

ALASKA LEGISLATURE COMMITTEE FILES, 2003-2004 8672

10746 HOUSE HEALTH EDUCATION & SOCIAL SERVICES

April 27, 2004

Representative Peggy Wilson
State Capitol, Room 104
Juneau, AK 99801

Dear Representative Wilson,

Although I was standing by for the hearing last Thursday, and was planning to attend the hearing tonight, my daughter's high school graduation dinner prevents me from doing so. I do, however, have strong feelings about HB 186 and would like to present those to your committee in writing.

My name is John Bringhurst. I am Administrator of Petersburg Medical Center, a 27-bed hospital and long-term care facility in Petersburg. We have 3,500 people living in our community whose only access to urgent health care services comes from our facility. Like most Southeast Alaskan communities, Petersburg has no road access at all. Airplane or ferry is required by our residents to access health care that is not made available to them here locally.

I was selected by the Alaska State Hospital and Nursing Home Association, along with Colleen Bridge from the Providence Hospital association, to represent both the small hospital and large hospital interests to work with the proponents of HB 186 to see if we could influence the bill in ways that would enable the Association to support it. I believe some progress has been made in that attempt, however at this time we feel it is a bill we cannot support.

We are opposed to passage of HB 186 as it is currently written for the following reasons:

1. The bill has serious flaws:

The bill now has provisions for "Limited License" personnel – something that may help smaller communities to comply with the requirements of this bill. However the drafters of this bill have used the definition of limited license to apply to the size of the community that this person is employed in, rather than the scope of work that he or she would be allowed to do. Many health care professions make provisions for limited scope workers (CNA's, LPN's, pharmacy techs, physical therapy aides, medical lab techs, just to name a few, all are limited scope positions). However the limitation lies in the role they are allowed to play in the delivery of this service, not in the size of the community the work in.

CT is a service that this bill excludes from the capability of limited license techs. Seward, Petersburg and Valdez are communities that have heretofore gone without the availability of these superior diagnostic modalities. They have now ordered and are installing these units in their hospitals for the first time. If these units are excluded from the scope of a limited license tech access to these services might continue to be denied individuals in these communities.

2. The timing for the legislation is bad:

The worst time to implement licensing is when there is a shortage. There is a serious shortage of radiology techs in Alaska and nationwide at this time. In the most recent pole conducted by the Alaska State Hospital and Nursing Home Association radiology technologists were number two in terms of scarcity – only surpassed by registered nurses. At our facility in Petersburg we currently have a 100% vacancy rate in radiology. One of those positions we have been recruiting for over 22 months. We are concerned with our hospitals' ability to attract technologists if this shortage is exacerbated by eliminating many of those currently practicing in the State.

3. It will hurt small hospitals:

Hospitals in small communities have a difficult time attracting and retaining radiology techs. The shortage of personnel has increased this problem. Many communities have found the only answer is to train their own personnel on the job. Radiology techs in many small communities have been providing satisfactory images and safe practices for 10 to 15 years. They are supervised by formally trained radiology technologists and operate under protocols and procedures approved by a licensed radiologist. Their images are reviewed by a trained radiologist. However, if these techs were suddenly eliminated from these small communities, the unavailability of any x-ray service at all might be the result.

In summary: I believe this legislation would have a short-term negative impact that would nullify the good that it is aimed at accomplishing. I believe it has serious flaws that erode its effectiveness. And I believe there are small communities that would find serious challenges to access to care if it were implemented in its present form.

John F. Dringhurst
102 Lewis Lane
Petersburg, AK 99833

FAX COVER SHEET

ANCHORAGE LEGISLATIVE INFORMATION OFFICE

Office 907-269-0111

Fax 907-269-0229

To: (H) H.E.S.S.

Attn: Rep Wilson

Fax: 465-3175 Phone: _____

From: Anc TC Phone: 269-0114

Instructions: Written (1) on HB 186

Sent: Date 4-23 Time _____ .

Disposal of Original: Discard: _____ Fouch Hold for Pickup _____

Number of Pages: 2 (counting cover sheet)

Transmitted by: Jenn



Alaska Native Health Board

3700 Woodland Drive, Suite 500
Anchorage, Alaska 99518

Phone: (907) 562-6006
FAX: (907) 563-2001

ANHB OPPOSES PASSAGE OF HB 186

The Alaska Native Health Board is a non-profit organization established in 1968 that advocates for 229 federally recognized tribes on healthcare issues. In regards to House Bill 186, the ANHB believes that its adoption as it is currently written could and would be harmful to tribal health providers' ability to provide x-ray services in some of our smaller communities that are unable to support radiology technicians. This is because Community Health Aides within our remote villages are sometimes the only provider available or able to take images, as there would be no "licensed practitioner" on site to supervise.

Therefore, the Alaska Native Health Board adamantly opposes the passage of House Bill 186.

ALASKA NATIVE TRIBAL HEALTH CONSORTIUM
ALEUTIAN/PRIIBILOF ISLANDS ASSOCIATION
ARCTIC SLOPE NATIVE ASSOCIATION
BRISTOL BAY AREA HEALTH CORPORATION
CHUGACHMIUT
COPPER RIVER NATIVE ASSOCIATION
COUNCIL OF ATHABASCAN TRIBAL GOVERNMENTS
EASTERN ALEUTIAN TRIBES

KETCHIKAN INDIAN COMMUNITY
KODIAK AREA NATIVE ASSOCIATION
MANILAQ ASSOCIATION
METLAKATLA INDIAN COMMUNITY
MT. SANFORD TRIBAL CONSORTIUM
NATIVE VILLAGE OF EKLUTNA
NATIVE VILLAGE OF TYONEK
NINILCHIK TRADITIONAL COUNCIL

NORTON SOUND HEALTH CORPORATION
SELDOVIA VILLAGE TRIBE
SOUTHCENTRAL FOUNDATION
SOUTHEAST ALASKA REGIONAL HEALTH CONSORTIUM
TANANA CHIEFS CONFERENCE
YUKON-KUSKOKWIM HEALTH CORPORATION
VALDEZ NATIVE TRIBE



**LEGISLATIVE AFFAIRS AGENCY
INFORMATION & TELECONFERENCING**

6 Main Street
Dillingham, AK 99576
Phone: 842-5319 Fax: 842-5105

Date: 4-22-04

Please accept the enclosed original(s) of written testimony for the House HES
teleconferenced hearing that was scheduled on 4-22-04 2:00 pm

A copy of this testimony was transmitted to your committee via fax on 4-22-04 11:20AM

Thank you.

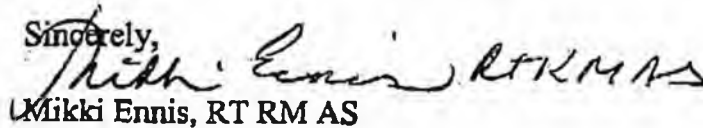
Dillingham LIO

Re: Proposed Licensure of Radiologic Technologist in the State of Alaska
HB 186

The proposed bill offered 3/31/03, does not meet the actual needs of rural (bush) Alaska as written. There are articles that need revision because they impact our sub-regional villages negatively, and in affect will impact the direct and initial care of residents and visitors alike in emergent situations. Unrealistic restraints will be imposed on villages with a population of over 800 residents, requiring a certified Radiological Technologist to be there to perform any x-ray procedure. The fact of the matter is that it is very difficult for the HUB facilities to hire full time Techs to fill their positions, let alone expect a small village to be able to do the same.

The bill as it stands cannot be supported by me or my facility. We here at Bristol Bay Health Corporation Medical Imaging Services believe in promoting quality care to all the people in our region. We totally support outfitting the sub-regional clinics with the means and training to provide emergent quality care to all their residents and any visitor that may be in need of medical support.

Sincerely,

A handwritten signature in cursive script, appearing to read "Mikki Ennis RT RM AS".

Mikki Ennis, RT RM AS

Manager

Medical Imaging Services

Bristol Bay Area Health Corporation

Re: Proposed Licensure of Radiologic Technologists in the State of Alaska (HB 186)

This bill, as proposed 3/03, does not meet the need of rural Alaska. It, in effect, denies our rural communities (less than 800) access to immediate imaging services where time and diagnosis may be critical to patient treatment and ultimately, survival.

I cannot support the passage of this bill as it was originally drafted.

Sincerely,

Maria C. Callowich RT RM

Maria C. Callowich, RT RM
Senior Staff Technologist
Medical Imaging Services
Kanakanak Hospital
Bristol Bay Area Health Corporation

**SUNSHINE COMMUNITY HEALTH CENTER**P.O. BOX 787 - (MILE 4.4 TALKEETNA SPUR RD.)
TALKEETNA, ALASKA 99676*****
TELEPHONE: (907) 733-2273 FAX: (907) 733-1735
"UNITED WAY PARTICIPATING AGENCY"**Fax Cover Sheet****Date:** April 23, 2004**To:** Representative Tom Anderson, Sponsor
Representative Peggy Wilson, Chair, HHSS**Telephone number:** **Fax number:** Rep. Anderson 907-465-2418
Rep. Wilson 907-465-3175
(Attn. Linda Miller)**From:** Susan Mason-Bouterse, Executive Director**Number of pages (including cover sheet):** 2**Message:** Attached is a letter which I'd appreciate included in the bill packet for CSHB186. I understand it may be scheduled in HHESS on Tuesday, April 27, at 3:00 p.m.; I will be unable to testify, but I will have my Assistant read the attached into the record.

WARNING: The information contained in this facsimile message, and any documents attached to it, is confidential and may be legally privileged. It is intended strictly for the use of the addressee. Access to the information by anyone else is unauthorized. If you are not the intended recipient, please destroy all copies of this message and notify our office immediately at the number listed above.



P.O. Box 787 • Mile 4.4 Talkeetna Spur Road • Talkeetna, AK 99676 (ph) (907)733-2273 • (fax) (907) 733-1735 • schc@sunshineclinic.org

CSHB 186 – “An Act requiring licensure of occupations relating to radiologic technology, radiation therapy, and nuclear medicine technology; and providing for an effective date.”

I support the overall aim and concept of this bill – to ensure the safety of Alaskans and to establish standards for education and credentialing of persons who are performing radiation therapy or diagnostic imaging.

However, I have serious concerns about the bill in its current state and the very real potential it poses of decreasing access to primary health care for certain Alaskans – people living in rural areas and people who are un-insured or under-insured.

The current bill proposes a licensure fee of \$543 biannually. This creates a barrier for poor areas that may have a solo provider practice, no hospital, and where the population served is largely impoverished.

As the bill is currently written, it would not be economically feasible for a small practice to provide radiology services. It would drive up the cost of radiation services, increase recruitment challenges, increasing the cost of service, and most likely prohibit the service in many communities where they may not do more than 3-10 films per week.

Unfortunately, the bill in its current state would negatively impact patient care in many ways – reducing options on local level, increase number of preventable and costly Emergency Room visits and ambulance runs, and have a negative impact on dental services that are already incredibly expensive and scarce in many areas of the State.

I support the continuing education requirements, but would like to see language in the bill that establishes opportunities through the university system for rural areas, solo providers to participate and that builds in support for training and educational programs that outreach, perhaps through distance learning, to practitioners in rural areas.

I would like to see this bill incorporate the growing potential of digital and teleradiology, perhaps building some incentives for more urban areas to support rural areas and for larger hospitals to support smaller practices that serve the under-served.

And I would like to see the proposed composition of the Radiology Board incorporate representation from rural areas instead of only Anchorage, Fairbanks and Juneau.

In closing, the Alaska Primary Care Association (PCA) would welcome the opportunity to partner with the sponsors of this bill to craft legislation that would not only ensure quality of care and safety for Alaskans, but also safeguard access to primary care for all Alaskans.

Susan Mason-Bouterse
Executive Director
April 22, 2004

Betty J. Anderson

From: Sonia Handforth-Kome [skome@ifhs.org]
Sent: Tuesday, April 27, 2004 12:47 PM
To: Betty J. Anderson
Subject: RE: Bill 186 Licensure of Radiology technicians

BJ,

None of our x-ray techs are licensed or certified. They are all excellent, however, as you know. We perform over 2500 x-rays per year. When one of our x-ray positions became open last year, we spent 6 months trying to fill it with a certified individual, with absolutely no success. Meanwhile, we managed to burn out both of our other lab/x-ray techs, who had to cover 24 hour call between themselves. Our nurses did help by performing some x-rays during that time. If we had to hire only licensed personnel, it would devastate our ability to provide x-ray services to our patients.

I have to wonder what problem the bill is trying to fix. In other words, is there real data showing that certified techs do better work than uncertified ones? Is there a clear benefit to requiring licensure that offsets the recruiting and reimbursement nightmares that such licensing requirements would cause in most Alaska clinics? Or is there some other, non-quality related issue or issues that brought this bill forward?

Our clinic fortunately has the budget to support continuing education and training for all of our staff, including our x-ray techs. We have hired individuals from our community, instead of bringing in people from other states or even other countries to do our lab and x-ray work. All of them had medical backgrounds, and all of them we trained on site, and continue to train with annual conferences and other forms of continuing education. We guarantee quality with quarterly audits by our medical director and Quality Improvement team, as well as continual feedback by all of our providers. Our techs all produce quality work which allows our providers to make appropriate medical decisions. How will they be better if they are required to become licensed? How will the licensing process guarantee on-going quality?

Just some thoughts...

Sonia Handforth-Kome
Executive Director
Iluulluk Family and Health Services, Inc.

FAX COVER SHEET

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Office 907-269-0111

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Sent: Date 4-27 Time 2:15

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Transmitted by: Jean

X-RAY MACHINE OPERATORS

*Clyde E. Pearce, RHS ,
State of Alaska, DH&SS, Labs
April 22, 2004*

WHY LICENSE?

- ▶ *Voluntary actions have failed*
- ▶ *The risk of injury is significant*
- ▶ *The extent of risk is not readily evident to the users of the system*
- ▶ *The costs include lost of quality of life as well as possible loss of life*
- ▶ *Risks can be minimized via education*

WHO IS AT RISK?

- ▲ *Patients*
- ▲ *Family members of patients*
- ▲ *The general public*
- ▲ *The unborn baby*
- ▲ *The operator of the device*

WHAT ARE THE RISKS?

- ▲ *High exposures that cause acute radiation injury (biological effects)*
- ▲ *Excessive exposures that lead to later development of cancer (biological effects)*
- ▲ *Radiation induced genetic and congenital effects (biological effects)*
- ▲ *Inadequate images that lead to a missed diagnosis (health care failure)*
- ▲ *Inappropriate images that lead to a misdiagnosis (health care failure)*
- ▲ *Delayed treatment, pathology, litigation*

New Machines=Lower dose?

- ✦ *INCORRECT! New imaging modalities often result in higher exposure doses with improved diagnostic capabilities so that care may proceed more quickly with reduced total costs.*
- ✦ *But... exposure doses in diagnostic x-ray imaging have been Increasing since 1980*

BROAD KINDS OF RISK IN MEDICAL IMAGING

- ▲ *Radiation*
- ▲ *Missed diagnosis and misdiagnosis*
- ▲ *Pathogens*
- ▲ *Chemicals*
- ▲ *Electrical*
- ▲ *Physical*
- ▲ *Fire*

Simplified Machines with Anatomical Buttons Increase Safety

- ▲ *INCORRECT! Safety depends upon a variety of factors that must be integrated by a knowledgeable and skilled operator. As with an automobile, with abundant safety features, ultimately safety depends on how you “drive” the machine. Over 40,000 people die each year in automobile accidents mostly caused by operator mistakes. 3,000,000 are injured.*

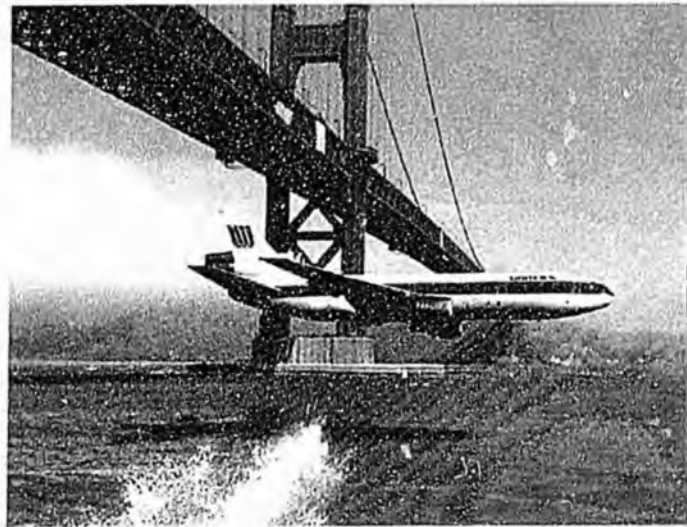
“I have operated an x-ray machine and gotten good pictures. It’s not difficult”

- ▲ *CORRECT!?* Almost anyone can operate an x-ray machine and may even obtain what appears to be a “good picture”. BUT... Medical imaging is not about getting pretty pictures. Medical imaging is about creating **DIAGNOSTIC** images with minimal radiation exposure, without further harm to the patient.

U.S. F.D.A. MODEL

- ▲ *ONLY certified or licensed individuals may perform mammography*
- ▲ *Only FULL SCOPE operators may perform this limited procedure*
- ▲ *There are NO EXCEPTIONS for rural populations. ALL facilities must meet the same federal standard*
- ▲ *While exposure dose is important, the major investigation in an inspection is of the QUALITY MANAGEMENT of imaging*

The U.S. FDA does not permit minimal regulation that just gets you in under the wire...er, bridge?



The Purpose of Regulation is:

- ▲ *To protect patients*
- ▲ *To protect operators*
- ▲ *To protect the public*
- ▲ *To protect the unborn baby*
- ▲ *To protect the community at large*

What about Alaska?

- ▶ *Alaska regulations do not require certification, licensure, or registration of operators*
- ▶ *Alaska has no requirements for trainer qualifications*
- ▶ *Alaska has no standards to measure the knowledge or skill of operators*
- ▶ *There is no mechanism to track those who expose humans to radiation, identify problems, or enforce remedies in Alaska*

Inspection Findings in Alaska

- ▲ *Failure to restrict beam to area of clinical interest*
- ▲ *Failure to shield the patient*
- ▲ *Failure to monitor exposures to operator*
- ▲ *Failure to post warning signs or control access to room by public*
- ▲ *Failure to post appropriate technique charts*
- ▲ *Failure to conduct processor quality control*

Inspection Findings in Alaska

- ▶ *No repeat analysis of spoiled images*
- ▶ *No training, or “trained” by unqualified individual who provided incorrect instruction*
- ▶ *Using incompatible screens and film*
- ▶ *Operators exposing each other for practice*
- ▶ *Incorrect use of Bucky grid*
- ▶ *Unable to identify fundamental procedures for reducing radiation exposure*

Inspection Findings in Alaska

- ▲ *Failure to wear protective apron during radiography when operator must be in room*
- ▲ *Inability to recognize why images are not diagnostic or how to correct the error(s)*
- ▲ *Misalignment of x-ray beam and localizer*
- ▲ *Failure to conduct machine calibrations and performance checks*
- ▲ *Misuse of exposure factors that destroyed a \$6,500 x-ray tube*
- ▲ *Five incidents in seven months where entire film bin was exposed to light, causing loss of at least \$4,000, all in the same facility (which uses uncertified operators)*

Where do acute injuries occur?

- ▲ *In diagnostic radiology acute injuries have become more common in fluoroscopic studies, “C” arm imaging, and related interventional procedures.*
- ▲ *Other acute injuries in diagnostic imaging occur as a result of ignorance and misuse of the device*

Acute Diagnostic X-ray Injury



Acute Diagnostic X-ray Injury



Acute Diagnostic X-ray Injury



What other injuries occur?

- ▲ *Low level exposure to radiation has been shown to have stochastic effects, such as the induction of cancer. Female radiation workers in medical imaging were shown to have higher than average levels of breast cancer in research conducted by the American Registry of Radiologic Technologists.*

...and others?

- ▲ *Moderate doses of x-ray exposure may cause nervous system tumors, according to the J Natl Cancer Inst 2002;94:1555-1563*
- ▲ *Some cancers may be due to diagnostic x-rays... Lancet 2004;363:340-341,345-351*
- ▲ *Radiation induced cancers do not become manifest disease until after a latent period of up to as much as 35 years post exposure*

What does this mean?

- ▶ *Improper medical x-ray procedures in a highly transient population complicate tracking causes and effects, and...*
- ▶ *Radiation induced cancers in Alaska may appear in cancer statistics in Washington, Arizona, and elsewhere*

..without adequate regulation of those who expose humans to x-radiation we may already be closer to the edge than we know



Other studies....

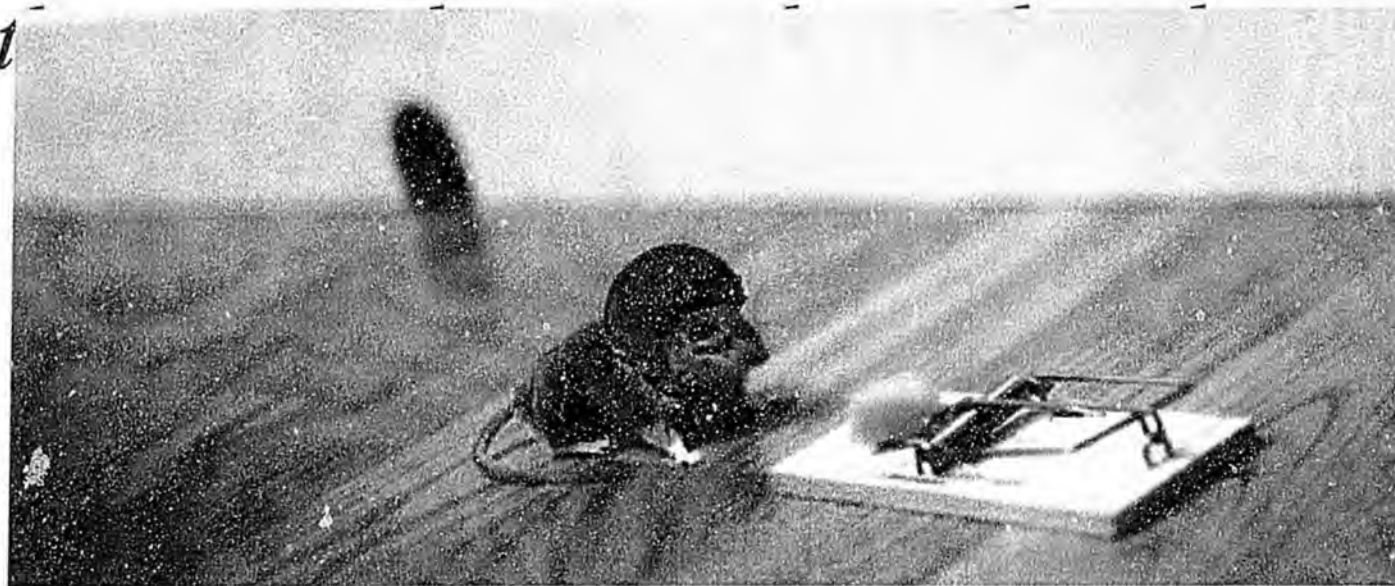
- ▲ *Only one-half of radiology studies performed in doctors offices are done correctly, which caused 5% of diagnoses to be wrong - Krug*
- ▲ *CT doses up to 50 times higher for a standard chest exam are common - Goodman*
- ▲ *As Much as 50% of diagnostic x-ray procedures are unnecessary, or of such poor quality they must be repeated at additional exposure, cost, delay in treatment to the patient – Gofman*
- ▲ *Misread scans lead to osteoporosis diagnosis in 53% of children with normal growth – Gafni, Baron*

...a cure...

- ▲ *Just as auto accidents are most effectively reduced by education and enforcement, misuse of radiation will be most effectively reduced by having:*
 - ▲ *Minimum education and skill requirements that are measured against a standard*
 - ▲ *Enforcement capability to stop those who are unwilling or unable to use radiation safely*
 - ▲ *A mechanism for tracking trends and problems*

Some Methods of Protection are just not sufficient

- ▲ *...while learning the three fundamental rules of radiation protection is important,*



All regulations are an evolving entity. As our society changes we must continue to adapt the regulations to fit the needs of the community



...but first, we must have regulations to meet current needs.

▲ *Presently, we have none that regulate this vitally important segment of healthcare services in Alaska*

Resources for Mammography

State level

- ▲ *Clyde E. Pearce, MQSA Inspector*
- ▲ *Telephone – 907-334-2107*
- ▲ *Fax – 907-334-2163*
- ▲ *Email – clyde_pearce@health.state.ak.us*
- ▲ *Internet – <http://www.hss.state.ak.us>*

Wrap up



THE END



HB

195

ALASKA STATE LEGISLATURE
House of Representatives

COMMITTEE ASSIGNMENTS:

RULES COMMITTEE, CHAIRMAN
LABOR & COMMERCE COMMITTEE, MEMBER
LEGISLATIVE COUNCIL, MEMBER
SPECIAL COMMITTEE ON OIL & GAS, MEMBER
LEGISLATIVE ETHICS COMMITTEE, MEMBER

website: <http://www.akrepublicans.org/rokeberg/>



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

Representative Norman Rokeberg

e-mail: Representative_Norman_Rokeberg@legis.state.ak.us

MEMORANDUM

TO: Representative Peggy Wilson
House HESS Committee

FROM: Representative Norman Rokeberg

DATE: April 15, 2003

RE: Request to hear HB 195

A handwritten signature in black ink, appearing to read "Norman Rokeberg".

I respectfully request that HB 195, Individual Health Care Insurance, be scheduled for a hearing. I have attached the following for your information: .

1. CS HB 195
2. Sponsor Statement
3. Sectional Analysis
4. Zero Fiscal Note
5. Relevant Statutes
6. Memo regarding mandates
7. E-mail from Division of Insurance on Individual Health Care
8. Letter w/attachments regarding TAA
9. Statistics from Anchorage Daily News
10. Article from Anchorage Daily News
11. Statistics and Information from Division of Insurance Annual Report
12. Letters of support

ALASKA STATE LEGISLATURE

House of Representatives

COMMITTEE ASSIGNMENTS:

RULES COMMITTEE, CHAIRMAN
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SESSION:
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JUNEAU, AK 99801-1182
PHONE: (907) 465-4968
FAX: (907) 465-2040

Representative Norman Rokeberg

e-mail: Representative_Norman_Rokeberg@legis.state.ak.us

SPONSOR STATEMENT FOR CSHB 195 (L&C)

BY: Representative Norman Rokeberg

TITLE: An Act relating to coverage offered under an individual policy of health care insurance; and providing for an effective date.

Alaska and the nation are in the midst of a health care financial crisis. Alaskans are being asked to contribute a greater percentage of their disposable income to the increasing costs of health care insurance. It is the legislature's responsibility to help contain these costs. This legislation is intended to lower the cost of insurance for individuals and families who are not part of a group health plan. In most group plans, employers typically contribute to the employee's cost of health insurance. Individuals seeking coverage do not have this benefit.

HB 195 allows a health insurance company to offer a new type of health insurance policy. This legislation gives insurance companies the authority to offer an individual health insurance plan that does not provide coverage for all of the insurance mandates currently required in state statute.

Alaska law requires insurance companies to provide for specific types of coverage; these are called "mandates." For example, some of the mandates required are coverage for services of midwives, substance abuse treatment, treatment of diabetes, and screening for prostate and cervical cancer. This legislation allows a health insurance company to offer an individual plan without covering these mandates, thus giving Alaskans a more affordable health insurance option.

In addition, sections 2-9 have been added to the bill at the request of the Division of Insurance. These sections relate to the Federal Trade Adjustment Assistance Reform Act of 2002 (TAA), which provides tax credits of 65% of the amount paid by an eligible individual for qualified health insurance coverage. Alaskans qualify for TAA assistance if they have lost their jobs to foreign imports, e.g. salmon and oil. These sections amend the Alaska Comprehensive Health Insurance Association (ACHIA) statutes to make Alaskans eligible under TAA, eligible for coverage under ACHIA. This will allow these Alaskans to get 65% of their premiums paid by the U.S. Department of Treasury.

HB 195 is a small step towards creating more affordable health care in Alaska. I encourage your support of this legislation.

Sponsor Statement For HB 195

“An Act relating to coverage offered under an individual policy of health care insurance; and providing for an effective date.”

Alaska and the nation are in the midst of a health care financial crisis. Alaskans are being asked to contribute a greater percentage of their disposable income to the increasing costs of health care insurance. It is the legislature's responsibility to help contain these costs. This legislation is intended to lower the cost of insurance for individuals and families who are not part of a group health plan. In most group plans, employers typically contribute to the employee's cost of health insurance. Individuals seeking coverage do not have this benefit.

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Alaska law requires insurance companies to provide for specific types of coverage; these are called “mandates.” For example, some of the mandates required are coverage for services of midwives, substance abuse treatment, treatment of diabetes, and screening for prostate and cervical cancer. This legislation allows a health insurance company to offer an individual plan without covering these mandates, thus giving Alaskans a more affordable health insurance option.

In addition, the legislation calls for a change in public policy by granting an exemption from premium tax for individual/family policies. This small amount of waived tax is a recognition of the high cost of individual/family health care insurance.

HB 195 is a small step towards creating more affordable health care in Alaska. I encourage your support of this legislation.

By: Representative Norman Rokeberg

ED 1: 3/31/03

ALASKA STATE LEGISLATURE

House of Representatives

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Representative Norman Rokeberg

e-mail: Representative_Norman_Rokeberg@legis.state.ak.us

SECTIONAL ANALYSIS FOR CSHB 195 (L&C)

BY: Representative Norman Rokeberg

TITLE: An Act relating to coverage offered under an individual policy of health care insurance; and providing for an effective date.

- Section 1:** Allows for individual health care insurance coverage without state mandated benefits.
- Section 2:** Amends AS 21.55.130 as required by the federal Trade Adjustment Assistance Act of 2002 (TAA), to prohibit a state plan issued to a qualified TAA eligible individual from imposing a preexisting condition exclusion.
- Section 3:** Amends the ACHIA statutes to conform to the TAA program requirement that a plan cannot exceed 150 percent of the standard risk premium rates.
- Section 4:** Amends the ACHIA statutes to allow for TAA eligible individuals to participate in ACHIA.
- Section 5:** Amends the ACHIA statutes to exempt TAA eligible individuals from restrictions on eligibility for participation in ACHIA, in order to conform to TAA requirements. Moves certain existing requirements for eligibility previously found in the exclusion statute to the eligibility section. See Section 9.
- Section 6:** Amends the ACHIA statutes to require that the ACHIA to notify the director that a TAA eligible individual is enrolled in ACHIA in order to allow the director to certify that a TAA eligible individual has qualified health coverage as required under the TAA.
- Section 7:** Amends the definition of "resident" to provide for TAA eligible individuals.
- Section 8:** Defines "qualified TAA eligible individual" and "TAA eligible individual."
- Section 9:** Repeals AS 21.55.140(b). The provisions were moved to AS 21.55.300 (b) (see section 5). They were moved to clarify that these are eligibility requirements, not exclusion provisions.
- Section 10:** This Act takes effect on July 1, 2003.

ED 1: 4/16/03

Sec. 21.55.140. Persons, care, and services not covered.

(a) A state plan may not provide benefits for charges for the following:

(1) care for an injury or disease either

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

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

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

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

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

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

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

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

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

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

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

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

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

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

who is a member of the covered individual's family or the family of the covered individual's spouse;

(14) experimental procedures; and

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

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

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

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

(§ 2 ch 126 SLA 1992)

Revisor's notes. In 1999, in (a)(6), "subsection" was substituted for "section" to correct a manifest error in ch. 126, SLA 1992.

ALASKA STATE LEGISLATURE

House of Representatives

COMMITTEE ASSIGNMENTS:

RULES COMMITTEE CHAIRMAN
LABOR & COMMERCE COMMITTEE, MEMBER
LEGISLATIVE COUNCIL, MEMBER
SPECIAL COMMITTEE ON OIL & GAS, MEMBER
LEGISLATIVE ETHICS COMMITTEE, MEMBER

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Representative Norman Rokeberg

e-mail: Representative_Norman_Rokeberg@legis.state.ak.us

MEMORANDUM

To: House HESS Committee

From: Representative Norman Rokeberg

Date: April 9, 2003

Re: Health Care Mandates

The health mandates are located in AS 21.42:

- 42.353: Acupuncture coverage (offer only, does not mandate coverage)
- 42.355: Coverage for services of midwives
- 42.363: Eye care (if plan provides for eye care, can use an optometrist)
- 42.365: Substance abuse treatment coverage
- 42.375: Mammography coverage
- 42.380: Phenylketonuria
- 42.385: Dental, Vision, Health coverage (offer only, does not mandate coverage)
- 42.390: Coverage for diabetes treatment
- 42.392: Requirements relating to dental (if coverage is provided)
- 42.395: Prostate and cervical cancer screening

Federal Mandates

- 42.345: Coverage of newly born children
- 42.347: Postpartum hospital stay coverage
- 42.400: Reconstructive surgery following mastectomies

Subject: Re: Quick Questions

Date: Wed, 09 Apr 2003 11:32:20 -0800

From: Katie Campbell <katie_campbell@dced.state.ak.us>

To: Heather Nobrega <Heather_Nobrega@legis.state.ak.us>

CC: Linda S Hall <linda_hall@dced.state.ak.us>, Sally A Saddler <sally_saddler@dced.state.ak.us>

Hi Heather,

According to the 2001 Health Insurance Survey the number of individual health policies in force at the end of 2001 was 5,843. The number of individuals covered under those policies (i.e. includes dependents) was 14,946. The premium collected during 2001 was about \$24 million.

Katie

Heather Nobrega wrote:

> Katie,

>

> Rep. Rokeberg would like to know the current number of individual health

> insurance policies currently issued in the state for today's meeting?

>

> Thanks Katie.

> Heather

The Honorable «Governor»
Governor of «State»
«Address»
«Address2»
«City_State_ZIP»

Dear Governor «Governor_Last_Name»:

The Trade Act of 2002, Public Law No. 107-210 ("the Act"), includes important provisions to assist certain workers who lose their jobs due to the effects of international trade in paying for qualified health insurance. The Act also provides such assistance to certain beneficiaries of the Pension Benefit Guaranty Corporation. The primary mechanism for assistance is a federal tax credit equal to 65 percent of the amount paid by eligible individuals for such health insurance. An additional interim mechanism to assist in paying for qualified health insurance is through National Emergency Grants (NEGs). We estimate these provisions could help over 500,000 Americans each year – many of whom may reside in your state – continue or obtain health insurance. To make the most of this opportunity, however, we need your assistance.

Under the law, the States play an important role in providing health insurance coverage options and assisting individuals to enroll. The Department of the Treasury administers the federal tax credit under the Act. NEG assistance, which is administered by the Department of Labor, is available without any cost to the State. Certain health insurance coverage options, such as continuation health coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (commonly known as COBRA coverage), are automatically available to all eligible individuals. Other options specified in the law are available only if the State elects them and certain conditions are met. Enclosed is more detailed guidance on how States may elect coverage options for eligible individuals under the Trade Act. Please note that funds are available to States through additional NEGs administered by the Department of Labor for start-up and administrative costs relating to the tax credit program. The Department of Health and Human Services will assist States in interpreting this guidance with respect to qualified health insurance.

We strongly encourage your state to take advantage of the benefits of these programs. We also encourage your state to elect options to increase the opportunities for eligible individuals to have health insurance.

We look forward to working with you. If you or your staff have any questions, please contact Ruben J. King-Shaw Jr., Senior Advisor to the Secretary of the Treasury for Health Insurance Initiatives, at 202-622-2336.

Sincerely,

John W. Snow
Secretary of the Treasury

Elaine L. Chao
Secretary of Labor

Tommy G. Thompson
Secretary of Health
and Human Services

Guidance for Elections of Qualified Health Insurance Under the Trade Act of 2002

I. Purpose and Background

On August 6, 2002, President Bush signed into law the Trade Act of 2002 ("the Act"), Public Law 107-210.¹ Title II of the Act contains provisions that provide assistance to certain individuals participating in the Trade Adjustment Assistance program (TAA) or receiving a payment from the Pension Benefit Guaranty Corporation (PBGC), to enable them to purchase health insurance. (A copy of Title II of the Act is available at http://www.doleta.gov/tradeact/2002act_index.asp). The primary mechanism for such assistance is a federal tax credit that is equal to 65 percent of the amount paid by the eligible individual for coverage for the individual and qualifying family members under qualified health insurance. The end of the year tax credit became available on December 1, 2002 for individuals who claim the credit on their subsequent income tax return. By August 1, 2003, the credit will also be available on a monthly basis as the premium is paid. The government's share (65 percent of the premium amount paid by the individual) will be combined with the eligible individual's payment of the 35 percent and paid on a monthly basis, in general to the qualified health plan in which the individual has enrolled. The Department of the Treasury (Treasury) is responsible for implementing this advance credit under its Health Coverage Tax Credit program (HCTC).

The Act also authorizes two types of National Emergency Grants (NEGs) for which States may apply under the Workforce Investment Act of 1998. One type of NEG is available to assist eligible TAA and PBGC recipients, on an interim basis, in paying up to 65 percent of the premiums for qualified health insurance (equivalent to the Federal share under the tax credit) until the advance tax credit mechanism becomes available in August. The second type of NEG is available to provide resources to assist the States with start-up and administrative costs relating to the tax credit. The Department of Labor (DOL) is responsible for administering both types of NEGs (see Section V below).

The Administration estimates that as many as 260,000 people nationwide may be able to claim this credit next year. When combined with qualifying dependents, this means more than a half million people could benefit from the credit. (Attachment A provides estimates of TAA and PBGC recipients eligible in each State).

The States play a critical role in the administration of this assistance. Particularly important to the success of this assistance are the States' efforts toward ensuring the availability of coverage for which the assistance can be used, making eligible individuals aware of the program, and increasing the options available to them. The purpose of this guidance is to inform the States of the program and to explain their role in making health insurance options available.

¹ The law is the Trade Act of 2002. Division A of the Trade Act contains its own title: The Trade Adjustment Assistance Reform Act of 2002. Title II of the Act (Division A) contains the health coverage assistance provisions.

II. Who Is Eligible

There are two basic categories of individuals who may be eligible for the tax credit and NEG assistance under the Act: (1) certain Trade Adjustment Assistance (TAA) recipients as described below, and (2) people who have attained age 55 but who are not on Medicare or other specified coverage who receive pension payments from the Pension Benefit Guaranty Corporation (PBGC).

A. TAA Recipients:

An eligible TAA recipient is defined as any individual who is receiving a trade readjustment allowance under the Trade Act of 1974 at any time during a month, or individuals who would be eligible for such an allowance except that they have not exhausted their regular unemployment insurance benefits. In addition, individuals receiving benefits under the alternative trade adjustment assistance program, established under section 246 of the Trade Act of 1974 (which commences on August 1, 2003) also will be eligible for assistance. All TAA recipients remain eligible for the tax credit for one month after the end of the month that their eligibility for TAA status ceases.

B. PBGC Pension Recipients:

A person who is receiving a benefit payment from PBGC and who has attained age 55 (but who is not eligible for Medicare) on the first of the month may be eligible for the tax credit.

C. Other factors:

An eligible individual is not entitled to the tax credit for any month if, on the first day of the month, the individual is covered by "other specified coverage".

The tax credit can be used to purchase qualified health insurance that also covers an eligible individual's spouse or dependent (i.e., anyone who qualifies as a dependent under the Internal Revenue Code), provided the spouse or dependent does not have "other specified coverage".

"Other specified coverage" includes:

- insurance coverage through the spouse's employer, and the spouse's employer contributes at least 50 percent of the cost of coverage for the spouse, the eligible individual and dependents (or the spouse receives coverage in lieu of an employer's cash or other benefits under a cafeteria plan);
- coverage under Medicare Part A or enrolled under Part B;
- a State's Medicaid program;
- a State's SCHIP program;
- a plan in the Federal Employees Health Benefit program; or
- a Defense Department health plan.

An individual who is imprisoned cannot be an eligible individual.

Individuals with questions about their TAA status or tax credit eligibility should contact their State workforce agency. PBGC beneficiaries with questions about their eligibility for the tax credit will be able to contact a toll free telephone number that we expect to establish in the near future.

III. Qualified Health Insurance

A. Types of Plans

The law identifies ten categories of health insurance that may be "qualified" as coverage for purposes of the tax credit and NEG assistance. The coverage must be for comprehensive health coverage.²

The ten categories are:

1. COBRA: any continuation coverage that the eligible individual has under the federal Consolidated Omnibus Budget and Reconciliation Act of 1985.
2. State COBRA or continuation coverage: any State-based continuation coverage in a group plan that is obtained under a State law that requires such coverage.
3. High risk pool: as defined in the Public Health Service Act section 2744(c)(2), coverage that is offered through a State high risk pool that is otherwise open to "HIPAA eligibles" without imposing a preexisting condition exclusion, and is consistent with the NAIC model act entitled "Health Plan for Uninsurables" that was in effect in August, 1996. (Attachment B is a list of the State high risk pools that are qualified based on the information currently available to the Department of Health and Human Services.³)
4. State employees' health plan: coverage under a State employees' health insurance program.
5. A State-based health insurance program that is comparable to the health insurance program offered to State employees.
6. A State arrangement: a State can enter into an arrangement with an issuer of health insurance coverage (including individual insurance) to offer coverage to eligible individuals. It can also enter into an arrangement with an administrator or an employer to offer coverage to the individual, or with a group health plan (including a multiemployer plan).
7. Purchasing pool: a State arrangement for coverage that is provided through a private sector purchasing pool.
8. Other State plans: coverage that is provided through a State operated health plan that does not receive any federal financial assistance.

² Examples of types of plans that are not eligible for the credit or NEG assistance are limited coverage plans such as dental or vision care; fixed dollar indemnity coverage; specific disease insurance; workers' compensation; health coverage under an automobile insurance policy; liability insurance; or coverage for on-site medical clinics.

³ The Act also provides a grant program that provides up to \$1 million to a State to establish a qualified high risk pool in FY 2003 or 2004, and a separate two year grant program that will provide a grant up to 50 percent of a qualified high risk pool's operating losses, up to a national total of \$40 million each year. The seed grant announcement can be found at www.cms.hhs.gov/riskpool. The grant announcement for the operating losses will be forthcoming.

9. Spouse's coverage: coverage under a group health plan that is available through the employment of the eligible individual's spouse, if the spouse's employer contributes less than 50 percent of the total cost of coverage for the spouse, the eligible recipient, and any dependents. (There is a distinction for Alternative TAA recipients—those aged 50 or older who are receiving income support. If these people are eligible for spousal coverage where the employer pays 50 percent or more, they are considered to have other specified coverage, even if they are not actually covered by the spouse's plan.)
10. Individual health insurance: coverage under individual health insurance if the eligible individual was covered under the insurance during the entire 30 day period that ended on the date that such individual became separated from the employment that qualifies the person as a TAA or PBGC recipient.

B. State Election

Coverage options 1, 9 and 10 above are automatically considered to meet the definition of "qualified health insurance" for all eligible individuals, without further state action. Options 2 through 8 only meet the definition if the State elects to have one or more of these options considered to be qualified health insurance. For individuals who have had at least three months of creditable coverage⁴ prior to seeking enrollment in any of these Options 2 through 8, the insurance will only be considered qualified health insurance if it meets the following four criteria:

1. Guaranteed issue: Qualifying individuals must be guaranteed enrollment regardless of their medical status and must be permitted to remain enrolled so long as they pay the premium.
2. No pre-existing condition restrictions: No pre-existing condition restriction may be imposed on qualifying individuals.
3. Nondiscriminatory premium: The premium charged for a qualifying individual may not be greater than the premium for a similarly situated person who is not receiving the credit.
4. Benefits are the same (or substantially the same) under coverage provided to similarly situated individuals who are not qualifying individuals.

Generally, periods of coverage prior to a break in coverage of 63 days or more do not count in determining whether an individual has three months of creditable coverage. However, individuals who do not have at least three months of creditable coverage may still use the tax

⁴ "Creditable coverage" is defined in section 9801(c) of the Internal Revenue Code, and includes most kinds of health coverage. (The identical definition also appears in section 2701(c) of the Public Health Service Act and section 701(c) of the Employee Retirement Income Security Act (ERISA). Periods of creditable coverage prior to a "significant break in coverage" do not count in determining whether an individual has three months of creditable coverage for purposes of the tax credit or NEG assistance. This also means that there can be a break in coverage between the loss of health plan coverage and applying for a new plan elected by the State. A significant break in coverage under federal law is a break in coverage of at least 63 consecutive days (days in a waiting period in which an individual has no other coverage are not considered creditable coverage nor are they taken into account when determining if there is a significant break in coverage). However, the length of time that passes before a significant break in coverage is reached may be longer under State law that applies to HMOs and health insurance carriers.

credit or NEG assistance in connection with enrollment in health insurance that the State has elected to have treated as qualified.

States may find that the four requirements can be met most easily by selecting as the State option(s) the coverage arrangements that now qualify as the State's alternative mechanism under section 2744 of the Public Health Service Act. These are typically either a high risk pool (#3) or individual coverage (#6).

The Department of Health and Human Services will assist States in interpreting this guidance with respect to qualified health insurance. Questions should be directed to:

Stephen Finan
Office of the Assistant Secretary for
Planning and Evaluation
Dept. of Health and Human Services
Room 442E
200 Independence Ave, SW
Washington, DC 20201
Telephone: 202.690.7387
E-mail: Stephen.Finan@hhs.gov

IV. State Elections

A. *Elections Letter*

Options 1, 9 and 10 are automatically considered to meet the definition of "qualified health insurance" for all eligible individuals without any further State action. However, under the law, the remaining options are available only if the State elects to provide one or more of them.

To facilitate implementation of the law, we request that the Governor, or the Governor's representative, send a letter indicating which options (2-8, above) the State is electing to make available to eligible recipients under the tax credit. (Note: DOL expects the coverage options for the interim assistance NEG to be identified in the application for the grant and will coordinate the review of these options with HHS). Please send the letter to:

John Hoff, Deputy Assistant Secretary
Office of the Assistant Secretary for
Planning and Evaluation
Dept. of Health and Human Services
Room 424E
200 Independence Ave, SW
Washington, DC 20201

B. Information Requested

The letter should:

1. Identify the State official responsible for implementing this decision, including address and telephone number.
2. State the option(s) chosen by the State (of options 2-8).
3. Provide the name, policy form number or other unique identifier for each qualifying plan under each option. Also, provide a name and contact number for the plan administrator or insurance carrier official who can provide additional information, if necessary.
4. Certify that the four requirements (III. B. above) are met for each plan under each option.
5. Certify that the benefits made available to tax credit recipients are the same or substantially the same as those in the plans who do not receive the tax credit.

C. Public Information

To assist eligible individuals, the State should take steps to publicize the options available to eligible individuals in their State. Such steps can include the listing of qualified plans on a website, providing lists at State TAA offices, unemployment offices, and other locations where eligible recipients may obtain information.

V. National Emergency Grant Assistance

As noted above, the Trade Adjustment Assistance Reform Act of 2002 authorizes two new NEG mechanisms relating to the provision of health insurance coverage assistance that are to be administered by the Department of Labor. The Department of Labor and the Department of Health and Human Services will work closely together to facilitate the provision of technical assistance to the States regarding these NEGs.

A. System Development Grants. These grants are intended to help States cover certain start-up and administrative costs. Guidance for applying for these grant funds have been issued in Training and Employment Guidance Letter (TEGL) 10-02. These grants may be used to establish and implement systems for:

- eligibility verification;
- certification of State-based health insurance coverage;
- notification to eligible individuals of available qualified health insurance options;
- providing assistance to individuals in enrolling in qualified health insurance;
- processing of certificates confirming eligibility of individuals for the advance payment of the tax credit;
- developing and installing necessary data management systems; and
- other expenses, as determined appropriate by the Secretary of Labor, including the start-up and ongoing administration of State-elected health-insurance coverage options.

B. Health Insurance Interim Assistance Grants. These grants are available to States to assist eligible TAA and PBGC recipients in paying up to 65 percent of the monthly premiums for

qualified health insurance coverage until the advance payment mechanism for the tax credit becomes available. The grants may also be used to provide additional support services to eligible individuals. Draft guidance was published in the Federal Register on December 4, 2002 (67 FR 72222-72234), and guidance for applying for Health Insurance Interim Assistance Grants will soon be issued through another TEGL .

C. Contact. For further assistance regarding these NEG's please contact:

Shirley M. Smith
Office of National Response
U.S. Department of Labor
Employment and Training Administration
Room N5420
200 Constitution Ave., NW
Washington DC 20210
202-693-3501

**Attachment A: Estimated Eligibles by State 2002 Level
Under The Trade Act of 2002**

	Estimated Population ⁵		
	Total	TAA	PBGC
Alabama	8,100	5,500	2,600
Alaska	200	100	100
Arizona	2,500	1,000	1,500
Arkansas	3,000	1,700	1,300
California	14,300	7,100	7,200
Colorado	1,800	500	1,300
Connecticut	2,600	1,100	1,500
Delaware	200	0	200
District of Columbia	100	0	100
Florida	13,000	1,700	11,300
Georgia	10,700	4,700	6,000
Hawaii	600	0	600
Idaho	1,100	800	300
Illinois	11,900	4,800	7,100
Indiana	9,700	5,100	4,600
Iowa	1,900	600	1,300
Kansas	3,600	2,600	1,000
Kentucky	4,200	2,900	1,300
Louisiana	1,400	400	1,000
Maine	1,600	1,300	300
Maryland	1,200	100	1,100
Massachusetts	3,900	2,000	1,900
Michigan	7,500	4,000	3,500
Minnesota	4,900	2,800	2,100
Mississippi	3,100	2,300	800
Missouri	6,500	1,300	5,200
Montana	100	0	100
Nebraska	500	200	300
Nevada	900	200	700
New Hampshire	1,300	800	500
New Jersey	5,900	1,200	4,700
New Mexico	600	300	300
New York	11,900	4,200	7,700
North Carolina	14,600	9,900	4,700

⁵ These estimates are intended to provide states with rough guidance as to the size of the eligible population at 2002 levels. States listed as having zero TAA eligibles may have a few participants. Actual enrollment will depend on many factors, including the size of the population currently eligible for TAA and PBGC benefits, the number and type of health plans available to the eligible population, and take-up rates. Moreover, in some states the number of workers eligible for Trade Adjustment Assistance varies significantly from year to year.

	Estimated Population		
	Total	TAA	PBGC
North Dakota	100	0	100
Ohio	19,600	5,200	14,400
Oklahoma	3,400	2,400	1,000
Oregon	5,100	4,500	600
Pennsylvania	20,000	8,400	11,600
Rhode Island	500	200	300
South Carolina	5,200	3,400	1,800
South Dakota	200	100	100
Tennessee	9,000	4,700	4,300
Texas	15,500	10,700	4,800
Utah	600	300	300
Vermont	500	300	200
Virginia	6,700	3,800	2,900
Washington	11,600	10,300	1,300
West Virginia	1,700	700	1000
Wisconsin	5,300	3,300	2,00
Wyoming	200	100	100

Source: TAA data are based on information from the Employment and Training Administration, U.S. Department of Labor. PBGC estimates are based on data provided by the Pension Benefit Guaranty Corporation.

Attachment B: Currently "Qualified" State High Risk Pools⁶

Alabama
Alaska
Arkansas
Colorado
Connecticut
Idaho
Illinois
Indiana
Iowa
Idaho
Kansas
Kentucky
Louisiana
Minnesota
Mississippi
Montana
Nebraska
New Hampshire
North Dakota
Oklahoma
South Carolina
Texas
Wisconsin
Wyoming

Note: To be "qualified," a high risk pool (as defined in the Public Health Service Act section 2744(c)(2)) must be open to "HIPAA eligibles" without imposing a preexisting condition exclusion and be consistent in its premium rates and benefits with the NAIC model act entitled "Health Plan for Uninsurables" that was in effect in August, 1996.

⁶ These States' risk pools meet the criteria set forth in section 2744(c)(2) of the Public Health Services Act. In addition, to be qualified health insurance under the credit or NEG assistance, the risk pools must meet the four conditions in III.B. above.

Trade Adjustment Assistance (TAA) Health Care Tax Credit (HCTC)

Trade Act of 2002, U.S. Public Law No. 107-210, includes important provisions to assist qualified TAA recipients purchase and pay for qualified health insurance.

The primary mechanism for the assistance is a federal tax credit equal to 65 percent of the amount paid by the eligible individual for qualified health coverage for the individual and qualifying family members.

Two tax credit options are available. An end of the year tax credit effective December 1, 2002 for the individual to claim on their subsequent income tax return or by August 1, 2003 an advance credit will be available on a monthly basis as the premium is paid. The U.S. Federal Government's share of 65 percent will be combined with the eligible individual's payment of 35 percent and paid on a monthly basis to the insurance provider.

The U.S. Department of the Treasury is responsible for implementing this advance credit under its Health Coverage Tax Credit Program (HCTC).

An HCTC office has been created within the Internal Revenue Service (IRS) to design the infrastructure for the advance tax credit options. The HCTC office will be responsible for the collection and verification of information related to eligibility, such as whether the individual is enrolled in qualified health coverage.

Each state has the responsibility to identify eligible Trade Adjustment Assistance (TAA) recipients and report those individuals to the HCTC office for its use in determining who qualifies for the credit. Each state will also be required to report the Alternative Trade Adjustment Assistance (ATAA) recipients when the ATAA program becomes operational later this year. The Interstate Connection (ICON) network currently used by each state for Unemployment Insurance purposes will be utilized as the communication vehicle for reporting the information to the HCTC office.

Each state plays a critical role in the administration of the assistance. Particularly important to the success of this assistance are the states' efforts toward ensuring the availability of coverage for which the assistance can be used, making eligible individuals aware of the program and increasing the options available to them.

The State of Alaska's role is to ensure that there is a health coverage plan available for all qualified TAA eligible individuals. Under proposed legislation, the high-risk insurance pool program will be able to accommodate TAA individuals, which will satisfy federal requirements established under the Trade Reform Act of 2002.

In the late 1990's there were thousands of Alaska workers who were eligible for TAA benefits. Since January 2003, over 1500 workers in Alaska have been approved for TAA benefits. While mostly timber and oil industry workers were eligible in the past, fishing industry workers have become eligible in recent months.

ALASKA TRADE ADJUSTMENT ASSISTANCE (TAA) ELIGIBLE WORKERS BY INDUSTRY

Year	Timber Industry		Oil Industry		Fishing Industry		Other	
	Company	Number of layoffs	Company	Number of layoffs	Company	Number of layoffs	Company	Number of layoffs
1992	Alaska Pulp Corp	260	BP Exploration	55			Micro Link	10
	Halliburton Logging	10	Western Atlas	30			Otis Engineering	25
	Wrangell Sawmill	190	Shell Oil Company	25			Eastman Teleco	12
			Camco	60				
			Doyon Drilling	80				
			Conoco Inc.	20				
			Alaska United Drilling	10				
1994			Baroid Corp.	45				
			Marathon Oil	15				
			Alaska Safety	15				
			Dresser Industries	45				
1997	Ketchikan Pulp Corp	535						
1999	Annette Hemlock Sawmill	62	BP Exploration	260				
			Veco Inc.	1101				
			Weatherford	3				
			Parker Drilling	99				
			Peak Oilfield Services	1461				
			Quadco	34				
			Schlumberger	75				
			Sperry Sun Drilling	30				
			MI Drilling	20				
			Nabors Alaska Drilling	508				
			Doyon Drilling	173				
			Fairweather E&P	30				
			Fairweather Inc.	32				
			ForceEnergy	4				
			Halliburton Energy Service	145				
			Baker Hughes Inteq	5				
			Baroid	33				
BJ Services	6							
Chevron	2							
ARCO	177							
ASCG Inspection	221							
Pool Arctic Alaska	205							
Baker Hughes Centrilift	3							
Inlet Drilling	51							
2000	Ketchikan Sawmill	226	Baker Atlas	6				
	Mellakalla Forest Products	15	Arctic Pipe Inspection	12				
2002			BP Exploration	120	Various Bristol Bay fishermen	150		
			ASCG Inspection	199				
2003 to date	Gateway Forest Products	70			Wards Cove Packing	1241		
					Cook Inlet Processing	204		
					Various fishermen	70		
TOTAL:	Timber Industry	1368	Oil Industry	5415	Fishing Industry	1665	Other	47

Trade Adjustment Assistance is a program that offers training benefits, job search allowances, relocation allowances and weekly benefits to workers who have lost their jobs due to competition from or a shift in production to a foreign country. Workers petition the United States Department of Labor for certification of eligibility for TAA benefits. Once a company is certified for TAA benefits, the certification is good for two years. Activity tends to follow general economic conditions in the State of Alaska. That is why there are breaks in years. This spreadsheet shows TAA activity in Alaska beginning 1992 through March 31, 2003. Source: Alaska Department of Labor and Workforce Development, Division of Employment Security



STATE OF ALASKA

Department of Community and
Economic Development



DIVISION OF INSURANCE 64th ANNUAL REPORT

Calendar Year 2001 ♦ Fiscal Year 2002



IX

**Statistical
& Financial
Data**



**2001 ALASKA HOSPITAL AND
MEDICAL SERVICE CORPORATIONS
(\$000)**

PREMIUMS WRITTEN

INSURER	COMPREHENSIVE		MEDICARE SUPPLEMENT	VISION ONLY	DENTAL ONLY	FEDERAL EMPLOYEES HEALTH PLAN	TOTAL
	Individual	Group					
PREMERA/ BLUE CROSS	15,353	183,269	1,597	0	0	48,535	248,754
ALASKA VISION	0	0	0	1,074	0	0	1,074

PREMIUMS EARNED

INSURER	COMPREHENSIVE		MEDICARE SUPPLEMENT	VISION ONLY	DENTAL ONLY	FEDERAL EMPLOYEES HEALTH PLAN	TOTAL
	Individual	Group					
PREMERA/ BLUE CROSS	15,269	184,247	1,573	0	0	48,965	250,055
ALASKA VISION	0	0	0	1,121	0	0	1,121

CLAIMS INCURRED

INSURER	COMPREHENSIVE		MEDICARE SUPPLEMENT	VISION ONLY	DENTAL ONLY	FEDERAL EMPLOYEES HEALTH PLAN	TOTAL	NUMBER OF SUBSCRIBERS*
	Individual	Group						
PREMERA/ BLUE CROSS	12,406	153,369	1,087	0	0	45,524	212,386	104,763
ALASKA VISION	0	0	0	919	0	0	919	19,187

*Numbers not rounded to the nearest thousand.

2001 ALASKA ACCIDENT & HEALTH MARKET SHARE

01 - GROUP (\$000)

COMPANY NAME	PERCENT OF MARKET	DIRECT PREMIUMS WRITTEN
Aetna Life Ins Co	15.43	18,188
Principal Life Ins Co	15.28	18,011
United Healthcare Ins Co	10.03	11,823
Great West Life & Annuity Ins Co	6.22	7,329
Golden Rule Ins Co	5.33	6,279
Unum Life Ins Co of Amer	5.23	6,166
United of Omaha Life Ins Co	4.34	5,115
Mega Life & Health Ins Co The	4.22	4,973
Guardian Life Ins Co of Amer	2.89	3,405
Hartford Life & Accident Ins Co	2.22	2,615
Safeco Life Ins Co	2.18	2,566
Stonebridge Life Ins Co	1.89	2,229
Standard Ins Co	1.79	2,104
States West Life Ins Co	1.48	1,748
Fortis Benefits Ins Co	1.47	1,733
Union Labor Life Ins Co	1.44	1,700
Metropolitan Life Ins Co	1.28	1,509
Life Ins Co of North Amer	1.23	1,451
Mutual of Omaha Ins Co	1.09	1,289
John Alden Life Ins Co	0.96	1,133
<hr/>		
TOTAL FOR TOP 20 RANKED INSURERS	86.01	101,367
TOTAL FOR ALL 151 INSURERS WRITING THIS LINE	100.00	117,859

02 - CREDIT (\$000)

COMPANY NAME	PERCENT OF MARKET	DIRECT PREMIUMS WRITTEN
Cuna Mut Ins Society	21.33	1,055
American Bankers Life Assur Co of FL	21.30	1,053
American Natl Ins Co	19.66	972
Union Security Life Ins Co	11.78	583
Minnesota Life Ins Co	9.82	486
North Central Life Ins Co	5.30	262
Resource Life Ins Co	4.77	236
Centurion Life Ins Co	2.25	111
Household Life Ins Co	1.01	50
Stonebridge Life Ins Co	0.73	36
Protective Life Ins Co	0.46	23
American Gen Assur Co	0.33	16
Life Investors Ins Co of Amer	0.31	15
Union Fidelity Life Ins Co	0.29	14
Associates Financial Life Ins Co	0.24	12
Allstate Life Ins Co	0.24	12
Balboa Life Ins Co	0.18	9
American Heritage Life Ins Co	0.11	5
USAA Life Ins Co	0.02	1
Central States H & L Co of Omaha	0.01	0
<hr/>		
TOTAL FOR TOP 20 RANKED INSURERS	100.14	4,952
TOTAL FOR ALL 30 INSURERS WRITING THIS LINE	100.00	4,945

2001 ALASKA ACCIDENT & HEALTH MARKET SHARE

9 - ALL OTHER (\$000)

COMPANY NAME	DIRECT PERCENT OF MARKET	PREMIUMS WRITTEN
American Family Life Assr Co Columbus	32.51	5,434
New York Life Ins Co	6.94	1,160
Physicians Mut Ins Co	4.49	750
Mutual of Omaha Ins Co	3.52	589
Unum Life Ins Co of Amer	3.31	553
Northwestern Mut Life Ins Co	3.17	530
Provident Life & Accident Ins Co	2.92	488
General Electric Capital Assur Co	2.87	481
Life Investors Ins Co of Amer	2.85	477
Golden Rule Ins Co	2.81	470
Paul Revere Life Ins Co	2.65	443
Colonial Life & Accident Ins Co	2.31	387
Guardian Life Ins Co of Amer	2.21	370
John Hancock Life Ins Co	1.77	296
Mony Life Ins Co	1.76	294
Equitable Life Assr Soc of The US	1.74	290
Continental General Ins Co	1.40	234
Conseco Senior Health Ins Co	1.38	230
USAA Life Ins Co	1.34	223
Bankers Life & Cas Co	0.89	149
<hr/>		
TOTAL FOR TOP 20 RANKED INSURERS	82.83	13,846
TOTAL FOR ALL 164 INSURERS WRITING THIS LINE	100.00	16,716

10 - TOTAL (\$000)

COMPANY NAME	DIRECT PERCENT OF MARKET	PREMIUMS WRITTEN
Aetna Life Ins Co	13.06	18,224
Principal Life Ins Co	12.98	18,104
United Healthcare Ins Co	8.44	11,823
Great West Life & Annuity Ins Co	5.26	7,342
Golden Rule Ins Co	4.84	6,749
Unum Life Ins Co of Amer	4.82	6,719
American Family Life Assr Co Columbus	3.90	5,438
United of Omaha Life Ins Co	3.67	5,115
Mega Life & Health Ins Co The	3.57	4,975
Guardian Life Ins Co of Amer	2.71	3,775
Hartford Life & Accident Ins Co	1.87	2,616
Safeco Life Ins Co	1.84	2,566
Stonebridge Life Ins Co	1.66	2,323
Standard Ins Co	1.51	2,112
Mutual of Omaha Ins Co	1.35	1,878
New York Life Ins Co	1.31	1,828
States West Life Ins Co	1.25	1,748
Fortis Benefits Ins Co	1.24	1,736
Union Labor Life Ins Co	1.22	1,704
Metropolitan Life Ins Co	1.14	1,590
<hr/>		
TOTAL FOR TOP 20 RANKED INSURERS	77.67	108,364
TOTAL FOR ALL 224 INSURERS WRITING THIS LINE	100.00	139,519

HEALTH INSURANCE BY PRODUCT LINE

INDIVIDUAL - CALENDAR YEAR 2001

PRODUCT	# POLICIES IN FORCE BEG OF YEAR	# INDIVIDUALS COVERED BEG OF YEAR	# NEW # INDIVIDUALS		# COVERED		# POLICIES IN FORCE END OF YEAR	# INDIVIDUALS COVERED END OF YEAR	EARNED PREMIUM*	INCURRED CLAIMS*
			POLICIES ISSUED DURING THE YEAR	NEWLY ISSUED COVERAGE DURING THE YEAR	POLICIES TERMINATED DURING THE YEAR	INDIVIDUALS TERMINATED DURING THE YEAR				
Accident	10,929	18,489	5,016	8,811	4,604	7,347	11,461	20,146	2,875,162	1,161,898
Comp MedPPO	5,163	9,308	725	1,320	461	991	5,427	9,637	15,268,979	12,405,798
Non-PPO	263	474	3	3	41	81	229	396	1,125,263	740,664
Dental PPO	0	0	0	0	0	0	0	0	0	0
Non-PPO	29	34	488	867	90	161	424	740	87,030	4,972
Disability Income	6,131	6,052	1,193	1,207	1,711	1,691	5,662	5,555	5,332,179	5,515,100
Hospital Expense	883	1,325	94	146	194	301	780	1,170	1,418,883	1,557,964
Hospital Indemnity	3,800	5,854	1,324	2,066	1,350	2,158	3,778	5,768	1,209,738	416,712
Limited Benefit	66	66	13	13	1	1	79	79	136,657	0
Long Term Care	1,072	1,103	578	533	55	61	1,593	1,648	2,196,447	509,619
Medical Expense	9	11	2	2	1	1	10	12	9,504	-8,426
Medicare Supplement	2,008	2,029	160	161	204	209	1,968	1,985	2,910,614	1,855,132
Specified Disease	4,658	9,053	2,341	4,103	1,320	2,500	5,703	10,690	1,823,060	693,468
Vision PPO	19	1,589	6	96	1	54	24	1,631	95,683	78,147
Non-PPO	0	0	0	0	0	0	0	0	0	0
Other	2,976	6,083	1,279	2,465	1,112	2,149	3,143	6,399	476,293	108,310
TOTAL	38,006	61,470	13,222	21,853	11,145	17,705	40,281	65,856	34,965,491	25,039,438

Note: This health survey report was compiled from data provided by the companies. The Division of Insurance does not warrant the accuracy of this information.



Alaska Insurance Consumer Guide

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.

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Alaska Insurance Consumer Guide

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?

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Alaska Insurance Consumer Guide

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 ten 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.

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Alaska Insurance Consumer Guide

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 after 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:

The limits specified by your insurance policy:	
Deductible	\$ 500
Coinsurance	80%
Out-of-pocket maximum	\$1,000
<i>Amount Insurer Owes:</i>	
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	<u>\$3,150</u>
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	<u>\$ 130</u>
Total amount insurer owes after out-of-pocket limit applied	\$2,650
<i>Amount You Owe:</i>	
Deductible	\$ 500
Coinsurance amount (20% of \$3,150)	<u>\$ 630</u>
Amount of eligible charges before out-of-pocket limit applied	\$1,130
Amount greater than your out-of-pocket limit	<u>-\$ 130</u>
Amount of eligible charges after out-of-pocket limit applied	\$1,000
Amount greater than the UCR for the procedure	<u>\$ 550</u>
Total amount you owe	\$1,550

Covered Services and Supplies