIFE INSURANCE CO	TX	14	15	0	241	220
BALBOA LIFE INSURANCE CO	CA	0	0	0	0	0
BANKERS LIFE & CASUALTY CO	IL	4	4	0	1	1
BCS LIFE INSURANCE CO	IL	2	-4	0	2	-13
BENEFICIAL STANDARD LIFE INS CO	CA	8	8	0	0	0
BEST LIFE ASSURANCE CO OF CA	CA	386	386	0	0	0
BOSTON MUTUAL LIFE INS CO	MA	51	51	0	19	20
BUSINESS MENS ASSURANCE CO OF AMER	MO	0	0	0	7	18
CANADA LIFE ASSURANCE CO	MI	5	5	0	54	81
CAPITOL AMERICAN LIFE INS CO	AZ	86	86	0	5	5
CELTIC LIFE INS CO	IL	91	94	0	39	45
CENTENNIAL LIFE INS CO	KS	93	97	0	270	353
CHESAPEAKE LIFE INS CO	OK	0	0	0	0	0
CITICORP LIFE INSURANCE CO	AZ	32	32	0	1	1
COLONIAL LIFE & ACCIDENT INS CO	SC	31	30	0	43	42
COLONIAL PENN LIFE INS CO	PA	1	0	0	0	0
COMBINED INS CO OF AMERICA	IL	367	258	0	94	-26
COMMERCIAL TRAVELERS MUTUAL INS CO	NY	8	8	0	3	3
COMMUNITY NATIONAL ASSURANCE CO	OH	0	0	0	0	0
COMPANION LIFE INS CO	SC	21	21	0	7	7
CONNECTICUT GENERAL LIFE INS CO	CT	546	531	0	702	693
CONNECTICUT NATIONAL LIFE INS CO	IL	0	0	0	0	0
CONTINENTAL ASSURANCE CO	IL	8	9	0	225	6
CONTINENTAL LIFE & ACCIDENT COMPANY	IL	3	3	0	0	0
CUNA MUTUAL INS SOCIETY	WI	893	876	0	221	223
DELTA DENTAL INSURANCE COMPANY	IL	1,285	1,285	0	824	824
EBP LIFE INS CO	OK	187	188	0	39	40
EMPLOYERS HEALTH INS CO	WI	8,838	8,813	0	3,986	4,110
FAMILY LIFE INS CO	WA	0	0	0	0	0
FIDELITY SECURITY LIFE INS CO	MO	171	169	0	16	16

COMPANY NAME	DOM	DIRECT PREMIUMS WRITTEN	DIRECT PREMIUMS EARNED	DIVIDENDS PAID	DIRECT LOSSES PAID	DIRECT LOSSES INCURRED
FIRST ALLMERICA FIN LIFE INS CO	MA	285	280	0	158	174
FIRST NATIONAL LIFE INS CO	AL	1	1	0	1	1
FORTIS BENEFITS INSURANCE COMPANY	MN	1,017	1,026	0	834	841
FRANKLIN LIFE INS CO	IL	208	208	0	89	86
GENERAL AMERICAN LIFE INSURANCE CO	MO	14	14	0	3	3
GENERAL ELECTRIC CAPITAL ASR CO	DE	21	29	0	8	52
GERBER LIFE INSURANCE CO	NY	6	6	0	6	7
GOLDEN RULE INSURANCE CO	IL	1,436	1,432	0	926	933
GREAT SOUTHERN LIFE INS CO	TX	15	15	0	54	68
GREAT-WEST LIFE & ANNUITY INS CO	CO	5,304	5,089	0	1,539	1,434
GREAT-WEST LIFE ASSURANCE CO	MI	82	64	0	26	-10
GUARANTEE LIFE INSURANCE CO	NE	140	134	0	88	81
GUARANTEE RESERVE LIFE INS CO	IN	0	0	0	5	5
GUARDIAN LIFE INS CO OF AMERICA	NY	8,801	8,896	0	7,171	6,965
HARTFORD LIFE & ACCIDENT INS CO	CT	489	474	0	85	0
HARTFORD LIFE INS CO	CT	203	211	0	109	0
HERITAGE LIFE INS CO	AZ	4	4	0	0	0
HORACE MANN LIFE INS CO	IL	17	16	0	2	6
JC PENNEY LIFE INSURANCE CO	VT	1,378	1,361	0	342	378
JOHN ALDEN LIFE INS CO	MN	571	571	0	376	365
JOHN HANCOCK MUTUAL LIFE INS CO	MA	444	465	2	283	285
LAMAR LIFE INSURANCE CO	MS	11	11	0	8	9
LIBERTY LIFE INS CO	SC	4	4	0	0	0
LIBERTY NATIONAL LIFE INS CO	AL	0	0	0	0	0
LIFE INS CO OF NORTH AMERICA	PA	449	449	0	483	275
LIFE INVESTORS INS CO OF AMERICA	IA	144	143	0	61	52
LINCOLN NATIONAL LIFE INS CO	IN	108	114	0	53	55
LOYAL AMERICAN LIFE INS CO	AL	0	0	0	0	0
MANUFACTURERS LIFE INS CO	MI	14	14	0	0	0
MASSACHUSETTS MUTUAL LIFE INS CO	MA	17	17	0	63	60
MEGA LIFE & HEALTH INS CO THE	OK	984	944	0	460	520
MEMBERS LIFE INSURANCE COMPANY	WI	0	0	0	0	0
METROPOLITAN LIFE INS CO	NY	672	1,949	73	1,682	1,685
MIC LIFE INS CORP	DE	2	2	0	0	0
MIDWEST NATIONAL LIFE INS CO OF TN	TN	2	2	0	1	0
MINNESOTA MUTUAL LIFE INS CO	MN	643	629	0	201	160
MONTGOMERY WARD LIFE INS CO	IL	151	155	0	57	58
MONUMENTAL LIFE INS CO	MD	344	351	0	107	107
MUTUAL LIFE INS CO OF NEW YORK	NY	4	4	0	0	0
MUTUAL OF OMAHA INS CO	NE	435	439	0	311	334
NATIONAL BENEFIT LIFE INS CO	NY	5	5	0	3	3
NATIONAL HEALTH INS CO	TX	5	5	0	0	0
NATIONWIDE LIFE INS CO	OH	422	421	0	297	293
NEW YORK LIFE INS CO	NY	3,753	4,042	4	2,595	3,127
NORTH AMERICAN CO LIFE & HLTH INS	IL	0	0	0	0	0
OXFORD LIFE INS CO	AZ	2	2	0	3	3
PACIFIC LIFE INSURANCE CO	CA	7	7	0	0	0
PAUL REVERE LIFE INS CO	MA	55	56	0	71	100
PFL LIFE INS CO	IA	2,898	2,877	0	1,591	1,479
PHILADELPHIA AMERICAN LIFE INS CO	TX	8	8	0	2	2
PHOENIX AMERICAN LIFE INS CO	CT	10	10	0	1	1
PHOENIX HOME LIFE MUTUAL INS CO	NY	58	62	0	33	36
PHYSICIANS MUTUAL INSURANCE CO	NE	6	6	0	1	1
PIONEER LIFE INSURANCE COMPANY	IL	1,199	1,216	0	424	400
PM GROUP LIFE INSURANCE CO	AZ	217	218	0	27	27

COMPANY NAME	DOM	DIRECT PREMIUMS WRITTEN	DIRECT PREMIUMS EARNED	DIVIDENDS PAID	DIRECT LOSSES PAID	DIRECT LOSSES INCURRED
PRIMERICA LIFE INS CO	MA	9	10	0	0	1
PRINCIPAL MUTUAL LIFE INS CO	IA	19,340	18,315	572	13,605	13,395
PROTECTIVE LIFE INS CO	TN	-2	-2	0	0	0
PROVIDENT INDEMNITY LIFE INS CO	PA	37	37	0	4	34
PROVIDENT LIFE & ACCIDENT INS CO	TN	870	849	0	399	464
PROVIDENT LIFE & CASUALTY INS CO	TN	0	0	0	0	0
PROVIDENT MUTUAL LIFE INS CO	PA	6	6	0	0	-3
PROVIDIAN LIFE AND HEALTH INS CO	MO	40	40	0	6	6
PRUDENTIAL INSURANCE CO OF AMERICA	NJ	4,569	4,228	7	3,841	702
RELIANCE STANDARD LIFE INS CO	IL	32	32	0	44	57
RELIASTAR LIFE INSURANCE COMPANY	MN	285	274	0	245	241
ROYAL MACCABEES LIFE INS CO	MI	1	1	0	0	0
SAFECO LIFE INSURANCE CO	WA	445	444	0	719	671
SECURITY LIFE INS CO OF AMERICA	MN	34	34	0	30	29
SECURITY LIFE OF DENVER INS CO	CO	3	3	0	0	4
SENTRY LIFE INS CO	WI	186	214	0	92	115
STANDARD INSURANCE CO	OR	2,262	2,265	0	1,251	2,798
STANDARD SECURITY LIFE INS CO OF NY	NY	3	3	0	19	19
STATES WEST LIFE INS CO	WA	1,017	1,042	0	477	591
SUN LIFE ASR CO OF CANADA	MI	64	61	0	87	59
TMG LIFE INSURANCE COMPANY	ND	571	572	0	471	475
TRANSAMERICA OCCIDENTAL LIC	CA	110	496	0	25	3
TRANSPORT LIFE INS CO	TX	31	32	0	32	-89
TRAVELERS INS CO (LIFE DEPT)	CT	1,097	1,115	0	628	496
TRUSTMARK INS CO	IL	72	73	0	25	26
UNION FIDELITY LIFE INSURANCE CO	IL	241	245	0	36	47
UNION LABOR LIFE INS CO	MD	185	191	2	30	27
UNITED AMERICAN INS CO	DE	2	2	0	0	0
UNITED HEALTH & LIFE INS CO	MN	180	202	0	129	139
UNITED HEALTHCARE INSURANCE CO	CT	609	602	0	267	318
UNITED OF OMAHA LIFE INS CO	NE	4,522	4,438	0	1,668	1,332
UNITED STATES LIFE INS CO IN NYC	NY	268	268	0	28	31
UNITED WORLD LIFE INS CO	NE	56	55	0	34	33
UNUM LIFE INS CO OF AMERICA	ME	1,943	1,889	0	907	1,149
USAA LIFE INS CO	TX	87	87	0	20	12
VETERANS LIFE INS CO	IL	28	28	0	16	19
WASHINGTON NATIONAL INS CO	IL	160	160	0	35	35
TOTALS		250,302	111,497	660	192,813	193,427
142 COMPANIES						

1996 ALASKA ACCIDENT & HEALTH - LIFE INSURERS

ALL OTHER - (\$00C)

COMPANY NAME	DOM	DIRECT PREMIUMS WRITTEN	DIRECT PREMIUMS EARNED	DIVIDENDS PAID	DIRECT LOSSES PAID	DIRECT LOSSES INCURRED
AETNA LIFE INSURANCE CO	CT	65	66	0	27	25
AIG LIFE INSURANCE CO	DE	7	10	0	0	0
ALEXANDER HAMILTON LIFE INS CO AMER	MI	0	0	0	0	0
ALLIANZ LIFE INS CO OF NORTH AMER	MN	3	3	0	0	0
ALLMERICA FINANCIAL LIFE & ANNUITY	DE	5	5	0	0	0
ALLSTATE LIFE INSURANCE CO	IL	2	2	0	0	0
AMERICAN BANKERS LIFE ASR CO OF FL	FL	0	0	0	0	-5
AMERICAN FAMILY LIFE ASR CO COLUMBUS	GA	1,785	1,799	0	456	500
AMERICAN FIDELITY ASSURANCE CO	OK	38	28	0	1	-14
AMERICAN FRANKLIN LIFE INS CO	IL	1	1	0	0	1
AMERICAN HERITAGE LIFE INS CO	FL	18	18	0	20	20
AMERICAN INCOME LIFE INS CO	IN	55	56	0	22	13
AMERICAN MEMORIAL LIFE INSURANCE CO	SD	0	0	0	0	0
AMERICAN NATIONAL INSURANCE CO	TX	23	25	0	10	12
AMERICAN REPUBLIC INSURANCE CO	IA	13	13	0	4	5
AMERICAN STANDARD LIFE & ACC INS CO	OK	0	0	0	0	0
AMERICAN TRAVELLERS LIFE INS CO	PA	115	111	0	31	41
AMERICAN UNITED LIFE INS CO	IN	1	1	0	0	0
AMERUS LIFE INSURANCE COMPANY	IA	0	0	0	0	0
AUSA LIFE INSURANCE COMPANY INC	NY	1	1	0	0	0
BANKERS LIFE & CASUALTY CO	IL	107	105	0	67	67
BANKERS UNITED LIFE ASSURANCE CO	IA	4	4	0	2	2
BENEFICIAL STANDARD LIFE INS CO	CA	3	3	0	0	0
BERKSHIRE LIFE INS CO	MA	26	25	0	0	0
BUSINESS MENS ASSURANCE CO OF AMER	MO	33	32	0	5	20
CANADA LIFE ASSURANCE CO	MI	0	1	0	0	0
CAPITOL AMERICAN LIFE INS CO	AZ	16	16	0	2	3
CENTRAL SECURITY LIFE INS CO	TX	0	0	0	0	0
CENTRAL STATES H & L CO OF OMAHA	NE	40	42	0	14	16
CERTIFIED LIFE INS CO	IL	1	1	0	3	2
CHUBB LIFE INS CO OF AMERICA	NH	14	14	0	18	17
CINCINNATI LIFE INS CO	OH	0	0	0	0	0
COLONIAL LIFE & ACCIDENT INS CO	SC	636	636	0	181	196
COLONIAL PENN LIFE INS CO	PA	7	7	0	1	1
COMBINED INS CO OF AMERICA	IL	78	59	0	6	-15
COMMERCIAL TRAVELERS MUTUAL INS CO	NY	0	1	0	6	6
COMMONWEALTH LIFE INS CO	KY	3	4	0	0	0
CONNECTICUT GENERAL LIFE INS CO	CT	1	1	0	0	0
CONNECTICUT NATIONAL LIFE INS CO	IL	1	1	0	0	0
CONTINENTAL GENERAL INS CO	NE	34	33	0	11	11
CONTINENTAL LIFE INS CO	TX	0	0	0	0	-1
CONTINENTAL WESTERN LIFE INS CO	IA	0	0	0	0	0
COUNTRY LIFE INSURANCE CO	IL	30	30	0	2	2
CROWN LIFE INS CO	MI	18	12	0	0	0
CUNA MUTUAL LIFE INS CO	IA	6	5	0	0	1
EQUITABLE LIFE & CASUALTY INS CO	UT	10	10	0	7	3
EQUITABLE LIFE ASR SOC OF THE US	NY	482	491	0	3,792	3,922
EQUITABLE LIFE INS CO OF IOWA	IA	0	0	0	0	0
FAMILY LIFE INS CO	WA	0	0	0	0	0
FEDERAL LIFE INS CO (MUTUAL)	IL	0	0	0	0	0
FIRST ALLMERICA FIN LIFE INS CO	MA	2	2	0	0	0

COMPANY NAME	DOM	DIRECT PREMIUMS WRITTEN	DIRECT PREMIUMS EARNED	DIVIDENDS PAID	DIRECT LOSSES PAID	DIRECT LOSSES INCURRED
FIRST COLONY LIFE INS CO	VA	0	0	0	0	0
FIRST NATIONAL LIFE INS CO	AL	7	10	0	4	4
FRANKLIN LIFE INS CO	IL	6	5	0	5	0
GENERAL AMERICAN LIFE INSURANCE CO	MO	22	22	0	14	12
GENERAL ELECTRIC CAPITAL ASR CO	DE	21	24	0	16	36
GERBER LIFE INSURANCE CO	NY	1	1	0	0	0
GLOBE LIFE & ACCIDENT INS CO	DE	12	12	0	3	2
GOLDEN RULE INSURANCE CO	IL	787	797	0	325	322
GREAT AMERICAN RESERVE INS CO	TX	4	3	0	2	-1
GREAT-WEST LIFE & ANNUITY INS CO	CO	5	5	0	0	0
GREAT-WEST LIFE ASSURANCE CO	MI	-80	-74	0	0	0
GUARANTEE LIFE INSURANCE CO	NE	5	5	0	0	0
GUARANTEE RESERVE LIFE INS CO	IN	1	1	0	0	0
GUARANTEE TRUST LIFE INS CO	IL	0	0	0	39	2
GUARDIAN LIFE INS CO OF AMERICA	NY	44	37	0	0	1
HARTFORD LIFE & ACCIDENT INS CO	CT	-2	0	0	0	0
HARTFORD LIFE INS CO	CT	-1	0	0	0	0
HORACE MANN LIFE INS CO	IL	1	1	0	0	0
IDS LIFE INSURANCE CO	MN	46	46	0	169	275
INDIVIDUAL ASR CO LIFE HEALTH&ACCID	MO	1	1	0	1	1
INTERCONTINENTAL LIFE INS CO	NJ	0	0	0	0	0
INVESTORS LIFE INS CO NORTH AMERICA	WA	1	1	0	2	1
ITT HARTFORD LIFE & ANNUITY INS CO	CT	1	1	0	6	4
JC PENNEY LIFE INSURANCE CO	VT	83	83	0	8	5
JEFFERSON-PILOT LIFE INS CO	NC	8	8	0	0	0
JOHN ALDEN LIFE INS CO	MN	1	1	0	0	0
JOHN HANCOCK MUTUAL LIFE INS CO	MA	228	222	0	20	25
LIBERTY LIFE INS CO	SC	2	2	0	0	0
LIBERTY NATIONAL LIFE INS CO	AL	6	6	0	4	4
LIFE INS CO OF NORTH AMERICA	PA	0	0	0	4	4
LIFE INS CO OF THE SOUTHWEST	TX	0	0	0	0	0
LIFE INVESTORS INS CO OF AMERICA	IA	17	16	0	8	7
LINCOLN NATIONAL LIFE INS CO	IN	89	92	0	26	256
LONE STAR LIFE INS CO	TX	78	80	0	44	37
LOYAL AMERICAN LIFE INS CO	AL	4	4	0	0	0
MADISON NATIONAL LIFE INS CO INC	WI	1	0	0	0	0
MANUFACTURERS LIFE INS CO	MI	0	0	0	0	0
MASSACHUSETTS CASUALTY INS CO	MA	134	138	0	2	-31
MASSACHUSETTS GENERAL LIFE INS CO	MA	1	1	0	0	0
MASSACHUSETTS MUTUAL LIFE INS CO	MA	118	119	5	19	18
MBL LIFE ASSURANCE CORP	NJ	30	36	0	78	103
MEDICO LIFE INS CO	NE	165	172	0	96	93
MEGA LIFE & HEALTH INS CO THE	OK	0	0	0	0	0
METROPOLITAN LIFE INS CO	NY	41	39	0	8	-150
MIDLAND NATIONAL LIFE INS CO	SD	0	0	0	0	0
MINNESOTA MUTUAL LIFE INS CO	MN	47	40	0	28	37
MONARCH LIFE INS CO	MA	33	34	0	8	1
MONUMENTAL LIFE INS CO	MD	12	11	0	3	3
MUTUAL LIFE INS CO OF NEW YORK	NY	392	404	4	129	-869
MUTUAL OF OMAHA INS CO	NE	619	632	0	553	592
NATIONAL BENEFIT LIFE INS CO	NY	0	0	0	0	0
NATIONAL FOUNDATION LIFE INS CO	DE	8	9	0	5	6
NATIONAL GUARDIAN LIFE INS CO	WI	1	2	0	0	0
NATIONAL HEALTH INS CO	TX	1	1	0	0	0
NATIONAL LIFE INS CO	VT	19	20	0	0	0
NATIONAL TRAVELERS LIFE CO	IA	2	2	0	0	0

COMPANY NAME	DOM	DIRECT PREMIUMS WRITTEN	DIRECT PREMIUMS EARNED	DIVIDENDS PAID	DIRECT LOSSES PAID	DIRECT LOSSES INCURRED
NATIONWIDE LIFE INS CO	OH	2	0	0	0	0
NETWORK AMERICA LIFE INS CO	PA	12	11	0	0	0
NEW YORK LIFE INS CO	NY	1,112	1,161	0	338	479
NORTH AMERICAN CO LIFE & HLTH INS	IL	0	0	0	0	0
NORTHERN LIFE INS CO	WA	0	1	0	0	0
NORTHWESTERN MUTUAL LIFE INS CO	WI	380	336	12	191	270
OCCIDENTAL LIFE INS CO OF NC	NC	4	4	0	0	0
OLD REPUBLIC LIFE INS CO	IL	6	6	0	0	0
PACIFIC GUARDIAN LIFE INS CO LTD	HI	0	0	0	0	0
PAUL REVERE LIFE INS CO	MA	547	559	0	101	255
PENN MUTUAL LIFE INS CO	PA	15	14	0	0	0
PENNSYLVANIA LIFE INS CO	PA	2	2	0	3	4
PFL LIFE INS CO	IA	4	4	0	6	6
PHOENIX HOME LIFE MUTUAL INS CO	NY	1	1	0	0	1
PHYSICIANS MUTUAL INSURANCE CO	NE	796	793	0	299	298
PIERCE NATIONAL LIFE INS CO	CA	0	0	0	0	0
PIONEER LIFE INSURANCE COMPANY	IL	63	62	0	46	46
PRESIDENTIAL LIFE INSURANCE CO	NY	0	0	0	0	0
PRIMERICA LIFE INS CO	MA	1	1	0	0	0
PRINCIPAL MUTUAL LIFE INS CO	IA	52	48	0	34	48
PROTECTIVE LIFE INS CO	TN	13	12	0	24	25
PROVIDENT LIFE & ACCIDENT INS CO	TN	31	30	0	29	27
PROVIDIAN LIFE AND HEALTH INS CO	MO	24	24	0	18	19
PRUDENTIAL INSURANCE CO OF AMERICA	NJ	59	62	0	27	33
RELIABLE LIFE INSURANCE CO	MO	0	0	0	0	0
RELIANCE STANDARD LIFE INS CO	IL	0	0	0	0	0
RELIASTAR LIFE INSURANCE COMPANY	MN	2	2	0	0	0
ROYAL MACCABEES LIFE INS CO	MI	44	46	0	0	-3
SECURITY LIFE INS CO OF AMERICA	MN	1	1	0	0	0
SECURITY NATIONAL LIFE INSURANCE CO	UT	0	0	0	0	0
SOUTHLAND LIFE INS CO	TX	0	0	0	0	0
STANDARD INSURANCE CO	OR	11	10	0	9	2
STANDARD LIFE & ACCIDENT INS CO	OK	31	30	0	16	15
SUNSET LIFE INS CO OF AMERICA	WA	1	1	0	3	3
TRANSAMERICA OCCIDENTAL LIC	CA	33	36	0	4	14
TRANSPORT LIFE INS CO	TX	12	12	0	0	-1
TRAVELERS INS CO (LIFE DEPT)	CT	71	83	0	34	21
TRUSTMARK INS CO	IL	22	21	0	15	18
UNION BANKERS INS CO	TX	8	8	0	7	7
UNION CENTRAL LIFE INS CO	OH	8	8	0	0	0
UNION FIDELITY LIFE INSURANCE CO	IL	11	11	0	1	2
UNION LABOR LIFE INS CO	MD	7	7	0	11	12
UNITED AMERICAN INS CO	DE	16	16	0	18	18
UNITED LIFE & ANNUITY INS CO	LA	0	0	0	0	0
UNITED OF OMAHA LIFE INS CO	NE	0	0	0	0	0
UNITED TEACHER ASSOCIATES INS CO	TX	1	1	0	0	0
UNIVERSE LIFE INS CO	ID	2	3	0	0	0
UNUM LIFE INS CO OF AMERICA	ME	452	397	0	60	91
USAA LIFE INS CO	TX	69	68	0	16	7
VALLEY FORGE LIFE INS CO	PA	1	1	0	0	0
VETERANS LIFE INS CO	IL	7	7	0	0	0
WABASH LIFE INS CO	KY	1	1	0	0	0
WASHINGTON NATIONAL INS CO	IL	2	2	0	3	2

TOTALS		10,652	10,712	21	7,627	7,373
160 COMPANIES						

1996 ALASKA ACCIDENT & HEALTH - LIFE INSURERS

TOTALS - (\$000)

COMPANY NAME	DOM	DIRECT PREMIUMS WRITTEN	DIRECT PREMIUMS EARNED	DIVIDENDS PAID	DIRECT LOSSES PAID	DIRECT LOSSES INCURRED
AAA LIFE INSURANCE CO	DC	30	20	0	0	0
ACADEMY LIFE INSURANCE CO	MO	19	19	0	2	2
AETNA LIFE INSURANCE CO	CT	161,590	22,509	0	138,851	141,650
AIG LIFE INSURANCE CO	DE	590	642	0	275	294
ALEXANDER HAMILTON LIFE INS CO AMER	MI	1	1	0	0	0
ALL AMERICAN LIFE INS CO	IL	4	4	0	23	8
ALLIANZ LIFE INS CO OF NORTH AMER	MN	577	589	0	192	201
ALLMERICA FINANCIAL LIFE & ANNUITY	DE	5	5	0	0	0
ALLSTATE LIFE INSURANCE CO	IL	465	467	0	75	68
AMERICAN BANKERS LIFE ASR CO OF FL	FL	726	727	0	158	139
AMERICAN CHAMBERS LIFE INSURANCE CO	OH	289	289	0	119	112
AMERICAN FAMILY LIFE ASR CO COLUMBUS	GA	1,787	1,802	0	469	514
AMERICAN FIDELITY ASSURANCE CO	OK	200	237	0	17	27
AMERICAN FRANKLIN LIFE INS CO	IL	1	1	0	0	1
AMERICAN HERITAGE LIFE INS CO	FL	203	212	0	85	47
AMERICAN INCOME LIFE INS CO	IN	60	60	0	24	14
AMERICAN INTERNATL LIFE ASR CO NY	NY	0	0	0	0	0
AMERICAN LIFE INS CO OF NEW YORK	NY	7	7	0	10	10
AMERICAN MEMORIAL LIFE INSURANCE CO	SD	0	0	0	0	0
AMERICAN NATIONAL INSURANCE CO	TX	136	51	0	10	24
AMERICAN NATIONAL LIFE INS CO OF TX	TX	7	7	0	0	0
AMERICAN REPUBLIC INSURANCE CO	IA	14	14	0	4	5
AMERICAN STANDARD LIFE & ACC INS CO	OK	0	0	0	0	0
AMERICAN TRAVELLERS LIFE INS CO	PA	115	111	0	31	41
AMERICAN UNITED LIFE INS CO	IN	1	1	0	0	0
AMERITAS LIFE INSURANCE CORP	NE	139	137	0	87	88
AMERUS LIFE INSURANCE COMPANY	IA	0	0	0	0	0
ANTHEM HEALTH & LIFE INSURANCE CO	IN	878	877	0	572	580
ANTHEM LIFE INSURANCE CO	TX	14	15	0	241	220
ASSOCIATES FINANCIAL LIFE INS CO	TN	13	13	0	2	-1
AUSA LIFE INSURANCE COMPANY INC	NY	1	1	0	0	0
BALBOA LIFE INSURANCE CO	CA	21	25	0	8	9
BANKERS LIFE & CASUALTY CO	IL	146	145	0	79	78
BANKERS UNITED LIFE ASSURANCE CO	IA	4	4	0	2	2
BCS LIFE INSURANCE CO	IL	2	-4	0	2	-13
BENEFICIAL STANDARD LIFE INS CO	CA	12	12	0	0	0
BERKSHIRE LIFE INS CO	MA	26	25	0	0	0
BEST LIFE ASSURANCE CO OF CA	CA	386	386	0	0	0
BOSTON MUTUAL LIFE INS CO	MA	51	51	0	19	20
BUSINESS MENS ASSURANCE CO OF AMER	MO	34	33	0	13	38
CANADA LIFE ASSURANCE CO	MI	6	6	0	54	81
CAPITOL AMERICAN LIFE INS CO	AZ	102	103	0	8	8
CELTIC LIFE INS CO	IL	91	94	0	39	45
CENTENNIAL LIFE INS CO	KS	93	97	0	270	353
CENTRAL SECURITY LIFE INS CO	TX	0	0	0	0	0
CENTRAL STATES H & L CO OF OMAHA	NE	42	43	0	14	19
CENTURION LIFE INS CO	MO	147	147	0	49	58
CERTIFIED LIFE INS CO	IL	24	24	0	85	75
CHESAPEAKE LIFE INS CO	OK	0	0	0	0	0
CHUBB LIFE INS CO OF AMERICA	NH	14	14	0	21	20
CINCINNATI LIFE INS CO	OH	0	0	0	0	0

COMPANY NAME	DOM	DIRECT PREMIUMS WRITTEN	DIRECT PREMIUMS EARNED	DIVIDENDS PAID	DIRECT LOSSES PAID	DIRECT LOSSES INCURRED
CITICORP LIFE INSURANCE CO	AZ	32	32	0	1	1
COLONIAL LIFE & ACCIDENT INS CO	SC	667	667	0	224	238
COLONIAL PENN LIFE INS CO	PA	8	8	0	1	1
COMBINED INS CO OF AMERICA	IL	445	317	0	101	-40
COMMERCIAL TRAVELERS MUTUAL INS CO	NY	9	9	0	9	9
COMMONWEALTH LIFE INS CO	KY	3	4	0	94	63
COMMUNITY NATIONAL ASSURANCE CO	OH	0	0	0	0	0
COMPANION LIFE INS CO	SC	36	35	0	10	10
CONNECTICUT GENERAL LIFE INS CO	CT	546	532	0	702	693
CONNECTICUT NATIONAL LIFE INS CO	IL	1	1	0	0	0
CONTINENTAL ASSURANCE CO	IL	3,657	3,658	0	4,385	3,461
CONTINENTAL GENERAL INS CO	NE	34	33	0	11	11
CONTINENTAL LIFE & ACCIDENT COMPANY	IL	3	3	0	0	0
CONTINENTAL LIFE INS CO	TX	0	0	0	0	-1
CONTINENTAL WESTERN LIFE INS CO	IA	0	0	0	0	0
COUNTRY LIFE INSURANCE CO	IL	30	30	0	2	2
CROWN LIFE INS CO	MI	18	12	0	0	1
CUNA MUTUAL INS SOCIETY	WI	1,830	1,869	0	651	730
CUNA MUTUAL LIFE INS CO	IA	6	5	0	0	1
DELTA DENTAL INSURANCE COMPANY	IL	1,285	1,285	0	824	824
EBP LIFE INS CO	OK	187	188	0	39	40
EMPLOYERS HEALTH INS CO	WI	8,838	8,813	0	3,986	4,110
EQUITABLE LIFE & CASUALTY INS CO	UT	10	10	0	7	3
EQUITABLE LIFE ASR SOC OF THE US	NY	482	491	0	3,792	3,922
EQUITABLE LIFE INS CO OF IOWA	IA	0	0	0	0	0
FAMILY LIFE INS CO	WA	0	0	0	0	0
FEDERAL HOME LIFE INS CO	IN	-13	34	0	16	14
FEDERAL LIFE INS CO (MUTUAL)	IL	0	0	0	0	0
FIDELITY SECURITY LIFE INS CO	MO	171	169	0	16	16
FIRST ALLMERICA FIN LIFE INS CO	MA	287	282	0	158	174
FIRST COLONY LIFE INS CO	VA	0	0	0	0	0
FIRST NATIONAL LIFE INS CO	AL	8	11	0	5	4
FORTIS BENEFITS INSURANCE COMPANY	MN	1,017	1,026	0	834	841
FRANKLIN LIFE INS CO	IL	213	213	0	94	86
FREMONT LIFE INSURANCE COMPANY	CA	-3	60	0	26	-2
GENERAL AMERICAN LIFE INSURANCE CO	MO	36	35	0	17	15
GENERAL ELECTRIC CAPITAL ASR CO	DE	43	53	0	23	88
GENERAL FIDELITY LIFE INS CO	CA	9	8	0	0	0
GERBER LIFE INSURANCE CO	NY	8	8	0	6	7
GLOBE LIFE & ACCIDENT INS CO	DE	12	12	0	3	2
GOLDEN RULE INSURANCE CO	IL	2,223	2,229	0	1,251	1,255
GREAT AMERICAN RESERVE INS CO	TX	1	1	0	3	0
GREAT SOUTHERN LIFE INS CO	TX	15	15	0	54	68
GREAT-WEST LIFE & ANNUITY INS CO	CO	5,309	5,094	0	1,539	1,434
GREAT-WEST LIFE ASSURANCE CO	MI	3	-10	0	26	-10
GUARANTEE LIFE INSURANCE CO	NE	145	140	0	88	81
GUARANTEE RESERVE LIFE INS CO	IN	1	2	0	5	5
GUARANTEE TRUST LIFE INS CO	IL	0	0	0	39	2
GUARDIAN LIFE INS CO OF AMERICA	NY	8,845	8,933	0	7,171	6,965
HARTFORD LIFE & ACCIDENT INS CO	CT	487	474	0	85	0
HARTFORD LIFE INS CO	CT	202	211	0	109	0
HERITAGE LIFE INS CO	AZ	505	351	0	79	112
HORACE MANN LIFE INS CO	IL	18	18	0	2	6
HOUSEHOLD LIFE INSURANCE CO	MI	7	8	0	2	7
IDS LIFE INSURANCE CO	MN	46	46	0	168	275
INDIVIDUAL ASR CO LIFE HEALTH&ACCID	MO	1	1	0	1	1

COMPANY NAME	DOM	DIRECT PREMIUMS WRITTEN	DIRECT PREMIUMS EARNED	DIVIDENDS PAID	DIRECT LOSSES PAID	DIRECT LOSSES INCURRED
INTERCONTINENTAL LIFE INS CO	NJ	0	0	0	0	0
INVESTORS LIFE INS CO NORTH AMERICA	WA	1	1	0	2	1
ITT HARTFORD LIFE & ANNUITY INS CO	CT	1	1	0	6	4
JC PENNEY LIFE INSURANCE CO	VT	1,474	1,456	0	351	386
JEFFERSON-PILOT LIFE INS CO	NC	8	8	0	250	415
JOHN ALDEN LIFE INS CO	MN	572	572	0	376	365
JOHN HANCOCK MUTUAL LIFE INS CO	MA	671	687	2	304	310
LAMAR LIFE INSURANCE CO	MS	11	11	0	8	9
LIBERTY LIFE INS CO	SC	6	6	0	0	0
LIBERTY NATIONAL LIFE INS CO	AL	6	6	0	4	4
LIFE INS CO OF NORTH AMERICA	PA	454	454	0	487	280
LIFE INS CO OF THE SOUTHWEST	TX	0	0	0	0	0
LIFE INVESTORS INS CO OF AMERICA	IA	176	165	0	73	60
LINCOLN NATIONAL LIFE INS CO	IN	198	207	0	79	311
LONE STAR LIFE INS CO	TX	78	80	0	44	37
LOYAL AMERICAN LIFE INS CO	AL	4	4	0	0	0
MADISON NATIONAL LIFE INS CO INC	WI	1	0	0	0	0
MANUFACTURERS LIFE INS CO	MI	14	14	0	0	0
MASSACHUSETTS CASUALTY INS CO	MA	134	138	0	2	-31
MASSACHUSETTS GENERAL LIFE INS CO	MA	1	0	0	0	0
MASSACHUSETTS MUTUAL LIFE INS CO	MA	136	136	5	83	77
MBL LIFE ASSURANCE CORP	NJ	30	36	0	78	103
MEDICO LIFE INS CO	NE	165	172	0	96	93
MEGA LIFE & HEALTH INS CO THE	OK	989	951	0	460	520
MEMBERS LIFE INSURANCE COMPANY	WI	0	0	0	34	3
METROPOLITAN LIFE INS CO	NY	713	1,988	73	1,689	1,535
MIC LIFE INS CORP	DE	-27	312	0	93	134
MIDLAND NATIONAL LIFE INS CO	SD	0	0	0	0	0
MIDWEST NATIONAL LIFE INS CO OF TN	TN	2	2	0	1	0
MINNESOTA MUTUAL LIFE INS CO	MN	719	669	0	267	202
MONARCH LIFE INS CO	MA	33	34	0	8	1
MONTGOMERY WARD LIFE INS CO	IL	154	156	0	57	58
MONUMENTAL LIFE INS CO	MD	355	362	0	110	110
MUTUAL LIFE INS CO OF NEW YORK	NY	396	409	4	129	-869
MUTUAL OF OMAHA INS CO	NE	1,158	1,181	0	914	973
NATIONAL BENEFIT LIFE INS CO	NY	5	5	0	3	3
NATIONAL FOUNDATION LIFE INS CO	DE	8	9	0	5	6
NATIONAL GUARDIAN LIFE INS CO	WI	1	2	0	0	0
NATIONAL HEALTH INS CO	TX	6	6	0	0	0
NATIONAL LIFE INS CO	VT	19	20	0	0	0
NATIONAL TRAVELERS LIFE CO	IA	2	2	0	0	0
NATIONWIDE LIFE INS CO	OH	424	421	0	297	294
NETWORK AMERICA LIFE INS CO	PA	12	11	0	0	0
NEW YORK LIFE INS CO	NY	4,865	5,203	4	2,932	3,606
NORTH AMERICAN CO LIFE & HLTH INS	IL	1	1	0	0	0
NORTH CENTRAL LIFE INS CO	MN	0	5	0	0	-1
NORTHERN LIFE INS CO	WA	0	1	0	0	0
NORTHWESTERN MUTUAL LIFE INS CO	WI	380	396	12	191	270
OCCIDENTAL LIFE INS CO OF NC	NC	4	4	0	0	0
OLD REPUBLIC LIFE INS CO	IL	6	6	0	0	0
OXFORD LIFE INS CO	AZ	2	2	0	3	3
PACIFIC GUARDIAN LIFE INS CO LTD	HI	0	0	0	0	0
PACIFIC LIFE INSURANCE CO	CA	7	7	0	0	0
PAUL REVERE LIFE INS CO	MA	603	615	0	172	355
PENN MUTUAL LIFE INS CO	PA	15	14	0	0	0
PENNSYLVANIA LIFE INS CO	PA	2	2	0	3	4

COMPANY NAME	DOM	DIRECT PREMIUMS WRITTEN	DIRECT PREMIUMS EARNED	DIVIDENDS PAID	DIRECT LOSSES PAID	DIRECT LOSSES INCURRED
PFL LIFE INS CO	IA	2,902	2,881	0	1,597	1,485
PHILADELPHIA AMERICAN LIFE INS CO	TX	8	8	0	2	2
PHOENIX AMERICAN LIFE INS CO	CT	10	10	0	1	1
PHOENIX HOME LIFE MUTUAL INS CO	NY	60	63	0	33	36
PHYSICIANS MUTUAL INSURANCE CO	NE	802	799	0	300	298
PIERCE NATIONAL LIFE INS CO	CA	0	0	0	0	0
PIONEER LIFE INSURANCE COMPANY	IL	1,263	1,278	0	470	446
PM GROUP LIFE INSURANCE CO	AZ	217	218	0	27	27
PRESIDENTIAL LIFE INSURANCE CO	NY	0	0	0	0	0
PRIMERICA LIFE INS CO	MA	11	12	0	0	1
PRINCIPAL MUTUAL LIFE INS CO	IA	19,392	18,363	572	13,639	13,443
PROTECTIVE LIFE INS CO	TN	11	10	0	24	25
PROVIDENT INDEMNITY LIFE INS CO	PA	37	37	0	4	34
PROVIDENT LIFE & ACCIDENT INS CO	TN	901	878	0	428	491
PROVIDENT LIFE & CASUALTY INS CO	TN	0	0	0	0	0
PROVIDENT MUTUAL LIFE INS CO	PA	6	6	0	0	-3
PROVIDIAN LIFE AND HEALTH INS CO	MO	64	64	0	24	25
PRUDENTIAL INSURANCE CO OF AMERICA	NJ	4,734	4,586	7	3,885	753
RELIABLE LIFE INSURANCE CO	MO	0	0	0	0	0
RELIANCE STANDARD LIFE INS CO	IL	32	32	0	44	57
RELIASTAR LIFE INSURANCE COMPANY	MN	288	276	0	245	241
ROYAL MACCABEES LIFE INS CO	MI	45	47	0	0	-3
SAFECO LIFE INSURANCE CO	WA	445	444	0	719	671
SECURITY LIFE INS CO OF AMERICA	MN	35	35	0	30	29
SECURITY LIFE OF DENVER INS CO	CO	3	3	0	0	4
SECURITY NATIONAL LIFE INSURANCE CO	UT	0	0	0	0	0
SENTRY LIFE INS CO	WI	186	214	0	92	115
SOUTHLAND LIFE INS CO	TX	0	0	0	0	0
STANDARD INSURANCE CO	OR	2,273	2,274	0	1,260	2,800
STANDARD LIFE & ACCIDENT INS CO	OK	31	31	0	16	15
STANDARD SECURITY LIFE INS CO OF NY	NY	3	3	0	19	19
STATES WEST LIFE INS CO	WA	1,017	1,042	0	477	591
SUN LIFE ASR CO OF CANADA	MI	64	61	0	87	90
SUNAMERICA LIFE INS CO	AZ	252	0	0	106	0
SUNSET LIFE INS CO OF AMERICA	WA	1	1	0	3	3
TMG LIFE INSURANCE COMPANY	ND	571	572	0	471	475
TRANSAMERICA OCCIDENTAL LIC	CA	143	532	0	25	17
TRANSPORT LIFE INS CO	TX	43	43	0	32	-90
TRAVELERS INS CO (LIFE DEPT)	CT	1,168	1,197	0	661	516
TRUSTMARK INS CO	IL	94	93	0	40	44
UNION BANKERS INS CO	TX	25	25	0	13	12
UNION CENTRAL LIFE INS CO	OH	8	8	0	0	0
UNION FIDELITY LIFE INSURANCE CO	IL	1,357	964	0	184	209
UNION LABOR LIFE INS CO	MD	191	198	2	41	38
UNION SECURITY LIFE INS CO	DE	246	158	0	20	28
UNITED AMERICAN INS CO	DE	18	18	0	19	19
UNITED FIDELITY LIFE INS CO	TX	0	0	0	0	0
UNITED HEALTH & LIFE INS CO	MN	180	202	0	129	139
UNITED HEALTHCARE INSURANCE CO	CT	609	602	0	267	318
UNITED LIFE & ANNUITY INS CO	LA	0	0	0	0	0
UNITED OF OMAHA LIFE INS CO	NE	4,522	4,438	0	1,668	1,332
UNITED STATES LIFE INS CO IN NYC	NY	268	268	0	59	65
UNITED TEACHER ASSOCIATES INS CO	TX	1	1	0	0	0
UNITED WORLD LIFE INS CO	NE	56	55	0	34	33
UNIVERSE LIFE INS CO	ID	2	3	0	0	0
UNUM LIFE INS CO OF AMERICA	ME	2,396	2,286	0	967	1,239

COMPANY NAME	DOM	DIRECT PREMIUMS WRITTEN	DIRECT PREMIUMS EARNED	DIVIDENDS PAID	DIRECT LOSSES PAID	DIRECT LOSSES INCURRED
USAA LIFE INS CO	TX	156	156	0	35	20
USLIFE CREDIT LIFE INS CO	IL	56	56	0	5	20
VALLEY FORGE LIFE INS CO	PA	1	1	0	0	0
VETERANS LIFE INS CO	IL	35	35	0	16	19
VISTA LIFE INS CO	MI	73	117	0	33	20
WABASH LIFE INS CO	KY	1	1	0	0	0
WASHINGTON NATIONAL INS CO	IL	164	163	0	39	40
TOTALS		269,271	130,274	681	206,476	206,203
226 COMPANIES						

1996 ALASKA PROPERTY AND CASUALTY MARKET SHARE

13 - GROUP ACCIDENT AND HEALTH (\$000)

COMPANY NAME	PERCENT OF MARKET	DIRECT PREMIUMS WRITTEN
CONTINENTAL CASUALTY CO	31.31	1,034
STATE FARM MUTUAL AUTOMOBILE INS CO	24.56	811
HARTFORD FIRE INS CO	14.51	479
AMERICAN BANKERS INS CO OF FL	9.57	316
AMEX ASSURANCE COMPANY	6.94	229
INSURANCE CO OF NORTH AMERICA	4.12	136
CONTINENTAL INS CO	3.48	115
NATIONAL CASUALTY CO	2.91	96
AMERICAN CASUALTY CO OF READING	1.03	34
ZURICH INS CO US BRANCH	0.79	26
BCS INSURANCE CO	0.30	10
EMPLOYERS INS OF WAUSAU A MUTUAL CO	0.27	9
SENTRY INS A MUTUAL CO	0.27	9
COLONIAL PENN FRANKLIN INS CO	0.27	9
TRAVELERS INDEMNITY CO OF CT	0.15	5
INSURANCE CO OF THE STATE OF PA	0.09	3
FEDERAL INS CO	0.06	2
GOVERNMENT EMPLOYEES INS CO	0.06	2
OLD REPUBLIC INS CO	0.03	1
TRAVELERS INDEMNITY CO	0.18	-6
TOTAL FOR TOP 20 RANKED INSURERS	100.55	3,320
TOTAL FOR ALL 21 INSURERS WRITING THIS LINE	100.00	3,302

14 - CREDIT ACCIDENT AND HEALTH: GROUP AND INDIVIDUAL (\$000)

COMPANY NAME	PERCENT OF MARKET	DIRECT PREMIUMS WRITTEN
AMERICAN SECURITY INSURANCE COMPANY	80.36	1,060
CENTRAL STATES INDEMNITY CO OF OMAHA	13.19	174
JC PENNEY CASUALTY INS CO	4.25	56
STATE FARM MUTUAL AUTOMOBILE INS CO	1.90	25
FORUM INS CO	0.30	4
TOTAL FOR TOP 5 RANKED INSURERS	100.00	1,319
TOTAL FOR ALL 5 INSURERS WRITING THIS LINE	100.00	1,319

1996 ALASKA PROPERTY AND CASUALTY MARKET SHARE

15.1 - COLLECTIVELY RENEWABLE ACCIDENT AND HEALTH (\$000)

COMPANY NAME	PERCENT OF MARKET	DIRECT PREMIUMS WRITTEN
GOVERNMENT EMPLOYEES INS CO	75.00	3
CONTINENTAL CASUALTY CO	25.00	1
TOTAL FOR TOP 2 RANKED INSURERS	100.00	4
TOTAL FOR ALL 3 INSURERS WRITING THIS LINE	100.00	4

15.2 - 15.6 - ALL OTHER ACCIDENT & HEALTH (\$000)

COMPANY NAME	PERCENT OF MARKET	DIRECT PREMIUMS WRITTEN
STATE FARM MUTUAL AUTOMOBILE INS CO	55.11	1,223
AMERICAN BANKERS INS CO OF FL	27.99	621
TIG INSURANCE COMPANY	5.54	123
CONTINENTAL CASUALTY CO	5.45	121
GULF INSURANCE CO	2.48	55
MARKEL INSURANCE COMPANY	1.58	35
OMAHA PROPERTY & CASUALTY INS CO	0.81	18
REPUBLIC WESTERN INS CO	0.32	7
MUTUAL PROTECTIVE INS CO	0.27	6
NATIONAL CASUALTY CO	0.23	5
AMERICAN HOME ASSURANCE COMPANY	0.09	2
NORTHWESTERN NTL INS CO MILWAUKEE	0.09	2
BANKERS MULTIPLE LINE INS CO	0.05	1
TOTAL FOR TOP 13 RANKED INSURERS	100.00	2,219
TOTAL FOR ALL 13 INSURERS WRITING THIS LINE	100.00	2,219