

11520 HOUSE LABOR & COMMERCE

HB

29

24-LS0101AR
Bailey
3/22/06

CS FOR HOUSE BILL NO. 29()
IN THE LEGISLATURE OF THE STATE OF ALASKA
TWENTY-FOURTH LEGISLATURE - SECOND SESSION

BY

Offered:
Referred:

Sponsor(s): REPRESENTATIVE ROKEBERG

A BILL
FOR AN ACT ENTITLED

1 "An Act relating to health care insurance and to the Comprehensive Health Insurance
2 Association."

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

4 * Section 1. AS 21.09.210 is amended by adding a new subsection to read:

5 (p) A qualified insurer is entitled to a premium tax credit under AS 21.55.220.

6 * Sec. 2. AS 21.55.010 is amended adding a new subsection to read:

7 (b) A member shall submit reports and provide information required by the
8 board or the director to implement this chapter as a condition of transacting business
9 in the state.

10 * Sec. 3. AS 21.55.020(c) is amended to read:

11 (c) In determining voting rights at association meetings, an association
12 member is entitled to vote in person or by proxy. The vote shall be a weighted vote
13 based on the association member's share of assessments as determined under
14 AS 21.55.220 [PREMIUMS FOR HEALTH INSURANCE FOR MAJOR MEDICAL

1 COVERAGE ON AN EXPENSE INCURRED BASIS, OR THE ASSOCIATION
2 MEMBER'S SUBSCRIBER FEES, DERIVED FROM OR ON BEHALF OF STATE
3 RESIDENTS IN THE PREVIOUS CALENDAR YEAR, AS DETERMINED BY
4 THE DIRECTOR].

5 * Sec. 4. AS 21.55.220(c) is amended to read:

6 (c) Each member of the association shall share the losses due to claims
7 expenses of the state plans issued or approved for issuance by the association, and
8 shall share in the operating and administrative expenses incurred or estimated to be
9 incurred by the association incident to the conduct of its affairs. Claims expenses of
10 the state plan that exceed the premium payments allocated to the payment of benefits
11 shall be the liability of the members. Each member shall share in the claims expense
12 of the state plans and operating and administrative expenses of the association in an
13 amount equal to the ratio of the member's [TOTAL FEES FOR SUBSCRIBER
14 CONTRACTS OR] total major medical [HEALTH INSURANCE] premiums,
15 received from or on behalf of state residents, as divided by the total major medical
16 [SUBSCRIBER FEES AND HEALTH INSURANCE] premiums received by all
17 members from or on behalf of state residents, as determined by the director.

18 * Sec. 5. AS 21.55.220(d) is amended to read:

19 (d) The board shall make an annual determination of each member's liability,
20 if any, and may make an annual fiscal year end assessment if necessary. The board
21 may also [, SUBJECT TO THE APPROVAL OF THE DIRECTOR,] provide for
22 interim assessments against the members as may be necessary to assure the financial
23 capability of the association in meeting the incurred or estimated claims expenses of
24 the state plans and operating and administrative expenses of the association until the
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26 within 30 days after [OF] receipt by a member of written notice of a fiscal year end or
27 interim assessment. A member who fails to pay a fiscal year end or interim assessment
28 as required in this subsection (1) shall pay a civil penalty to the director in the amount
29 of \$100 for each day the member fails to pay the required assessment, and (2) may
30 have the member's certificate of authority revoked by the director. A member that
31 ceases to do [HEALTH INSURANCE] business in the state [, OR CEASES TO

1 OFFER SUBSCRIBER CONTRACTS IN THE STATE, DUE TO REVOCATION,
2 SUSPENSION, OR VOLUNTARY SURRENDER OF ITS CERTIFICATE OF
3 AUTHORITY,] remains liable for assessments until the board determines under (c)
4 of this section that no assessment is due [THROUGH THE CALENDAR YEAR
5 THAT THE HEALTH INSURANCE BUSINESS CEASED]. The board may decline
6 to levy an assessment against a member if the assessment would be minimal.
7 Assessments paid by a member are a general expense of the member.

8 * **Sec. 6.** AS 21.55.220 is amended by adding a new subsection to read:

9 (f) A member may offset 50 percent of the amount of the assessment under
10 this section as a premium tax credit reducing the premium tax payable by the member
11 under AS 21.09.210. The offset shall apply to the tax levied for the calendar year
12 following an annual determination of each member's liability under (d) of this section.
13 The offset may not reduce the premium tax payable by a member to less than zero or
14 create a premium tax credit for the member. An unused offset may be carried over to
15 the immediately following calendar year.

16 * **Sec. 7.** AS 21.55.500(14) is repealed and reenacted to read:

17 (14) "major medical"

18 (A) means health insurance or medical care coverage provided
19 on an expense incurred basis, including Medicare supplement insurance;

20 (B) does not include coverage for dental only, vision only,
21 long-term care, nursing home care, home health care, community-based care,
22 accident only, disability income, hospital confinement indemnity or other fixed
23 indemnity, or credit, specified disease or specified accident, or other
24 supplemental health insurance or coverage determined by the board not to
25 constitute major medical and approved by the director;

26 * **Sec. 8.** The uncodified law of the State of Alaska is amended by adding a new section to
27 read:

28 APPLICABILITY. The provisions of sec. 6 of this Act apply to offset the premium
29 tax payable under AS 21.09.210 on January 1, 2007, based on assessments for the previous
30 year's determination of each member's liability, and shall continue annually thereafter.

ALASKA STATE LEGISLATURE

House of Representatives

COMMITTEE ASSIGNMENTS

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

Website: <http://www.akrepulicans.com/~roberg/index.php>



INTERIM
716 WEST 4TH AVENUE, SUITE 600
ANCHORAGE, AK 99501
PHONE (907) 269-0117
FAX (907) 269-0119

SESSION
ALASKA STATE CAPITOL
JUNEAU, AK 99801-1182
PHONE (907) 465-4068
FAX (907) 465-2040

Representative Norman Rokeberg

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

SPONSOR STATEMENT FOR CSHB 29()

By: Representative Norman Rokeberg

Title: An Act relating to health care insurance and to the Comprehensive Health Insurance Association.

The Alaska Comprehensive Health Insurance Association (ACHIA) was established to provide access to health insurance to all residents of the state who are unable to find or are denied health insurance or who are considered uninsurable. It is also required coverage for those federally eligible individuals under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The plan was first implemented in 1993 and is funded through premiums collected from insureds and assessments received from health insurers transacting business in Alaska. Prior to the time the State of Alaska became self-insured, the State was also a participant in providing funds to ACHIA (through assessments received from its health insurer). The effect of the Knowles' Administration's decision not to stay in ACHIA was to reduce ACHIA's funding by approximately \$400,000 per year.

At the end of December 2003, there were 484 insured individuals participating in ACHIA. As the insurer of last resort, it is necessary that we make sure that ACHIA remains viable and in place. During 2003, over \$4 million was collected in assessments from ACHIA members (those companies or entities who do business in Alaska and pay into ACHIA) and over \$2.6 million was collected in premiums from insured individuals. ACHIA paid out over \$6.6 million in claims expenses in that same year.

The majority of Alaskans that receive health care benefits do not contribute to our high-risk pool, thereby shifting the cost to only those individuals and small groups that purchase health insurance. This is poor public policy, particularly on an unfunded Federal mandate.

Many of the self-insured companies objected to the original version of the bill. Therefore, in order to accommodate the needs of ACHIA, this bill has been modified to grant a tax credit to the insurance companies who are currently assessed for the entire ACHIA shortfall by using a small portion of the premium taxes paid into the state. A premium tax credit is justifiable given the importance of maintaining the viability of the Association and its requirement under HIPAA.

When viewed against the demands of the general fund, the viability of this organization far exceeds those of most other legislation before the legislature. I urge your support of this legislation.

ED 2: 3/23/06

ALASKA STATE LEGISLATURE

House of Representatives

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LEGISLATIVE COUNCIL MEMBER
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INTERIM
716 WEST 4TH AVENUE SUITE 800
ANCHORAGE, ALASKA 99501
PHONE (907) 269-0117
FAX (907) 269-0119

SESSION
ALASKA STATE CAPITOL
JUNEAU AK 99801-1182
PHONE (907) 465-4966
FAX (907) 465-2040

Representative Norman Rokeberg

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

SECTIONAL ANALYSIS FOR CSHB 29()

By: Representative Norman Rokeberg

Title: An Act relating to health care insurance and to the Comprehensive Health Insurance Association.

- Section 1:** Insurers who contribute to ACHIA are entitled to a premium tax credit.
- Section 2:** Insurers who contribute to ACHIA shall submit reports and provide information required by the board or director.
- Section 3:** Amends the voting rights section of ACHIA.
- Section 4:** Clarifies that insurers' contributions to ACHIA are based on the "major medical" premiums they write in Alaska.
- Section 5:** Amends the way ACHIA determines liability for unpaid assessments for those insurers who cease to do business in the state.
- Section 6:** An insurer who is required to contribute to ACHIA, may offset 50% of its ACHIA assessment as a tax credit on their premium taxes. The tax credit is applied in the following year based on the previous year's ACHIA assessment.
- Section 7:** Redefines "major medical."
- Section 8:** Premium tax credit applied starting January 1, 2007.

FISCAL NOTE

STATE OF ALASKA
2006 LEGISLATIVE SESSION

Fiscal Note Number: _____
 Bill Version: HB 29
 () Publish Date: _____

Revision Date/Time (Note if correction): _____
 Title Health Care Insur./Comp Health Ins. Assn.
 Sponsor Rokeberg
 Requester House Labor & Commerce

Dept. Affected: Commerce
 RDU Insurance (116)
 Component Insurance Operations
 Component No. 354

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0

CAPITAL EXPENDITURES						
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CHANGE IN REVENUES (1004)		(1,750.0)	(1,925.0)	(2,120.0)	(2,330.0)	(2,560.0)
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FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type--Do not abbreviate)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2006) cost: 0.0

Mark this box (X) if funding for this bill is included in the Governor's FY 2007 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: (Attach a separate page if necessary)

This legislation would result in a reduction to the general fund of the amount of premium tax that would no longer be collected from insurers who pay ACHIA assessments, to the extent that these insurers have a reduced cost of premium taxes and the cost to the insured's may be reduced. This would go into effect in FY 2008 because the offset "shall apply to the tax levied for the calendar year following an annual determination of each member's liability".

Prepared by: Linda S. Hall, Director
 Division: Insurance
 Approved by: William Noll, Commissioner
 Agency: Commerce, Community and Economic Development

Phone 907-269-7900
 Date/Time 3/28/06 11:33 / M
 Date _____



Comprehensive
Health
Insurance
Association
P.O. Box 1090
2015 16th Street
Great Bend, KS 67530

Directors:
Jeffrey W. Davis (Chairperson)
J. Brian Angel
Marilyn Walsh Kasmar
Chester Lozowski
Monr McAleese
Shawn Pollock
Chris Palme-Krizak
Katherine Campbell (Ex-Officio)
Cecil D. Bykerk, Executive Director

March 31, 2006

The Honorable Norman Rokeberg
State Capitol Room 214
Juneau, AK
99801-1182

Dear Chairman Rokeberg:

Thank you for your continued interest and assistance with the risk pool legislation. Heather has provided us the March 23 draft committee substitute for HB 29. We are pleased that the Labor & Commerce Committee will be holding a hearing on the bill today. Unfortunately, Jeff Davis, Chair of ACHIA, Brian Angel, Vice-Chair of ACHIA, and I are unavailable to participate by telephone due to previous commitments.

As you know, the Board believes strongly that ACHIA benefits Alaskans by providing affordable access to health insurance for those individuals that, due to health conditions, cannot obtain coverage in the private market. Consumers in the private market benefit from more stable and otherwise lower premiums. Moreover, by providing coverage for otherwise uncovered catastrophic health conditions, ACHIA ultimately reduces the uncompensated care rolls, thereby benefiting all Alaskans.

Because ACHIA benefits all Alaskans, the most equitable funding approaches are those that are broad-based. To this end, ACHIA supports the inclusion of a premium tax offset for fifty-percent of member assessments. This mechanism not only achieves broad-based funding, but also ensures ACHIA has a stable source of operating funds. The board believes that this bill will provide some relief to those insured Alaskans who currently carry the burden of the assessments through increased premiums for major medical insurance.

Additionally, the board supports the clean-up provisions in Sections 2-5 and 7 of the bill. We believe these provisions are both important and non-controversial and therefore, respectfully urge your support for these provisions as well.

Thank you and your staff again for supporting ACHIA. We stand ready to meet with you as well as other members of the legislature in Juneau to discuss the bill as time permits.

Sincerely,



Cecil D. Bykerk, FSA, MAAA
Executive Director

cc: Director Linda Hall
Board of Directors

ALASKA STATE HOUSE OF REPRESENTATIVES

716 W. 4th Ave
Anchorage, AK 99501
Room 610



Phone (907)-269-0265
Fax# (907)-269-0264

Representative Tom Anderson

FACSIMILE

To: Legislative Legal Fax: 2029
From: Josh Applebee Date: 4/3/2006
Re: Amendments to HB 29
CC:

Urgent For Review Please Comment Please Reply Please Recycle

Good afternoon,

Attached is the amendment adopted by the House Labor & Commerce Committee to HB 29 version 24-LS0191\R.

Please let me know if you have any questions or if there is anything else you need.

Please deliver the bill final to Room 408.

Thank you.

-Josh Applebee

465-4954

Amendment # 1

By: Rep. Rokeberg

Page 3, line 29

Delete "January 1, 2007"

Insert "March 1, 2008"

24-LS019:R
Bailey
3/22/06

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MARCH 1
2008

CONC. AMEND.
#1

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ALASKA STATE LEGISLATURE

House of Representatives

COMMITTEE ASSIGNMENTS

RULES COMMITTEE CHAIRMAN
LABOR & COMMERCE COMMITTEE MEMBER
LEGISLATIVE COUNCIL MEMBER
SPECIAL COMMITTEE ON OIL & GAS MEMBER
SPECIAL COMMITTEE ON WAYS & MEANS MEMBER

website: <http://www.akrepublish.com/groksberg/index.php>



INTERIM
716 WEST 4TH AVENUE SUITE 600
ANCHORAGE AK 99501
PHONE (907) 269-0117
FAX (907) 269-0119

SESSION
ALASKA STATE CAPITOL
JUNEAU AK 99801-1182
PHONE (907) 485-4962
FAX (907) 485-2040

Representative Norman Rokeberg

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

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By: Representative Norman Rokeberg

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Section 6: An insurer who is required to contribute to ACHIA, may offset 50% of its ACHIA assessment as a tax credit on their premium taxes. The tax credit is applied in the following year based on the previous year's ACHIA assessment.

Section 7: Redefines "major medical."

Section 8: Premium tax credit applied starting January 1, 2007.

ALASKA STATE LEGISLATURE

House of Representatives

COMMITTEE ASSIGNMENTS:

LEGISLATION COMMITTEE, CHAIRMAN
LABOR & COMMERCE COMMITTEE, MEMBER
LEGISLATIVE COUNCIL, MEMBER
SPECIAL COMMITTEE ON OIL & GAS, MEMBER
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INTERIM:
716 WEST 4TH AVENUE, SUITE 600
ANCHORAGE, AK 99501
PHONE: (907) 269-0117
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Representative Norman Rokeberg

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

SPONSOR STATEMENT FOR HB 29

By: Representative Norman Rokeberg

Title: An Act relating to health care insurance and to the Comprehensive Health Insurance Association; and providing for an effective date.

House Bill 29 would expand the base of entities paying into the Alaska Comprehensive Health Insurance Association (ACHIA), our "high risk pool," to ensure its future solvency and lower a barrier to entry into the Alaska market by health insurance underwriters.

ACHIA was established to provide access to health insurance to all residents of the state who are unable to find or are denied health insurance or who are considered uninsurable. It is also required coverage for those federally eligible individuals under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The plan was first implemented in 1993 and is funded through premiums collected from insureds and assessments received from health insurers transacting business in Alaska. Prior to the time the State of Alaska became self-insured, the State was also a participant in providing funds to ACHIA (through assessments received from its health insurer). The effect of the Knowles' Administration's decision not to stay in ACHIA was to reduce ACHIA's funding by approximately \$400,000 per year.

HB 29 would require that, to the extent permitted by federal law, all self-insured entities and other ERISA covered entities that provide major medical benefits be contributing entities to ACHIA. This would include the State of Alaska. The legislation indicates that entities subject to a collective bargaining agreement in effect on the date of the legislation would not be impacted by this legislation until such time as a new agreement went into effect. This would permit unions, for example, to negotiate with employers for any increased costs. State employees not covered by union agreements would not see their cost for health insurance increases as this legislation provides that the State will provide funds above any set contribution amount to cover any ACHIA assessment.

At the end of December 2003, there were 484 insured individuals participating in ACHIA. As the insurer of last resort, it is necessary that we make sure that ACHIA remains viable and in place. During 2003, over \$4 million was collected in assessments from ACHIA members (those companies or entities who do business in Alaska and pay into ACHIA) and over \$2.6 million was collected in premiums from insured individuals. ACHIA paid out over \$6.6 million in claims expenses in that same year.

The majority of Alaskans that receive health care benefits do not contribute to our high-risk pool, thereby shifting the cost to only those individuals and small groups that purchase health insurance. This is poor public policy, particularly on an unfunded Federal mandate.

I urge your support of this legislation.

ED 1: 2/7/05

Insurers Writing Comprehensive Health Insurance in Alaska

The Alaska Division of Insurance surveys insurers each year to gather health insurance market share information. For calendar year 2003 the following companies indicated on the survey that they were actively marketing comprehensive health insurance (i.e. writing new business) in Alaska. Note that the following chart does not include insurers that indicated on the survey that they did not actively market comprehensive health insurance in Alaska in 2003. *For information regarding coverage and premiums contact one or more agents or brokers licensed to sell health insurance in Alaska. You can search for agents or brokers in your area on the Division's website at <http://www.commerce.state.ak.us/insurance/producerinfo.htm>. Also, if you click on company name in the following chart you will see a list of agents or brokers that are authorized to sell insurance for that company in Alaska.*

Company Name	Type	Premium	Share of Active Market
Premera Blue Cross Blue Shield of Alaska	<ul style="list-style-type: none"> • Individual • Small Employer • Large Employer 	\$256,727,435	79.27%
Principal Life Insurance Company	<ul style="list-style-type: none"> • Small Employer • Large Employer 	\$23,932,613	7.39%
Aetna Life Insurance Company	<ul style="list-style-type: none"> • Small Employer • Large Employer 	\$16,793,513	5.19%
Golden Rule Insurance Company	<ul style="list-style-type: none"> • Individual 	\$7,362,503	2.27%
Mega Life and Health Insurance Company	<ul style="list-style-type: none"> • Individual • Small Employer 	\$6,145,604	1.90%
United HealthCare Insurance Company	<ul style="list-style-type: none"> • Small Employer • Large Employer 	\$5,578,953	1.72%
Trustmark Insurance Company	<ul style="list-style-type: none"> • Small Employer 	\$3,913,270	1.21%
United of Omaha Life Insurance Company	<ul style="list-style-type: none"> • Large Employer 	\$2,348,204	0.73%
New York Life Insurance Company	<ul style="list-style-type: none"> • Large Employer 	\$585,858	0.18%
John Alden Life Insurance Company	<ul style="list-style-type: none"> • Individual 	\$145,733	0.04%
Celtic Insurance Company	<ul style="list-style-type: none"> • Individual 	\$143,416	0.04%
Connecticut General Life Insurance Company	<ul style="list-style-type: none"> • Large Employer 	\$68,518	0.02%
Continental Assurance Co.	<ul style="list-style-type: none"> • Small Employer 	\$61,820	0.02%
Fortis Insurance Company	<ul style="list-style-type: none"> • Individual 	\$55,784	0.02%
American Heritage Life Insurance Company	<ul style="list-style-type: none"> • Large Employer 	\$8,671	0.00%

HB 29

Analysis of Change in Assessment Formula

Current Assessment Formula (AS 21.55)

An insurer is a member of Alaska Comprehensive Health Insurance Association (ACHIA) if it offers major medical insurance on an expense-incurred basis in Alaska. Major medical is defined as a health insurance contract or subscriber contract that provides benefits for hospital and medical care with potential lifetime maximum benefits of at least \$10,000. Major medical does not include a stop loss insurance policy, a fixed indemnity health insurance product, or a product with lifetime maximum benefits of less than \$10,000.

If an insurer offers major medical insurance on an expense-incurred basis in Alaska, then all health insurance premiums offered by that insurer, including stop loss insurance, fixed indemnity and other non-major medical health insurance (such as long term care, disability income, specified disease) premiums would be assessed. However, if an insurer only wrote stop loss insurance, fixed indemnity or other non-major medical health insurance, then the insurer would not be assessed.

A member's share of ACHIA assessments is the insurer's health insurance premiums written in Alaska in the base year divided by the total health insurance premiums written in Alaska by all ACHIA members in the base year.

For example, assume that only the following 7 insurers write the health insurance in Alaska as shown.

	<u>Major Medical Premiums</u>	<u>Stop Loss Premiums</u>	<u>Other Non-Major Medical Premiums</u>
Insurer1	5,000	0	1,500,000
Insurer2	0	0	5,000,000
Insurer3	150,000,000	0	70,000
Insurer4	15,000,000	0	0
Insurer5	0	3,000,000	0
Insurer6	400,000	300,000	0
Insurer7	0	100,000	300,000

In this example Insurer2, Insurer5, and Insurer7 would not be members of ACHIA and subject to assessment, since they have not written any major medical insurance.

Assessment shares would be determined as follows:

	<u>Major Medical Premiums</u>	<u>Stop Loss Premiums</u>	<u>Other Non-Major Medical Premiums</u>	<u>Total Premiums</u>	<u>Assessment Share* %</u>
Insurer1	5,000	0	1,500,000	1,505,000	.90
Insurer3	150,000,000	0	70,000	150,070,000	89.72
Insurer4	15,000,000	0	0	15,000,000	8.96
Insurer6	400,000	300,000	0	700,000	.42
				<u>167,275,000</u>	<u>100.00</u>

* Assessment share = Each member's total premium / total premium for all members

If the total ACHIA assessment required is \$5,000,000:

Insurer1 would pay	45,000	(.0090*5,000,000)
Insurer3 would pay	4,486,000	(.8972*5,000,000)
Insurer4 would pay	448,000	(.0896*5,000,000)
Insurer6 would pay	<u>21,000</u>	(.0042*5,000,000)
	5,000,000	

Proposed Assessment Formula (HB 29)

An insurer is a member of ACHIA if it offers major medical insurance on an expense-incurred basis in Alaska. In addition a self-insured entity for which the State is not preempted from regulating under federal law that provides major medical benefits is also a member. Major medical benefits are defined to include stop loss insurance and to exclude benefits such as dental, vision, accident, disability income and other benefits that are not major medical benefits. Under HB 29 ACHIA membership would be expanded to include stop loss insurers and self-insured entities for which the state is not preempted from regulating under federal law which includes self-funded governmental plans, church plans, and multiple employer welfare arrangements. Also, the change in the definition of major medical in HB 29 would result in some insurers no longer being members.

ACHIA members would be assessed on the number of lives covered under their major medical health plans in Alaska instead of all health insurance premiums written in Alaska. Since the number of lives covered under major medical plans is not currently reported to the Division, each member would be required to report such data to the director for purposes of determining the ACHIA assessment.

Each member's share of the ACHIA assessment is the member's reported number of lives with major medical coverage in the base year divided by the total number of lives with major medical reported by all ACHIA member in the base year.

For example, assume that only the following 7 insurers write the health insurance in Alaska as shown:

	<u>Stop Loss Number of Lives</u>	<u>Major Medical Number of Lives</u>	<u>Non-Major Medical Number of Lives</u>
Insurer1	0	3	1,000
Insurer2*	0	0	20,000
Insurer3	0	65,000	0
Insurer4	0	6,500	500
Insurer5	11,000	0	0
Insurer6	200	150	2,000
Insurer7	350	0	5,000

*Insurer2 is not a member of ACHIA and therefore would not be assessed, since none of the coverage that Insurer2 wrote meets the definition of major medical.

Assessment shares would be determined as follows:

	<u>Stop Loss Number of Lives</u>	<u>Major Medical Number of Lives</u>	<u>Total Number of Lives</u>	<u>Share %*</u>
Insurer1	0	3	3	0.00
Insurer3	0	65,000	65,000	78.12
Insurer4	0	6,500	6,500	7.82
Insurer5	11,000	0	11,000	13.22
Insurer6	200	150	350	.42
Insurer7	350	0	350	.42

*Share % = Each insurer's total number of lives / total number of lives for all insurers

If the total assessment required is \$5,000,000:

Insurer1 would pay	0	(.0000*5,000,000)
Insurer3 would pay	3,906,000	(.7812*5,000,000)
Insurer4 would pay	391,000	(.0782*5,000,000)
Insurer5 would pay	661,000	(.1322*5,000,000)
Insurer6 would pay	21,000	(.0042*5,000,000)
Insurer7 would pay	21,000	(.0042*5,000,000)
	<u>5,000,000</u>	

Illustration of impact of HB29 on ACHIA assessments:

- This analysis uses the 2003 Health Insurance Survey and State of Alaska data
- *The assessment formula in HB 29 requires that to the extent practicable, each covered life should be count only once. The Division does not have the necessary data to adjust the number of covered lives to remove duplicates. Therefore, the below impact should be considered illustrative only.*
- The below analysis assumes that the state employee union health trusts and other self-funded governmental plans and self-funded church plans purchase stop-loss insurance and therefore the covered lives are already included the stop loss insurance data
- The 2003 premium assessment base was approximately \$423,625,000
- The 2003 estimated total covered lives base under HB 29 is 303,800.

Assuming a \$5 million ACHIA assessment:

<u>Member</u>	<u>Premium</u> <u>(000s)</u>	<u>Covered</u> <u>Lives</u>	<u>Current</u> <u>Share</u>	<u>Current Amt</u> <u>Assessed</u>	<u>HB29</u> <u>Share</u>	<u>HB29 Amt</u> <u>Assessed</u>
Premera Blue Cross	263,000	83,400	62.01%	\$3,100,000	27.4%	\$1,372,000
State of Alaska*	160,000	63,600	0%	\$0	20.9%	\$1,047,000
Principal	27,500	7,000	6.50%	\$325,000	2.3%	\$114,000
Aetna	19,300	5,700	4.57%	\$228,000	1.9%	\$94,000
United HealthCare	12,800	11,000	3.02%	\$151,000	3.6%	\$180,000
Great-West	7,880	13,000	1.86%	\$93,000	4.3%	\$216,000
Golden Rule	7,500	3,800	1.77%	\$88,000	1.3%	\$63,000
Mega L&H	7,500	3,000	1.77%	\$88,000	1.0%	\$49,000
AFLAC	7,500	0	1.77%	\$88,000	0%	\$0
Avemco	3,700	6,700	0.87%	\$44,000	2.2%	\$110,000
Companion	1,900	2,200	0%	\$0	.7%	\$36,000
All Stop Loss Insurers	42,000	96,000	10%	\$465,000	32%	\$1,580,000

* Only includes employees and dependents covered under Select Benefits (i.e. plans administered by the State, with no stop loss insurance coverage), and Retirees

Notes:

AFLAC writes low premium limited benefit health insurance products that are not included in the HB 29 definition of major medical.

Companion is not assessed under the current formula because Companion only wrote stop loss insurance, which is not considered major medical insurance under the current assessment formula

Great-West and Avemco primarily write stop loss insurance, the premium per covered life is smaller for stop loss coverage compared with major medical coverage. This means that assessments on stop loss insurance will be higher under the HB 29 covered lives based formula compared with the current premium based formula.

Illustration of impact of HB29 on ACHIA assessments (Without State Retirees):

- This analysis uses the 2003 Health Insurance Survey and State of Alaska data
- *The assessment formula in HB 29 requires that to the extent practicable, each covered life should be count only once. The Division does not have the necessary data to adjust the number of covered lives to remove duplicates. Therefore, the below impact should be considered illustrative only.*
- The below analysis assumes that the state employee union health trusts and other self-funded governmental plans and self-funded church plans purchase stop-loss insurance and therefore the covered lives are already included the stop loss insurance data
- The 2003 premium assessment base was approximately **\$423,625,000**
- The 2003 estimated total covered lives base under HB 29 is **254,000**.

Assuming a \$5 million ACHIA assessment:

<u>Member</u>	<u>Premium Covered</u> <u>(000s)</u>	<u>Covered</u> <u>Lives</u>	<u>Current Current Amt</u> <u>Share</u>	<u>Assessed</u>	<u>HB29</u> <u>Share</u>	<u>HB29 Amt</u> <u>Assessed</u>
Premiera Blue Cross	263,000	83,400	62.01%	\$3,100,000	32.8%	\$1,639,000
State of Alaska*	160,000	63,600	0%	\$0	5.5%	\$277,000
Principal	27,500	7,000	6.50%	\$325,000	2.7%	\$136,000
Aetna	19,300	5,700	4.57%	\$228,000	2.2%	\$112,000
United HealthCare	12,800	11,000	3.02%	\$151,000	4.3%	\$215,000
Great-West	7,880	13,000	1.86%	\$93,000	5.2%	\$259,000
Golden Rule	7,500	3,800	1.77%	\$88,000	1.5%	\$75,000
Mega L&H	7,500	3,000	1.77%	\$88,000	1.2%	\$58,000
AFLAC	7,500	0	1.77%	\$88,000	0%	\$0
Avemco	3,700	6,700	0.87%	\$44,000	2.6%	\$131,000
Companion	1,900	2,200	0%	\$0	.9%	\$43,000
All Stop Loss Insurers	42,000	96,000	10%	\$465,000	38%	\$1,887,000

*Only includes employees and dependents covered under Select Benefits (i.e. plans administered by the State, with no stop loss insurance coverage). DOES NOT INCLUDE STATE RETIREES.

Notes:

AFLAC writes low premium limited benefit health insurance products that are not included in the HB 29 definition of major medical.

Companion is not assessed under the current formula because Companion only wrote stop loss insurance, which is not considered major medical insurance under the current assessment formula

Great-West and Avemco primarily write stop loss insurance, the premium per covered life is smaller for stop loss coverage compared with major medical coverage. This means that assessments on stop loss insurance will be higher under the HB 29 covered lives based formula compared with the current premium based formula.

Assessments provided by ACHIA Board
March 16, 2005

NAIC	CARRIER	WRITTEN PREMIUM	% OF MARKET	ASSESSMENT
77879	5 Star Life Ins Co	23,539	0.005566919%	\$130
22657	Ace American Ins Co	44,246	0.0104446400%	\$261
60054	Acta Life Co	19,342,481	4.5659577638%	\$114,149
60186	Allstate Life Ins Co	257,111	0.0605932465%	\$1,517
67399	Alta Health & Life Ins Co	401,834	0.09448583461%	\$2,371
60080	American Family Life Assur Co Columbus	7,472,429	1.7639306584%	\$44,628
60410	American Fidelity Assur Co	1,030,244	0.2431978912%	\$6,080
60534	American Heritage Life Ins Co	407,010	0.0960781851%	\$2,402
27928	Amex Assur Co	416,318	0.0982754179%	\$2,457
10367	Avemco Ins Co	3,700,977	0.8736472155%	\$21,841
61212	Baltimore Life Ins Co	27,887	0.0065782432%	\$162
61263	Bankers Life & Cas Co	145,796	0.0351245660%	\$878
38245	BCS Ins Co	76,729	0.0181125355%	\$453
90538	Best Life And Health Ins Co	18,840	0.0044001311%	\$110
80799	Citic Ins Co	167,748	0.0395983474%	\$990
80896	Centre Life Ins Co	62,499	0.0147534225%	\$369
62049	Colonial Life & Accident Ins Co	411,142	0.0970535790%	\$2,426
62146	Combined Ins Co Of Amer	73,134	0.0172760885%	\$432
62398	Connecticut General Life Ins Co	87,347	0.0206190050%	\$515
78174	Conseco Health Ins Co	138,002	0.0325765502%	\$814
78225	Conseco Senior Health Ins Co	256,647	0.0605837153%	\$1,515
62413	Continental Assur Co	60,882	0.0143953217%	\$360
20443	Continental Cas Co	2,212,362	0.5222489367%	\$13,058
71404	Continental General Ins Co	106,704	0.0251883901%	\$630
62553	Country Life Ins Co	49,738	0.0117410795%	\$294
62944	Equitable Life Assr Soc Of The US	253,031	0.0597301276%	\$1,493
71870	Fidelity Security Life Ins Co	33,815	0.0079823194%	\$200
38830	Fort Wayne Hlth & Cas Ins Co	1,823,881	0.3833309729%	\$9,583
70408	Fortis Benefits Ins Co	1,810,356	0.4273499385%	\$10,884
80926	GE Grp Life Assur Co	127,958	0.0302055783%	\$755
70025	General Electric Capital Assur Co	1,528,653	0.3608515905%	\$9,021
91472	Globe Life & Accident Ins Co	65,874	0.0155501201%	\$389
62286	Golden Rule Ins Co	7,502,818	1.7711042393%	\$44,270
63312	Great American Life Ins Co	93,205	0.0220018359%	\$550
68322	Great West Life & Annuity Ins Co	7,882,617	1.8607590355%	\$46,519
64211	Guarantee Trust Life Ins Co	19,712	0.0046531859%	\$116
64246	Guardian Life Ins Co Of Amer	2,239,544	0.5286634798%	\$13,217
22217	Gulf Ins Co	19,737	0.0046590873%	\$116
70815	Hartford Life & Accident Ins Co	3,629,778	0.8567220545%	\$21,418
88072	Hartford Life Ins Co	124,582	0.0294086446%	\$735
73288	Humana Ins Co	146,473	0.0345762021%	\$864
70580	Humanadental Ins Co	677,342	0.1598923815%	\$3,997
65005	IDS Life Ins Co	99,643	0.0235215808%	\$588
70254	Jefferson Pilot Financial Ins Co	1,249,917	0.2950535782%	\$7,376
65080	John Alden Life Ins Co	172,468	0.0407125437%	\$1,018
65099	John Hancock Life Ins Co	756,106	0.1784852761%	\$4,462
65315	Liberty Life Assur Co Of Boston	84,330	0.0199068164%	\$498
65323	Liberty Life Ins Co	43,327	0.0102277082%	\$256
65498	Life Ins Co Of North Amer	1,750,924	0.4133205576%	\$10,333
64130	Life Investors Ins Co Of Amer	784,573	0.1852051544%	\$4,630
65676	Lincoln Natl Life Ins Co	74,120	0.0174966588%	\$437
71471	Medico Life Ins Co	136,587	0.0322425274%	\$806
97055	Mega Life & Health Ins Co The	7,475,106	1.7645625851%	\$44,114
65978	Metropolitan Life Ins Co	2,423,139	0.5720026469%	\$14,300
66087	Mid West Natl Life Ins Co Of TN	23,017	0.0054333593%	\$136
66281	Monumental Life Ins Co	432,184	0.1020207227%	\$2,551
66370	Money Life Ins Co	247,661	0.0584624933%	\$1,462
71412	Mutual Of Omaha Ins Co	1,194,383	0.2819443034%	\$7,049
66915	New York Life Ins Co	2,105,432	0.4970051973%	\$12,425
24147	Old Republic Ins Co	41,343	0.0098773974%	\$247
97268	Pacific Life & Annuity Co	369,378	0.0871948302%	\$2,160
67598	Paul Revere Life Ins Co	468,271	0.1105333671%	\$2,763
63282	Penn Treaty Network Amer Ins Co	111,350	0.0262851181%	\$657
67660	Pennsylvania Life Ins Co	57,891	0.0136656648%	\$342
66605	Peoples Benefit Life Ins Co	58,591	0.0138309057%	\$346
80578	Physicians Mut Ins Co	717,949	0.1694779905%	\$4,237
47570	Premier Blue Cross	262,706,411	62.0140909997%	\$1,550,352
61271	Principal Life Ins Co	27,520,815	6.4965233216%	\$162,413
68133	Protective Life Ins Co	45,905	0.0108362671%	\$271
68195	Provident Life & Accident Ins Co	940,313	0.2219689110%	\$5,549
68209	Provident Life & Cas Ins Co	26,837	0.0063351030%	\$158
68241	Prudential Ins Co Of Amer	327,727	0.0773627561%	\$1,934

Assessments provided by ACHIA Board
 March 16, 2005

NAIC	CARRIER	WRITTEN PREMIUM	% OF MARKET	ASSESSMENT
65765	Reassure America Life Ins Co	301,689	0.0712162639%	\$1,780
67105	Reliastar Life Ins Co	2,709,522	0.6396057989%	\$15,990
61360	Reliastar Life Ins Co Of NY	88,444	0.0208779812%	\$522
68608	Safeco Life Ins Co	8,785,075	2.0737919505%	\$51,845
69214	Sears Life Ins Co	144,779	0.0341763189%	\$854
68721	Security Life Ins Co Of Amer	61,632	0.0145487597%	\$364
86355	Standard Life & Accident Ins Co	25,380	0.0059911657%	\$150
25178	State Farm Mut Auto Ins Co	3,793,888	0.8955820108%	\$22,390
77399	Sterling Life Ins Co	271,901	0.0641845522%	\$1,605
65021	Stonebridge Life Ins Co	2,046,169	0.4830156603%	\$12,075
87726	The Travelers Ins Co	88,246	0.0203591046%	\$509
60142	TIAA Cref Life Ins Co	22,093	0.0052152413%	\$130
86231	Transamerica Life Ins Co	25,010	0.0059038240%	\$148
67121	Transamerica Occidental Life Ins Co	45,262	0.0106844815%	\$267
61425	Trustmark Ins Co	83,865	0.0197970492%	\$495
37893	Ulico Cas Co	139,385	0.0329053797%	\$823
80314	Unicare Life & Health Ins Co	331,754	0.0782133638%	\$1,958
62596	Union Fidelity Life Ins Co	153,880	0.0363246876%	\$908
69744	Union Labor Life Ins Co	1,535,028	0.3623564627%	\$9,059
9291	United American Ins Co	88,186	0.0208170581%	\$520
79413	United Healthcare Ins Co	12,786,116	3.0206324202%	\$75,516
69868	United Of Omaha Life Ins Co	4,660,575	1.1001685153%	\$27,504
70106	United States Life Ins Co In NYC	1,054,504	0.2489246713%	\$6,223
62235	Unum Life Ins Co Of Amer	6,148,871	1.4514934915%	\$36,287
80659	US Bus of the Canada Life Assur Co	62,022	0.0146408226%	\$366
69863	USAA Life Ins Co	165,269	0.0390131583%	\$975
81027	Veterans Life Ins Co	20,424	0.0048212596%	\$121
70319	Washington Natl Ins Co	67,255	0.0158761169%	\$397
16535	Zurich American Ins Co	689,835	0.1628414408%	\$4,071
		423,623,739	100.0000000000%	\$2,500,000

FISCAL NOTE

STATE OF ALASKA
2005 LEGISLATIVE SESSION

Fiscal Note Number: _____
 Bill Version: HB 29
 () Publish Date: _____

Revision Date/Time (Note if correction): _____ Dept. Affected: Commerce
 Title Health Care Insurance-ACHIA RDU Insurance (116)
 Component Insurance
 Sponsor Rokeberg
 Requester House Labor & Commerce Component No. 354

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2006	FY 2007	0	FY 2009	FY 2010	FY 2011
Personal Services	0.0	0.0		0.0	0.0	0.0
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0

CAPITAL EXPENDITURES						
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CHANGE IN REVENUES ()						
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FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type--Do not abbreviate)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2005) cost: 0.0
 Mark this box (X) if funding for this bill is included in the Governor's FY 2006 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: (Attach a separate page if necessary)

HB 29 would expand membership of ACHIA to include stop loss insurers and self-insured entities for which the state is not preempted from regulating under federal law which includes self-funded governmental plans, church plans, and multiple employer welfare arrangements. The bill would change the definition of major medical which would result in some insurers no longer being members. It would modify the assessment formula from a premium based formula to formula based on the number of lives covered under their major medical health plans in Alaska. Since the number of lives covered under major medical plans is not currently reported to the Division, each member would be required to report such data to the director for purposes of determining the ACHIA assessment. The director reports this information to the board and the board is responsible for determining the assessments. This bill would have no fiscal impact on the Division.

Prepared by: Linda S. Hall, Director Phone 907-269-7900
 Division: Insurance Date/Time 4/7/05 3:15 PM
 Approved by: Edgar Blatchford, Commissioner Date 4/7/2005
 Agency: Commerce, Community, and Economic Development

FISCAL NOTE

STATE OF ALASKA
2005 LEGISLATIVE SESSION

Fiscal Note Number: _____
 Bill Version: HB 29
 () Publish Date: _____

Revision Date/Time (Note if correction): _____ Dept. Affected: Statewide
 Title: An Act relating to health care insurance (CHIA) RDU: Statewide
 Component: Statewide
 Sponsor: Representative Rokeberg
 Requester: Labor and Commerce, Health, Educati Component No. _____

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011
Personal Services	1,047.0	1,047.0	1,047.0	1,047.0	1,047.0	1,047.0
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	1,047.0	1,047.0	1,047.0	1,047.0	1,047.0	1,047.0

CAPITAL EXPENDITURES						
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CHANGE IN REVENUES ()						
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FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts
1003 GF Match
1004 GF	ALL FUNDING SOURCES					
1005 GF/Program Receipts	.	.	.	.	.	.
1037 GF/Mental Health	.	.	.	.	.	.
Other (Specify Type--Do not abbreviate)	.	.	.	.	.	.
TOTAL	1,047.0	1,047.0	1,047.0	1,047.0	1,047.0	1,047.0

Estimate of any current year (FY2005) cost: 0.0
 Check this box (X) if funding for this bill is included in the Governor's FY 2006 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: (Attach a separate page if necessary)

This bill would add self-insured plans (to the extent permitted under federal law) to the membership of the Comprehensive Health Insurance Association (CHIA).

Based on the anticipated CHIA assessment for 2005, this bill would assess the Select Benefits Plan (5,300 employees) an annual estimated amount of \$232,000 and the Retiree Health Plan an estimated annual amount of \$815,000 for a total of \$1,047,000 per year.

Prepared by: Melanie Millhorn, Director Phone 465-4408
 Division: Retirement and Benefits Date/Time 4/7/05 2:37 PM
 Approved by: Mike Tibbles, Deputy Commissioner Date 4/7/2005
 Agency: Department of Administration

FISCAL NOTE

STATE OF ALASKA
2005 LEGISLATIVE SESSION

BILL NO. HB 29

This estimate is being provided and would need to be followed-up by an actuarial analysis, which is estimated to take approximately two weeks from the date of the request.

AS 24.08.036 FISCAL NOTES ON BILLS AFFECTING STATE RETIREMENT SYSTEMS, requires an additional analysis of the long term and short term costs to the state if a bill is adopted, as well as the impact of the bill on the actuarial soundness of the funds. This bill would increase the average PERS contribution rate by _____% (to be determined) of PERS payroll. For FY 06 this would be an added cost to the state of approximately \$1,047,000. In addition, the funding ratio of the PERS as of June 30, 2004 was 70.2%. Passage of this bill would decrease the funding ratio to % _____(to be determined).

This bill would also increase the TRS contribution rate by _____(to be determined) % of TRS payroll. The funding ratio of the TRS as of June 30, 2004 was 62.8%. The passage of this bill would decrease the funding ratio by _____% (to be determined) .



Comprehensive
Health
Insurance
Association
P.O. Box 1090
2015 16th Street
Great Bend, KS 67530

Directors:
Jeffrey W. Davis (Chairperson)
J. Brian Angel
Marilyn Walsh Kasmar
Chester Lozowski
Mona McAleese
Shawn Pollock
Chris Palme-Krizak
Katherine Campbell (Ex-Officio)
Cecil D. Bykerk, Executive Director

March 31, 2006

The Honorable Norman Rokeberg
State Capitol Room 214
Juneau, AK
99801-1182

Dear Chairman Rokeberg:

Thank you for your continued interest and assistance with the risk pool legislation. Heather has provided us the March 23 draft committee substitute for HB 29. We are pleased that the Labor & Commerce Committee will be holding a hearing on the bill today. Unfortunately, Jeff Davis, Chair of ACHIA, Brian Angel, Vice-Chair of ACHIA, and I are unavailable to participate by telephone due to previous commitments.

As you know, the Board believes strongly that ACHIA benefits Alaskans by providing affordable access to health insurance for those individuals that, due to health conditions, cannot obtain coverage in the private market. Consumers in the private market benefit from more stable and otherwise lower premiums. Moreover, by providing coverage for otherwise uncovered catastrophic health conditions, ACHIA ultimately reduces the uncompensated care rolls, thereby benefiting all Alaskans.

Because ACHIA benefits all Alaskans, the most equitable funding approaches are those that are broad-based. To this end, ACHIA supports the inclusion of a premium tax offset for fifty-percent of member assessments. This mechanism not only achieves broad-based funding, but also ensures ACHIA has a stable source of operating funds. The board believes that this bill will provide some relief to those insured Alaskans who currently carry the burden of the assessments through increased premiums for major medical insurance.

Additionally, the board supports the clean-up provisions in Sections 2-5 and 7 of the bill. We believe these provisions are both important and non-controversial and, therefore, respectfully urge your support for these provisions as well.

Thank you and your staff again for supporting ACHIA. We stand ready to meet with you as well as other members of the legislature in Juneau to discuss the bill as time permits.

Sincerely,



Cecil D. Bykerk, FSA, MAAA
Executive Director

cc: Director Linda Hall
Board of Directors



Comprehensive
Health
Insurance
Association
P.O. Box 1090
2015 16th Street
Great Bend, KS 67530

Directors:
Jeffrey W. Davis (Chairperson)
J. Brian Angel
Marilyn Walsh Kasmar
Chester Lozowski
Mona McAleese
Snawn Pollock
Chris Palme-Krizak
Katherine Campbell (Ex-Officio)
Cecil D. Bykerk, Executive Director

March 17, 2006

The Honorable Rep. Tom Anderson
State Capitol Room 408
Juneau, AK 99801-1182

The Honorable Rep. Tom Anderson:

It is with great pleasure that we are forwarding the enclosed copy of the Alaska Comprehensive Health Insurance Association (ACHIA) 2004 Report. The Report indicates that the number of covered individuals continues to grow. While the assessment burden carried by the health insurers in the state had leveled off a few years ago, trends in 2003 and 2004 as well as other factors suggest that the absolute assessment amount will resume its upward movement. While the initial affect of the increasing assessment burden is carried by the health insurers doing business in the state, that affect, i.e., increased cost, is passed on to those individuals who are insured by those carriers. While the Board is continuing its efforts to hold costs in line by implementing changes allowed by the 1999 legislation amending A.S. 21.55, increasing health care costs in general limit what the Board can do to bring these costs under control. Additionally, the Board is committed to keeping the premiums paid by ACHIA policyholders at an appropriate, but reasonable, level relative to the insured private marketplace. While the Board has indicated that it would maintain the ACHIA premiums at approximately 125% of the average premiums of the five top companies in the market, due to the pressure on assessment levels, the Board has moved that target level up somewhat. In any case, A.S. 21.55 limits the premium levels to no more than 150% of the average premium and the Board intends to stay well below that level.

While costs and premiums keep spiraling up, the assessment base, i.e., insured health plans in Alaska, continues to shrink or at least not keep pace with the ACHIA claims. As the assessment percentage becomes larger, it increases the premiums that groups, primarily small groups, and individuals pay for insured major medical plans. If this trend continues, some small groups and individuals may drop coverage due to high premium levels, resulting in an increased number of uninsureds in the state. The Board stands ready to enter into discussions with you regarding possible ways to address this issue.

ACHIA did receive some relief due to the Federal Trade Assistance Act which was enacted in 2003. The Act provides for funding based on losses in 2002 and 2003. ACHIA received \$541,883 for 2002 and \$427,227 so far for 2003 losses and just received a clean up grant for 2003 of \$56,328. While this Act was the subject of a 2004 Congressional bill for extension to 2009, it died. However, similar legislation was passed on February 1, 2006. This will provide for funding in the five year period 2006 through 2010.

The Board is composed of five representatives from the top health insurers in Alaska and two consumer members. Mona McAleese has filled one of the consumer positions for a number of years. We were pleased that Marilyn Walsh Kasmar agreed to take an appointment to the second consumer position in the Fall of 2005. The Board has spent many hours of, basically, volunteer time, managing this program. We have a passion to make it work the best that it can for the citizens of Alaska. Over the years the Division of Insurance has worked closely with the Board. The Board is appreciative of the assistance that the Division gives it in administering the program. Additionally, in an effort to assist the Board with its efforts, Cecil Bykerk was hired in September 2004 as Executive Director. Cecil previously served as Chairman of the Board for 10+ years, but retired from Mutual of Omaha in August 2004. Cecil has nearly 15 years experience working on high risk pool boards including serving as Chair of the National Association of Comprehensive Health Insurance Associations.

The Board continues to be enthused about the potential for ACHIA and what it can do for the people of Alaska. Please feel free to contact any of the board members listed in the Annual Report, or Cecil, if you would like to discuss the ACHIA Annual Report or any other issues relating to ACHIA. Also, if the Board, or Cecil, can be of any assistance to you in providing testimony at hearings, please let us know. Jeff's telephone number is (907) 258-5065 x 304, his fax is (907) 258-1619 and his e-mail is jeff.davis@premera.com. Cecil's telephone is (402) 351-2534, his fax is (402) 351-2465 and his e-mail is oakoffice1@cox.net.

Sincerely,



Jeffrey W. Davis
Chair, Comprehensive Health Insurance Association

Sincerely,



Cecil D. Bykerk, FSA, MAAA
Executive Director

cc: Director Linda Hall
Board of Directors

Enclosures

ANNUAL REPORT
OF
ALASKA COMPREHENSIVE
HEALTH INSURANCE ASSOCIATION

JANUARY 1, 2004 - DECEMBER 31, 2004



ACHIA ANNUAL REPORT

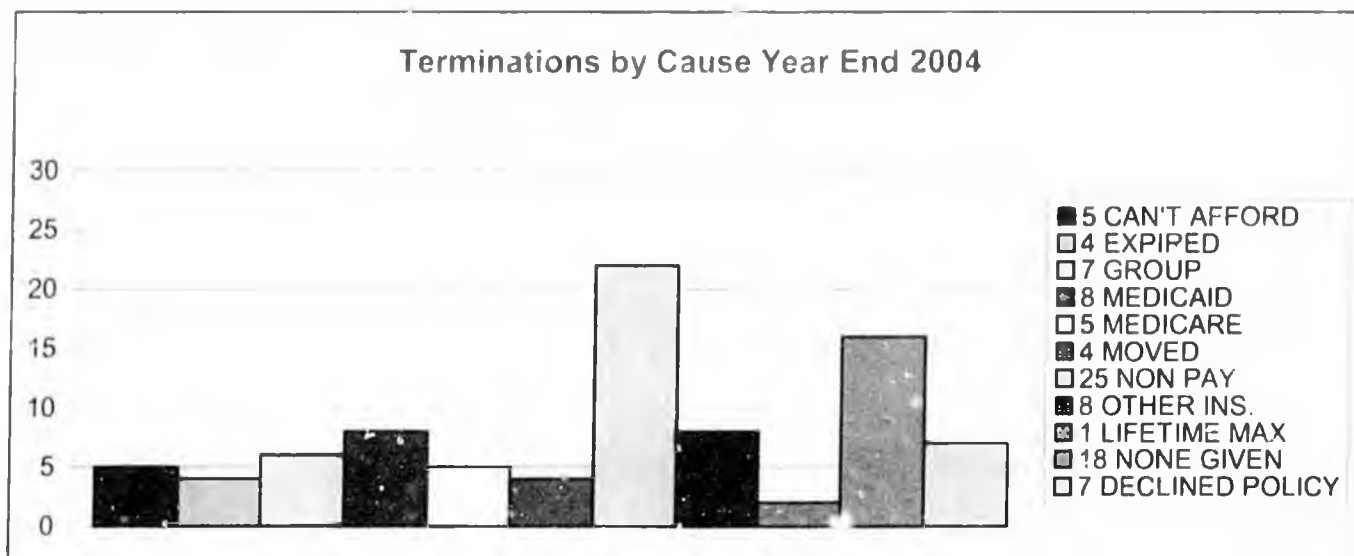
Introduction

The Alaska Comprehensive Health Insurance Association (ACHIA) was established by the Alaska Legislature to provide access to health insurance to all residents of the state who are unable to find or are denied health insurance or who are considered uninsurable. During 1997, legislation was passed that also made ACHIA coverage available to individuals who are considered 'federally eligible individuals' under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Additional legislation was passed in 1999 that allowed the introduction of Preferred Provider (PPO) discount plans. Legislation in 2003 allows for ACHIA to provide coverage to those individuals who are eligible for the Federal Trade Adjustment Act of 2002.

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

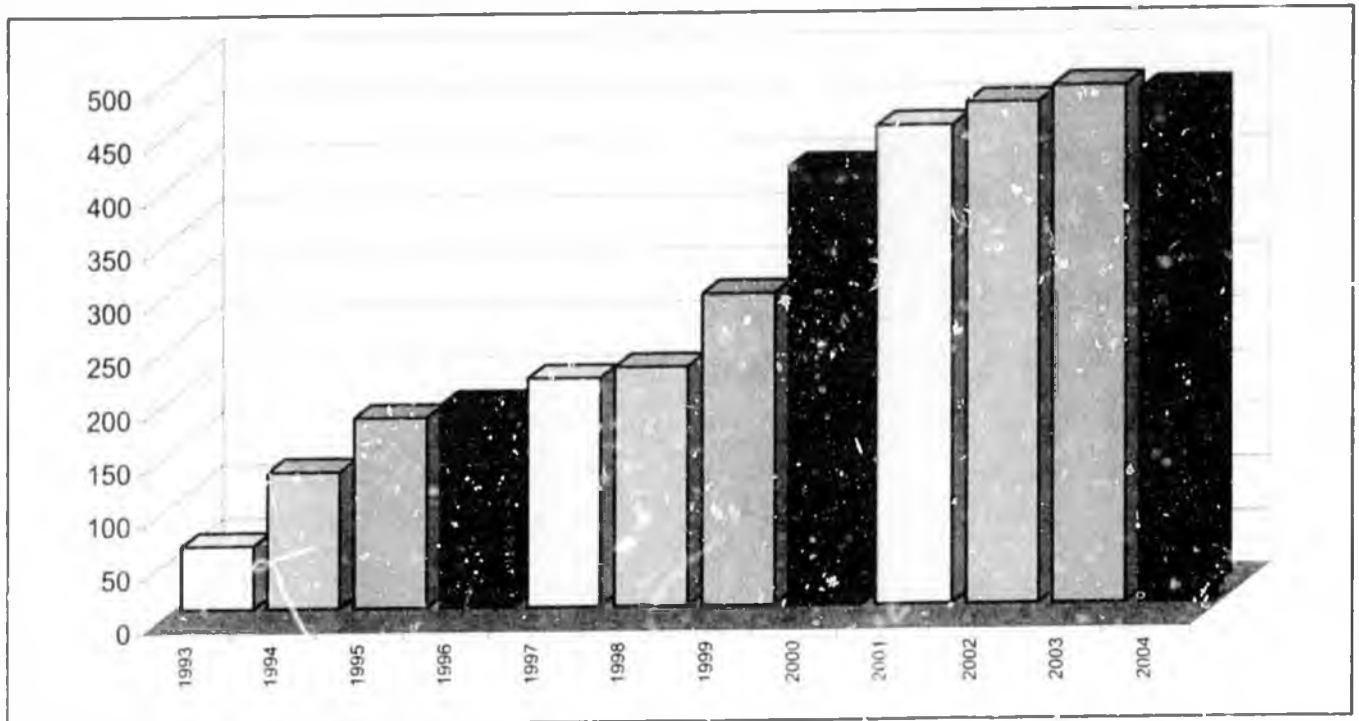
Effective July 1, 2002, Benefit Management became the new administrative carrier. As administrator, BMI processes applications for coverage under the plan, collects premium, pays claims on behalf of the association and performs other administrative functions as provided in the administrative contract. Prior to that and from inception of the Plan, January 1, 1993, Aetna Insurance Company had served as the administrator of the Plan. The Plan is funded through premiums collected from insured's and assessments received from health insurers transacting business in Alaska.

At the beginning of 2004, there were 484 insured's on the plan. As of December 31, 2004, there were 480 insured's. During the year, there were 83 new issues from January 1 - December 31, 2004 and 87 terminations from January 1 - December 31, 2004. Since inception, 826 terminations have occurred. The following chart shows the distribution for reason for termination from January 1 - December 31, 2004.



In 2004, 83 policies were issued. As of December 31, 2004, there were a total of 480 policies in force.

In-force by Year



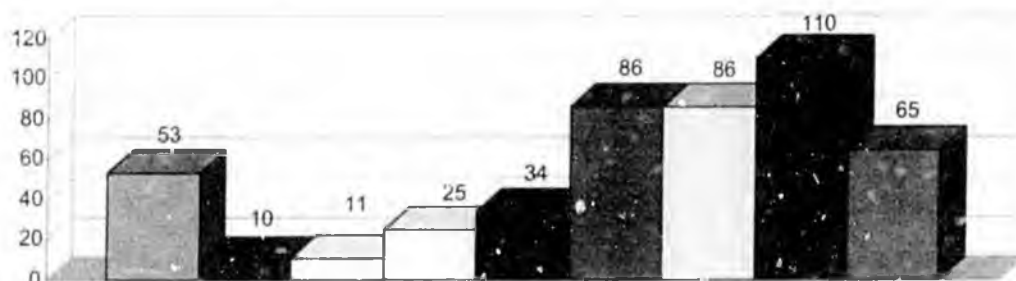
Active Policyholder by Geographic Area



Policyholders by Plan and Age at Year End 2004

Age	Medicare Plans			Trad. Plan		PPO Plans					
	Carveout	Med Supp A	Med Supp I	Age	\$1,000	Age	\$1,000	\$1,500	\$2,500	\$5,000	\$10,000
0-17	0	0	0	0-17	4	0-17	7	7	2	4	1
18-29	0	0	0	18-29	4	18-29	6	12	10	4	1
30-34	0	1	0	30-34	2	30-34	2	4	6	2	3
35-39	2	0	0	35-39	2	35-39	4	8	7	7	3
40-44	6	0	0	40-44	5	40-44	3	11	5	9	4
45-49	4	0	3	45-49	2	45-49	6	14	11	12	6
50-54	11	0	2	50-54	3	50-54	3	13	10	17	9
55-59	11	1	1	55-59	2	55-59	2	11	23	18	19
60-64	19	5	1	60-64	1	60-64	1	6	12	37	19
65-69	0	2	0	65-69	0	65-69	0	0	0	0	0
70-74	0	1	2	70-74	0	70-74	0	0	0	0	0
75-79	0	0	3	75-79	0	75-79	0	0	0	0	0
80-84	0	0	2	80-84	0	80-84	0	0	0	0	0
85+	0	0	0	85+	0	85+	0	0	0	0	0
Total	53	10	11	Total	25	Total	34	96	86	110	65

TOTAL ENROLLMENT: 480



Carveout
 Med Supp A
 Med Supp I
 \$1,000 Plan
 Traditional
 \$1,500 Plan
 \$2,500 Plan
 \$5,000 Plan
 \$10,000 Plan

Observations & Recommendations

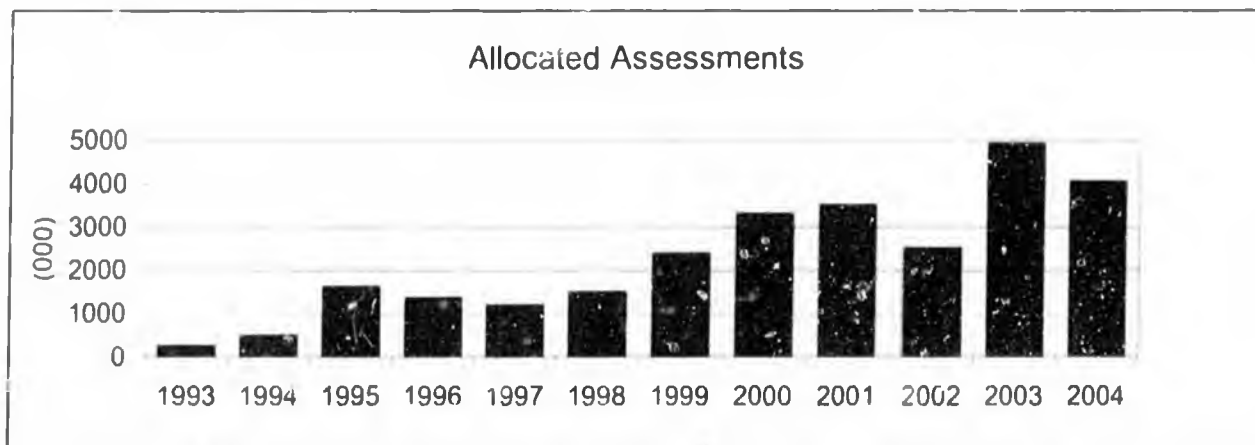
After the administrative change to BMI effective July 1, 2002, the enrollment count did drop. At the end of July 2002, the number of policyholders was at 467. At the end of August, 2002, the number of policyholders was 443, a decrease of 24. This was mostly due to the fact that ineligible people were being sifted out. Since September 2002, the enrollment count has been steadily increasing to finish out the 2004 year with 480 total insured's. This figure is down by only 4 from year end 2003. As for claim cost, BMI paid claims in the amount of \$6,333,543 for the time period of 1/1/04-12/31/04. This amount includes some high cost insured's who have hemophilia and continuously need very expensive infusions. Fortunately, each identified insured of these large claim dollars has been assigned to large case management that has been successful in obtaining discounts for their medications.

Pre-transplant and post-transplant care is the diagnosis for several other insured's. These individuals are followed by case management until they become eligible for

Medicare or indefinitely if they don't become eligible for Medicare. BMI has identified 68 individuals since 7/1/02 and assigned them to large case management. Numerous insured's leave the State of Alaska to seek medical care, particularly to the State of Washington. Fortunately, the PPO network provides for discounts at many commonly used facilities. Diabetes and Heart/Coronary also take a large number of claim dollars.

Expected reasons for increased claim levels include the expiration of pre-existing condition limits as well as the initial behavioral changes that result when someone who has not had health insurance coverage for some period of time, obtains coverage and sees physicians for long standing conditions. This is exacerbated in the case of non-HIPAA individuals who are eligible for ACHIA coverage since they must prove that they have significant health conditions in order to participate. 2002 continued the trend toward increased prescription drug costs. 2004 has also seen very high prescription drug utilization and costs despite the use of the drug vendor PNK which provides for discounts for those using a member pharmacy. Product for hemophilia insureds has also been a very costly item. Cancer and coronary disease as you will notice in the graphs to follow have been looked at through case management as well. The total savings that have been tracked by case management has been \$696,336.40 from July 1, 2002 through December 31, 2004, whereas ACHIA paid \$89,677.00 in that same time frame for those large case management services.

During 2000 the assessment rate reached a level that was about 1.0% of premium but it dropped off for two years to around 0.8% in 2002. This percentage drop was the result of fairly constant assessment needs coupled with an increasing premium assessment base with that base growing from \$300 million in 2000 to \$400 million in 2002. 2003 saw a reversal of this downward trend with the assessment rate exceeding 1% again with a slight downward dip in 2004. When compared to other high risk pools around the country, this level stands out as being high. It should be noted that during the early years of the program the Board's ability to anticipate the needed assessment amount caused some irregular assessment patterns. In more recent years, the Board has attempted to allocate the assessments by accounting methodology to the appropriate year of need. The following graph has been developed by actually calculating the revenue shortfall that occurred in each designated year.



<u>Assessment Year</u>	<u>Assessment Amount</u>	<u>Allocated Amount</u>
1993	\$ 330,000	\$ N/A
1994	0	N/A
1995	1,800,000	N/A
1996	2,700,000	N/A
1997	0	1,200,000
1998	2,500,000	1,500,000
1999	1,500,000	2,500,000
2000	3,300,000	3,300,000
2001	3,500,000	3,500,000
2002	2,500,000	2,500,000
2003	4,500,000	4,913,238
2004	5,000,000	4,041,789

The last two years have been affected by two unusual events. During 2003 some exceptionally large claims were incurred which resulted in a sizeable increase in reserves at yearend. 2004's experience was favorably improved by receiving a grant from the Federal Government in the amount of \$969,110. To more fairly represent the need for premium subsidization, this grant money is noted above as if it were an assessment since its use was designated by the Board to reduce the need for additional assessments. Given the characteristics of the Alaska insurance market it is important to consider other possible funding sources. If a broader base of funding can not be achieved, the burden on the insured marketplace will begin to have a negative impact on the ability of individuals to afford coverage. At the current time, it is extremely difficult if not impossible to derive any funding support from the self-insured market. While premiums do support some of the cost, the loss ratio (claims divided by premiums) in 2000 exceeded 300%. The Board raised premiums July 1, 2000. As a result the loss ratio for 2001 dropped back close to 250%. The Board raised the premiums again February 1, 2002 with the loss ratio for 2002 dropping again to around 225%. However, premiums can only do so much. Individuals can only afford so much. 2003 saw the loss ratio climb to around 285%. This was in part due to some very large drug claims for hemophiliacs and two transplants. 2004 has seen the loss ratio drop back to 255% which is still very high. As is stated elsewhere in this report, this pool was never intended to be self-supporting. If it could be, then the private market would be able to price and sell products to these individuals.

High risk pool legislation across the country was never intended to result in an insurance operation that was self sustaining and Alaska is no exception. Legislative history indicates that this fact was discussed during the deliberations of the Alaska legislation. At times, the poor claim to premium ratio (loss ratio) of the pool has been very distressing to everyone connected with the pool, particularly those not familiar with this type of legislation. But, high risk pools were developed to cover individuals who have been deemed to be essentially uninsurable by insurance carriers. If actuarially sound premiums could be developed for these individuals, insurance carriers would sell them appropriately priced coverage and a high risk pool would be unnecessary.

However, in order to prevent the premium charged from getting too high, a maximum premium was established by statute. This maximum premium is developed by obtaining the average standard risk premium rates of the top 5 carriers in the state and multiplying that average by 1.5. Legislation in 2003 reduced this maximum from 2.0 to 1.5, i.e., 150%. The Board initially set the premiums at 1.75 times that average, which was less than the maximum allowed. In 1993, the Board chose to set the premium at 1.75 rather than 2.00 because they felt that the 200% level would be too high to be affordable. In adjusting premium rates in 2000, the Board decided to further reduce the target ratio to 1.50. This decision was made in an effort to balance the cost of the plan with the ability of people to pay. Consideration was also given to what other state high risk pools target. Due to the extremely high trend rates and the large absolute premium levels, the Board chose in 2002 to target a ratio of 1.25%. Due to the extreme shortfalls of claims over premiums, the target was increased to the 1.25% to 1.4% range in 2004.

Over the fourteen years that ACHIA has existed, the Board has used several strategies in an effort to manage ACHIA's financial condition. These include (1) implementation of higher deductible/out-of-pocket maximum plans that are priced at lower rates and encourage individuals to manage their costs better, (2) hiring of a case manager to help control costs while achieving better care for the individuals, (3) raising the premium levels to offset inflation, (4) requiring, in cooperation with the Administrator, better and more timely financial reports with which to monitor the plan, (5) establishment of more efficient and appropriate assessment procedures and (6) development of a PPO plan that will take advantage of hospital discounts. This later approach required legislation which was enacted during 1999.

During 2000, the Board developed PPO plans which were implemented on January 1, 2001. The \$500 deductible non-PPO plan was increased to \$1000 in 2002, and remains a straight indemnity plan with an 80/20 coinsurance level for all covered benefits over the \$1000 up to the out-of-pocket maximum of \$2500. All other non-Medicare related plans are now on a PPO basis with in-network benefits covered at the 80/20 level while out-of-network benefits are 60/40 up to the out-of-pocket maximum. Also, following a great deal of input from the consumer representatives on the Board as well as policyholders that are Medicare eligible, the Board implemented a Medicare Carveout plan during 2000. This product better meets the needs of individuals who wanted to have better prescription drug coverage within their plan but are frustrated by the fact that Medicare does not currently provide such on an outpatient basis. At the end of 2004, 53 individuals had selected the plan compared to 10 on Plan A and 11 on Plan I of the Medicare Supplement products. In 2002, the out-of-pocket maximum was increased on most plans. Effective January 1, 2003, the Carveout Plan was modified to ensure an equitable out of pocket for each insured enrolled. Effective January 1, 2003, only the amounts that insured's are actually responsible for paying and for which ACHIA is not responsible, would be applied to the deductible and out of pocket. That meant that, unlike in the past, the amount that Medicare paid on an insured's behalf would NOT be applied to the deductible and out of pocket.

2006 will see changes for the Medicare Carveout and the Medicare Supplement Plan I due to the passage of the Medicare Modernization Act in 2004. Medicare Part D will provide drug coverage to individuals who are Medicare eligible. This will cause the

Board to take some action with respect to the two plans with drug coverage that are offered to those individuals.

In summary, the Board feels that ACHIA has served a useful purpose to the citizens of Alaska. With the HIPAA legislation, ACHIA has provided a vehicle which will allow the private insurers continued flexibility to provide private health insurance to the citizens of Alaska as well as allow them to help fund ACHIA. The ACHIA Board revised the Plan of Operation, application, contracts and other support information during 2000 and early 2001. As the Board looks forward in 2005 and beyond, it continues to strive to balance a plan that provides coverage for some who are most in need while keeping it somewhat affordable without competing with the private marketplace which is funding its shortfall through assessments. Board seeks input, dialogue and suggestions from the policyholders, the public, the insurance industry, legislators and others who are interested in reducing the number of uninsured in the State of Alaska.

Note: For a more extensive history of ACHIA prior to 2000 please see the 1999 Annual Report that is available on www.achia.com or from the Chair.

What are the Benefits?

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

What Is Not Covered?

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

Does a Waiting Period Apply?

The Plan will not cover expenses incurred during the first six months after the policy date for a preexisting condition. Payments will be in accordance with the provisions of the policy, however, if the person had coverage under another medical plan which was involuntarily terminated and coverage is applied for under ACHIA within 31 days after such involuntary termination, the preexisting condition waiting period will apply only to the excess, if any, of six months over the time coverage was in force under the prior plan. Additionally, 'federally eligible individuals' under the HIPAA and TAA legislation will have all waiting periods and preexisting condition limitations waived provided they apply for ACHIA coverage within 90 days after coverage under an employer-sponsored group.

Who Is Eligible?

Any person is eligible for the ACHIA plan if he or she:

- *is not currently covered by any other health plan or health insurance policy;
- *is not eligible for coverage under AS 21.56, Small Employer Health Reform;
- *has been a resident for the past 12 months and continues to be a resident of Alaska; **and *at least one of the following:**

- has received from one health insurers notice of rejection for health insurance dated within the last six months; [1999 legislation changed this two to one rejection]
- has received restrictive riders that substantially reduce coverage; **or**
- has any of the conditions listed below:

Acquired Immune Deficiency Syndrome (AIDS)	Malignant Tumor (if treated or has occurred within last 4 yrs)
Alzheimer's	Mental Retardation
Angina Pectoris	Metastatic Cancer
Anorexia Nervosa	Motor or Sensory Aphasia
Arteriosclerosis Obliterans	Multiple or Disseminated Sclerosis
Artificial Heart Valve	Muscular Atrophy or Dystrophy
Ascites	Myasthenia Gravis
Brain Tumors	Myotonia
Cardiomyopathy	Obesity - Morbid
Cerebral Palsy	Open Heart Surgery
Chronic Pancreatitis	Paraplegia or Quadriplegia
Cirrhosis of the Liver	Parkinson's Disease
Coronary Insufficiency	Peripheral Arteriosclerosis (if treatment within last 3 yrs)
Coronary Occlusion	Poliomyelitis
Crohn's Disease	Polyarteritis (Periarteritis Nodosa)
Cystic Fibrosis	Polycystic Kidney
Dermatomyositis	Postero-lateral Sclerosis
Diabetes	Psychotic Disorders
Epilepsy	Rheumatoid Arthritis
Friederich's Disease	Sickle Cell Anemia
Heart Disorders	Silicosis
Hemophilia	Splenic Anemia (True Banti's Syndrome)
Hepatitis C (Active) (1998)	Still's Disease
HIV+	Stroke (CVA)
Hodgkin's Disease	Syringomyelia
Huntington's Chorea	Tabes Dorsalis (locomotor Ataxia)
Hydrocephalus	Thalassemia (Cooley's or Mediterranean Anemia)
Intermittent Claudication	Topectomy and Lobotomy
Kidney Failure	Ulcerative Colitis
Lead Poisoning with Cerebral Involvement	Wilson's Disease
Leukemia	
Lupus Erythematosus Disseminate	

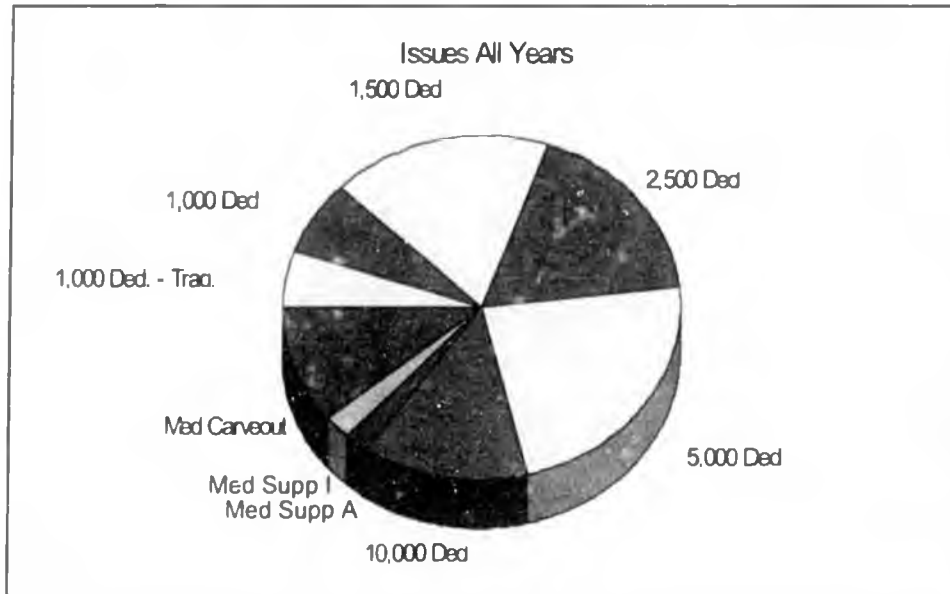
Individuals covered by Medicare may still be eligible for coverage under this plan. Additionally, effective July 1, 1997, a 'federally eligible individual' may purchase ACHIA coverage provided they are a resident of Alaska at the time of application. . Following the passage of the Federal Trade Adjustment Act (TAA) eligibility for TAA qualified individuals was added to the ACHIA eligibility criteria.

Policyholder Profile

Six deductible options were available during 2004: \$1,000, \$1,500, \$2,500, \$5,000, and \$10,000. In addition, Medicare Supplements Plan A, Plan I and a Carveout Plan were also available. As of December 31, 2004, the plan insured the following:

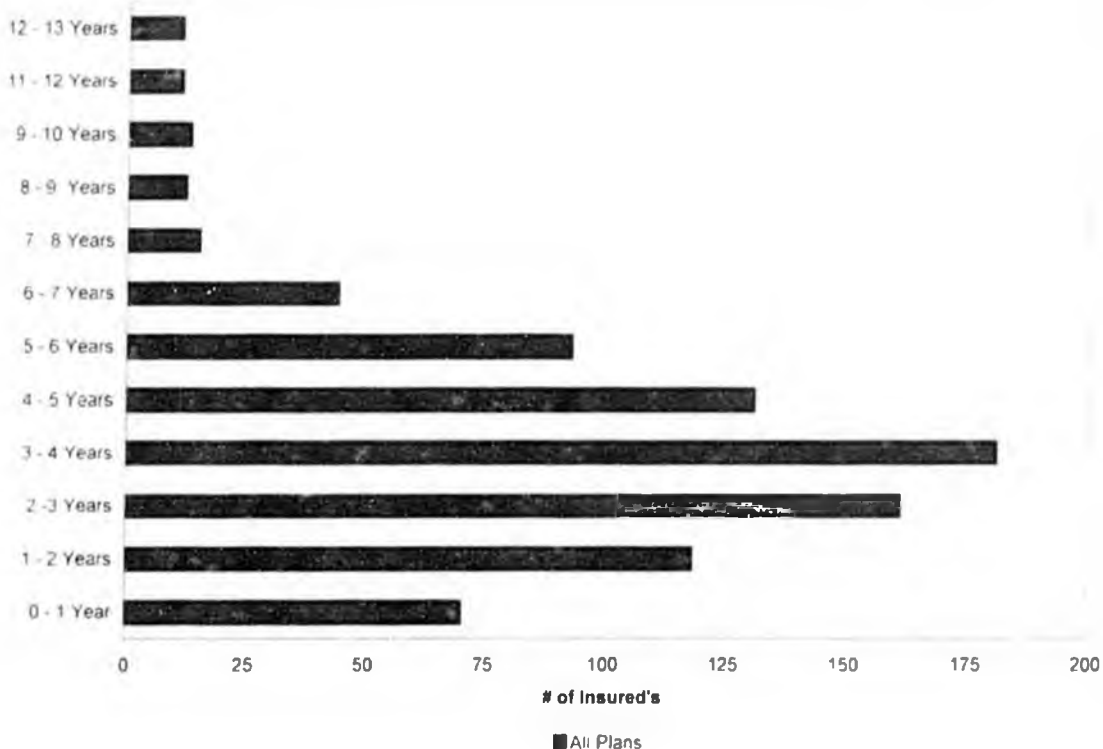
2004 Year End Active Policyholders by Plan Type

Issues	PPO Deductible					Traditional	Medicare Supplement		Medicare Carveout	Total
	1,000	1,500	2,500	5,000	10,000	\$1,000	A	I		
All	34	86	86	110	65	25	10	11	53	480



The following shows the historic durations of our policyholders since ACHIA's start.

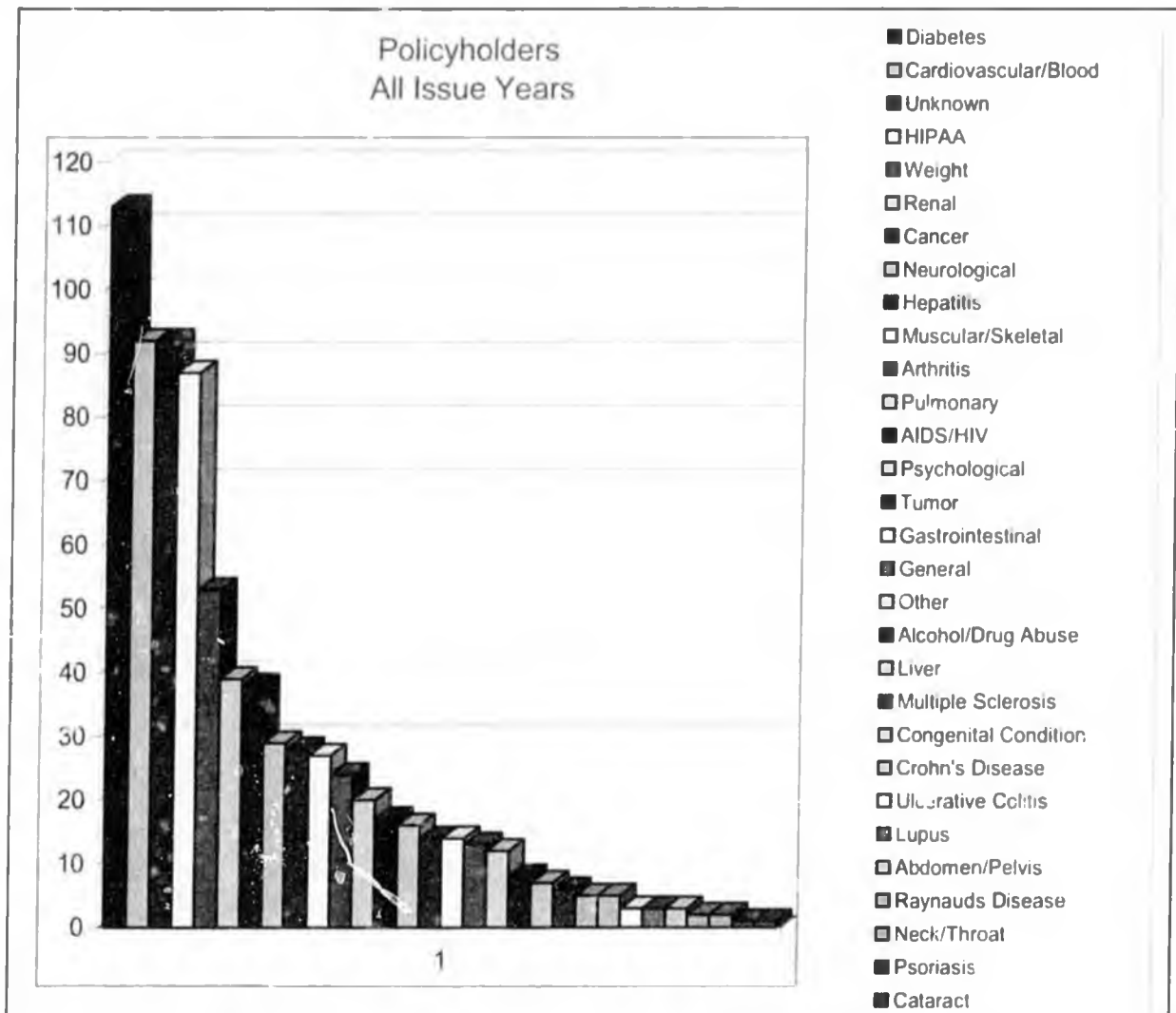
Average Time Enrolled in ACHIA



Primary Medical Condition

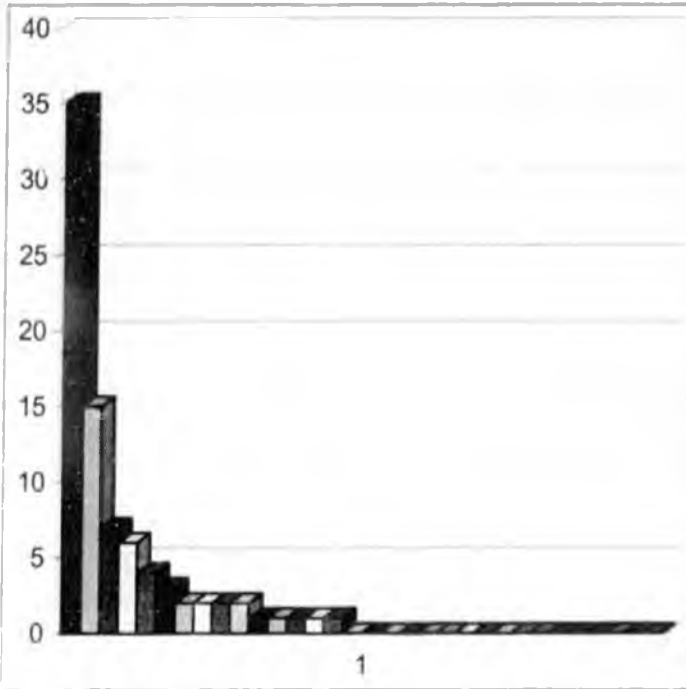
Applicants for ACHIA coverage are asked to identify their primary medical condition. The most frequently listed category includes conditions related to a history of diabetes. The next most frequently listed condition is cardiovascular/blood. These conditions, as well as experience from member companies, make up the list of specified conditions for which eligibility in ACHIA will be considered without the normal requirement that individuals have at least one rejection for coverage in the last six months. Insured's who qualified for ACHIA coverage through HIPAA eligibility provisions are counted in the tables and charts, including the primary medical condition chart.

In order as listed



In order as listed

Policyholders
2004 Issues

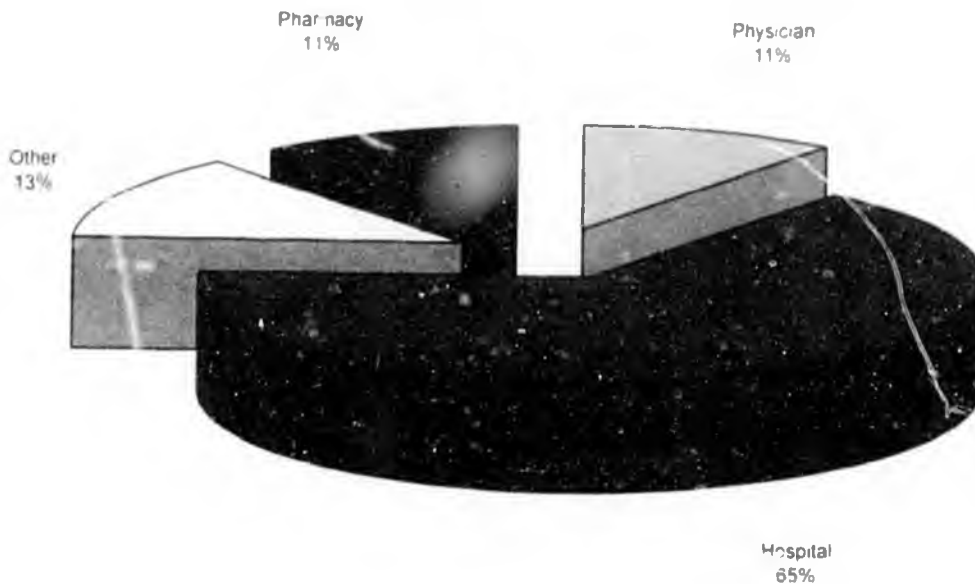


- Federally Defined
- Unknown
- Diabetes
- Heart Disorders
- Kidney Failure
- Metastatic Cancer
- Rheumatoid Arthritis
- Multiple Sclerosis
- Hepatitis C
- Crohn's Disease
- Morbid Obesity
- Cirrhosis of the Liver
- Open Heart Surgery
- Coronary Occlusion
- Hodgkin's
- Angina Pectoris
- Cardiomyopathy
- Malignant Tumor
- AIDS/HIV
- Psychotic Disorders
- Parkinson
- Alcoholism
- Emphysema
- Leukemia
- Mental Retardation
- Psoriasis
- Lupus
- Hydrocephalus
- Ulcerative Colitis
- Silicosis
- Alzheimers
- Brain Tumor

Claims & Providers

The following details the distribution of claim payments by type of provider, by ICD-9 codes and by institution.

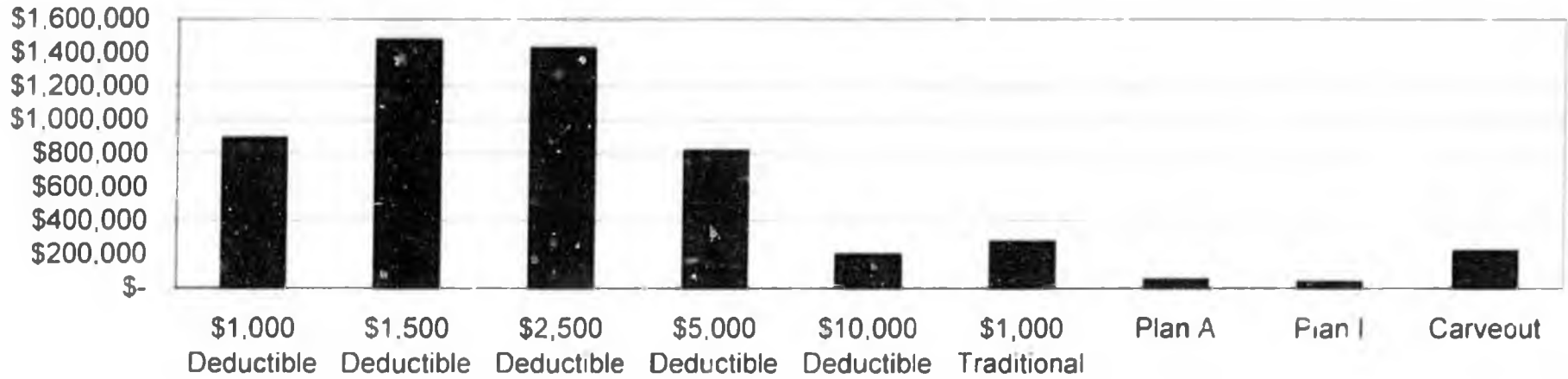
2004 Distribution of Claim Payments by Provider Type



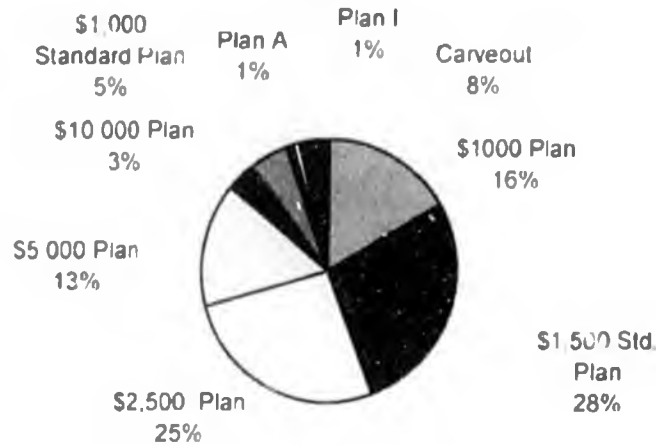
For the calendar year 2004, a total of \$5,358,111 was paid in medical claims.

\$1,000	\$1,500	\$2,500	\$5,000	\$10,000	\$1,000	Plan A	Plan I	Carveout
\$ 887,378	\$ 1,474,241	\$ 1,425,555	\$ 810,143	\$ 196,353	\$ 273,563	\$ 44,920	\$ 31,801	\$ 214,156

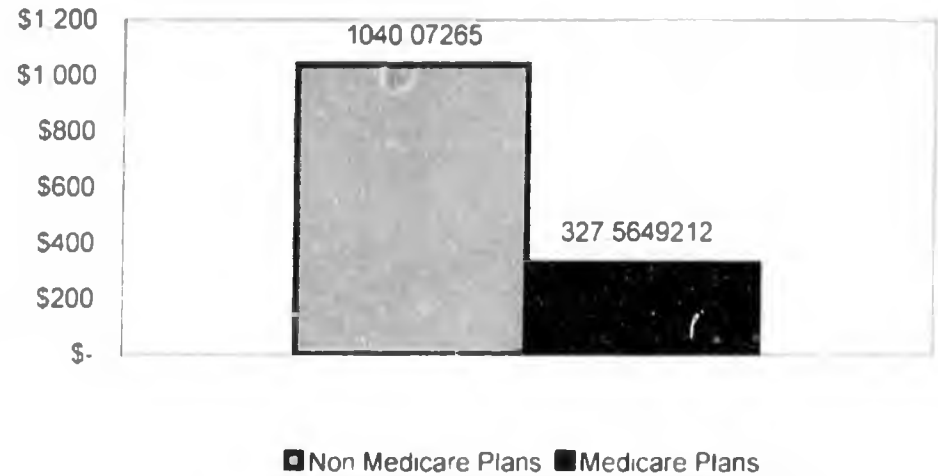
Medical Claims Paid by Plan



Medical Claims Paid by Plan Percentage Comparison



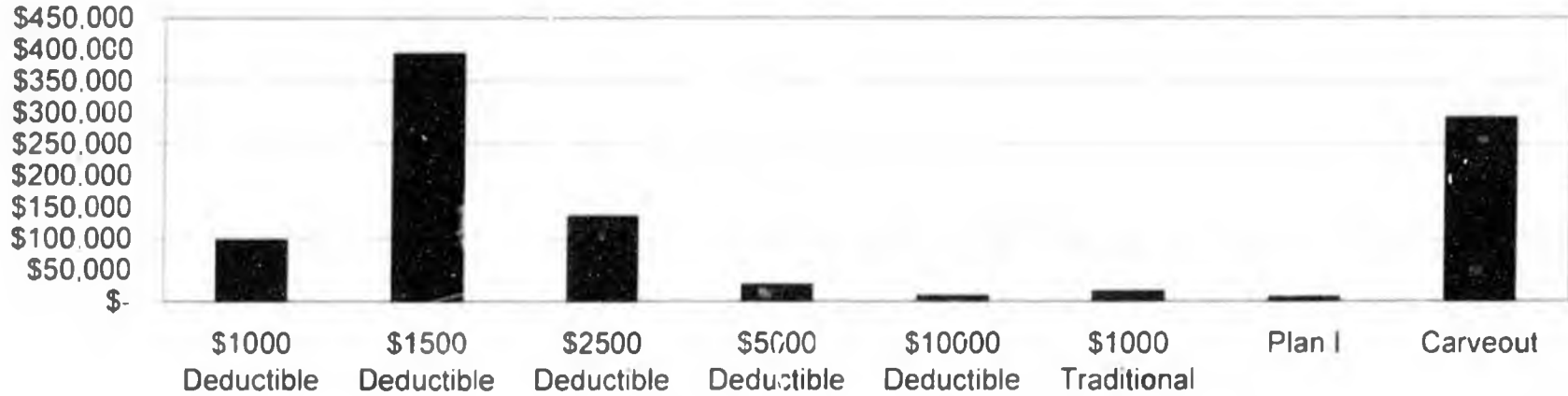
Medical Claims Paid by Plan (PMPM Basis)



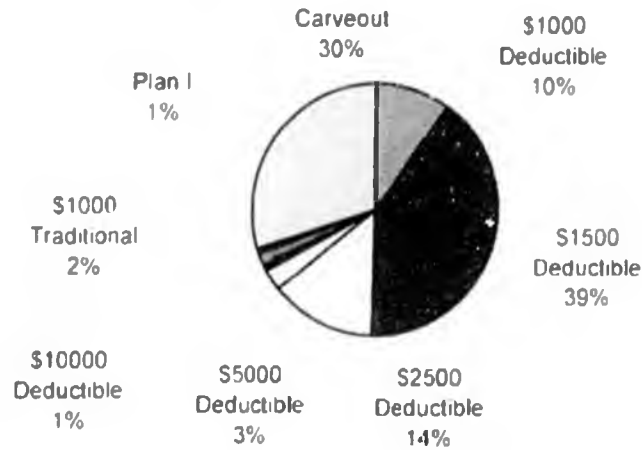
For the calendar year 2004, a total of \$970,295 was paid in pharmacy claims.

\$1,000	\$1,500	\$2,500	\$5,000	\$10,000	\$1,000	Plan I	Carveout
\$ 96,260	\$ 391,869	\$ 135,350	\$ 25,910	\$ 9,576	\$ 15,087	\$ 6,347	\$ 290,594

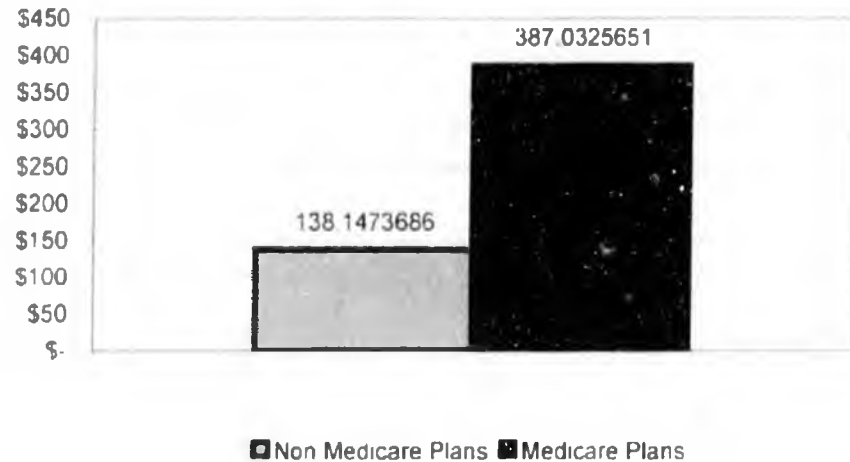
Pharmacy Claims Paid by Plan



Pharmacy Claims Paid by Plan Percentage Comparison



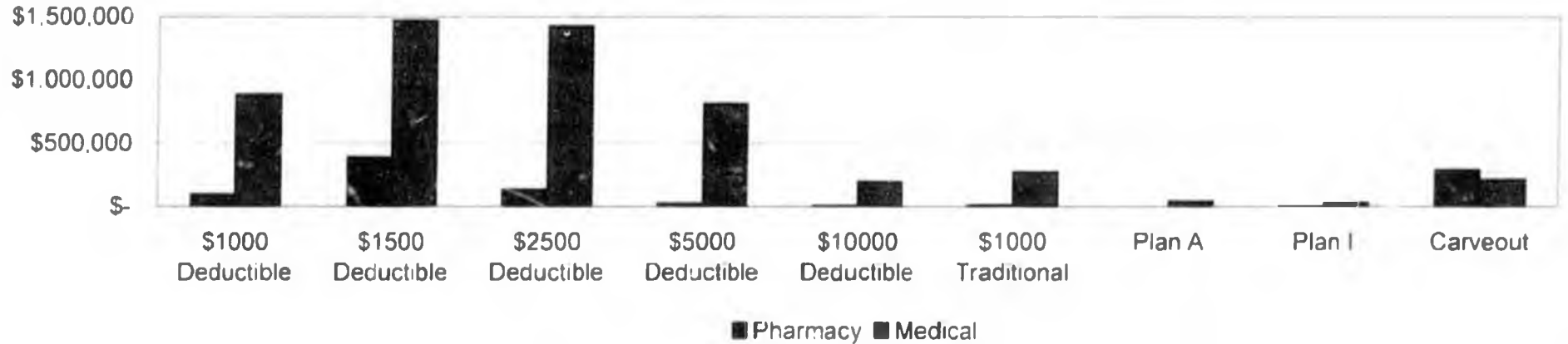
Pharmacy Claims Paid by Plan (PMPM Basis)



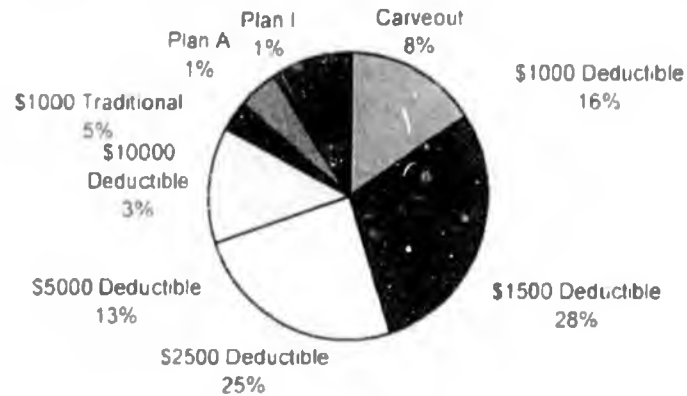
For the calendar year 2004, a total of \$6,328,406 was paid in both pharmacy and medical claims.

	\$1,000	\$1,500	\$2,500	\$5,000	\$10,000	\$1000 Traditional	Plan A	Plan I	Carveout
Medical	\$887,378	\$1,474,241	\$1,425,555	\$810,143	\$196,353	\$273,563	\$44,921	\$31,801	\$214,172
Pharmacy	\$96,260	\$391,869	\$135,350	\$25,910	\$8,576	\$15,087		\$6,647	\$290,594
Total	\$983,639	\$1,866,111	\$1,560,905	\$836,054	\$204,930	\$288,650	\$44,921	\$38,447	\$504,766

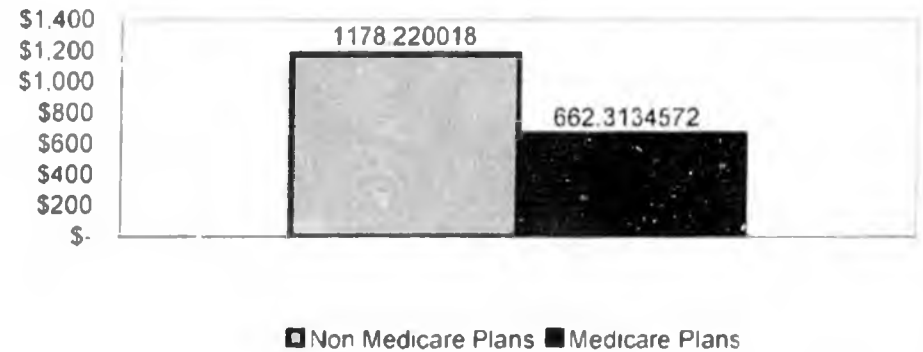
Medical and Pharmacy Claims Paid by Plan



Medical and Pharmacy Claims Paid by Plan Percentage Comparison



Medical and Pharmacy Claims Paid by Plan (PMPM Basis)



Top 25 Facilities by Revenue

The top 25 providers account for 62% of all medical claims paid

Provider Name	Paid Amount	Number of Claims
PROVIDENCE HEALTH SYSTEM WASHI	\$ 894,414 62	516
PAUL JOSEPH GIONET	\$ 818,377 88	46
PROFESSIONAL INFUSION PHARMACY	\$ 299,608 64	319
KANSAS PHARMACY SERVICE CORPORATION	\$ 244,700 46	1910
SEATTLE CANCER CARE ALLIANCE	\$ 213,612 18	4
UNIVERSITY OF WASHINGTON	\$ 120,020 98	17
NOVA FACTOR INC	\$ 115,900 00	8
VIRGINIA MASON MEDICAL CENTER	\$ 110,392 67	59
BANNER HEALTH SYSTEM	\$ 109,029 78	96
J MICHAEL CARROLL MD PC	\$ 93,843 57	109
CAREMARK INC	\$ 79,108 00	4
SWEDISH HEALTH SERVICES	\$ 76,621 44	9
GENEVA WOODS PHARMACY INC	\$ 75,695 75	280
UCSF MEDICAL CENTER	\$ 75,393 27	12
JOHN MUIR/MT DIABLO HEALTH SYS	\$ 74,067 25	9
S C C A	\$ 73,662 99	21
BANNER HEALTH SYSTEM	\$ 67,062 49	45
ONCOLOGY ALASKA LLC	\$ 64,298 10	69
SWEDISH HEALTH SERVICES	\$ 51,867 61	6
CHILDRENS HOSPITAL & REGIONAL	\$ 51,505 82	7
PROCARE PHARMACY DIRECT INC	\$ 50,122 50	141
UNIVERSITY OF WASHINGTON	\$ 50,017 86	23
AIRLIFT NORTHWEST	\$ 49,848 12	2
RENAL CARE GROUP ALASKA INC	\$ 47,901 70	160
PHARMACARE SPECIALTY PHARMACY	\$ 47,417 14	146
	\$ 3,954,490 82	

TOP ICD-9 sorted by Dollars

ICD 9 Code	Number of Claims	Claim Totals
COAGULATION DEFECTS	32	\$ 464 533 33
CONGENITAL FACTOR IX DISORDER	6	\$ 263 184 00
MYELOID LEUKEMIA	12	\$ 253 533 26
CONGENITAL FACTOR VIII DISORDER	29	\$ 174 534 31
MALIGNANT NEOPLASM OF BREAST UNSPECIFIED SITE	236	\$ 159 713 15
OTHER MALIGNANT LYMPHOMA UNSPECIFIED SITE	107	\$ 150 976 93
CHEMOTHERAPY	38	\$ 139 106 43
LIPIDOSES	11	\$ 116 401 13
CIRRHOSIS OF THE LIVER W/O MENTION OF ALCOHOL	10	\$ 114 635 39
MALIGNANT NEOPLASM OF PROSTATE	74	\$ 111 886 74
UNSPECIFIED ACUTE RENAL FAILURE	27	\$ 102 012 49
MALIGNANT NEOPLASM OF OVARY	57	\$ 87 153 42
ENCOUNTER OTH&UNSPEC PROC&AFTERCARE	21	\$ 65 821 71
OTHER DISEASES OF ENDOCARDIUM	13	\$ 85 201 26
CHRONIC RENAL FAILURE	582	\$ 83 069 34
ATRIAL FIBRILLATION	78	\$ 73 234 09
OSTEOARTHRITIS UNSPECIFIED GENERAL LOCATION PELVIS REGION & THIGH	14	\$ 62 178 69
OTHER SPECIFIED FORMS OF CHRONIC ISCHEMIC HEART DISEASE	4	\$ 58 886 87
MALIGNANT NEOPLASM OF OTHER SOFT TISSUE LW LIMB W/HP	19	\$ 55 094 90
ACQUIRED SPONDYLOLISTHESIS	4	\$ 54 399 42
DISPLACEMENT OF LUMBAR DISC W/O MYELOPATHY	18	\$ 52 064 08
KIDNEY REPLACED BY TRANSPLANT	251	\$ 44 022 84
INTERVERTEBRAL DISC DISORDERS	32	\$ 43 754 85
OSTEOARTHRITIS-PELVIC REGION & THIGH	3	\$ 42 783 79
PAIN IN SOFT TISSUES OF LIMB	39	\$ 40 557 88

What are the current rates?

ALASKA COMPREHENSIVE HEALTH INSURANCE ASSOCIATION (ACHIA)

Premium Rates Effective January 1, 2005 through December 31, 2005

	Major Medical Plans					
Plan Type:	Traditional	PPO	PPO	PPO	PPO	PPO
Deductible:	\$1,000	\$1,000	\$1,500	\$2,500	\$5,000	\$10,000
Coinsurance In Network:	80%	80%	80%	80%	80%	80%
Coinsurance out of Network:		60%	60%	60%	60%	60%
Out of Pocket Maximum:	\$2,500	\$2,500	\$3,000	\$5,000	\$10,000	\$15,000
Lifetime Maximum:	\$1,000,000	\$1,000,000	\$1,000,000	\$1,000,000	\$1,000,000	\$1,000,000
Age	Monthly Premium Rate					
0-18	\$225	\$205	\$170	\$	\$105	\$87
19	\$404	\$367	\$306	\$250	\$188	\$156
20	\$406	\$369	\$307	\$251	\$189	\$157
21	\$409	\$372	\$310	\$253	\$191	\$158
22	\$412	\$374	\$312	\$255	\$192	\$159
23	\$415	\$377	\$314	\$257	\$194	\$161
24	\$417	\$380	\$316	\$258	\$195	\$162
25	\$421	\$382	\$319	\$260	\$196	\$163
26	\$424	\$385	\$321	\$262	\$198	\$164
27	\$427	\$388	\$324	\$264	\$199	\$166
28	\$438	\$398	\$332	\$271	\$205	\$170
29	\$449	\$409	\$340	\$278	\$210	\$174
30	\$463	\$424	\$349	\$285	\$215	\$178
31	\$472	\$429	\$358	\$292	\$220	\$183
32	\$484	\$440	\$366	\$300	\$226	\$187
33	\$498	\$452	\$377	\$308	\$232	\$193
34	\$512	\$465	\$388	\$317	\$239	\$198
35	\$529	\$486	\$400	\$326	\$246	\$204
36	\$541	\$492	\$410	\$335	\$253	\$210
37	\$557	\$506	\$422	\$345	\$260	\$216
38	\$575	\$522	\$435	\$356	\$268	\$223
39	\$594	\$540	\$449	\$367	\$277	\$230
40	\$616	\$568	\$472	\$385	\$288	\$238
41	\$632	\$575	\$479	\$391	\$295	\$245
42	\$652	\$593	\$494	\$404	\$304	\$253
43	\$678	\$617	\$514	\$420	\$317	\$263
44	\$706	\$642	\$534	\$437	\$329	\$273
45	\$761	\$681	\$576	\$471	\$355	\$286
46	\$763	\$694	\$578	\$472	\$356	\$296
47	\$794	\$722	\$601	\$491	\$371	\$308
48	\$829	\$754	\$628	\$513	\$387	\$321
49	\$867	\$788	\$656	\$536	\$405	\$336
50	\$911	\$841	\$709	\$560	\$439	\$353
51	\$947	\$860	\$717	\$586	\$442	\$367
52	\$990	\$900	\$749	\$612	\$467	\$383
53	\$1,030	\$936	\$780	\$637	\$481	\$399
54	\$1,072	\$975	\$812	\$664	\$501	\$415
55	\$1,123	\$1,022	\$846	\$692	\$521	\$433
56	\$1,162	\$1,057	\$880	\$719	\$543	\$450
57	\$1,210	\$1,100	\$916	\$749	\$565	\$469
58	\$1,254	\$1,140	\$950	\$776	\$585	\$486
59	\$1,301	\$1,182	\$985	\$805	\$607	\$504
60	\$1,348	\$1,226	\$1,021	\$834	\$629	\$522
61	\$1,398	\$1,271	\$1,058	\$865	\$652	\$541
62	\$1,449	\$1,317	\$1,097	\$897	\$676	\$561
63	\$1,479	\$1,344	\$1,120	\$915	\$690	\$573
64	\$1,506	\$1,369	\$1,140	\$932	\$703	\$583

What are the current rates?

ALASKA COMPREHENSIVE HEALTH INSURANCE ASSOCIATION (ACHIA)
Premium Rates Effective January 1, 2005 through December 31, 2005

Medicare Supplement Plan		
Monthly Premium Rates		
Age	Plan A	Plan I
0-64	\$153	\$344
65	\$126	\$344
66	\$131	\$359
67	\$137	\$379
68	\$144	\$400
69	\$148	\$415
70	\$152	\$430
71	\$157	\$446
72	\$161	\$461
73	\$167	\$477
74	\$171	\$490
75	\$175	\$502
76	\$180	\$517
77	\$184	\$530
78	\$189	\$548
79	\$193	\$556
80+	\$207	\$621

ALASKA COMPREHENSIVE HEALTH INSURANCE ASSOCIATION (ACHIA)
Premium Rates Effective January 1, 2005 through December 31, 2005

Medicare Carveout Plan	
Deductible:	\$1,000
Coinsurance:	80%
Out of pocket maximum:	\$2,500
Lifetime Maximum:	\$1,000,000
Age	Monthly Premium Rates
0-18	\$137
19+	\$298

What were past Rates?

ALASKA COMPREHENSIVE HEALTH INSURANCE ASSOCIATION (ACHIA)

Premium Rates Effective January 1, 2004 through December 31, 2004

Major Medical Plans						
Plan Type:	Traditional	PPO	PPO	PPO	PPO	PPO
Deductible:	\$1,000	\$1,000	\$1,500	\$2,500	\$5,000	\$10,000
Coinsurance in Network:	80%	80%	80%	80%	80%	80%
Coinsurance out of Network:		60%	60%	60%	60%	60%
Out of Pocket Maximum:	\$2,500	\$2,500	\$3,000	\$5,000	\$10,000	\$15,000
Lifetime Maximum:	\$1,000,000	\$1,000,000	\$1,000,000	\$1,000,000	\$1,000,000	\$1,000,000
Age	Monthly Premium Rate					
0-18	\$225	\$205	\$170	\$139	\$105	\$87
19	\$404	\$367	\$306	\$250	\$188	\$156
20	\$406	\$369	\$307	\$251	\$189	\$157
21	\$409	\$372	\$310	\$253	\$191	\$158
22	\$412	\$374	\$312	\$255	\$192	\$159
23	\$415	\$377	\$314	\$257	\$194	\$161
24	\$417	\$380	\$316	\$258	\$195	\$162
25	\$421	\$382	\$319	\$260	\$196	\$163
26	\$424	\$385	\$321	\$262	\$198	\$164
27	\$427	\$388	\$324	\$264	\$199	\$166
28	\$438	\$398	\$332	\$271	\$205	\$170
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36	\$541	\$492	\$410	\$335	\$253	\$210
37	\$557	\$506	\$422	\$345	\$260	\$216
38	\$575	\$522	\$435	\$356	\$268	\$223
39	\$594	\$540	\$449	\$367	\$277	\$230
40	\$627	\$570	\$472	\$385	\$288	\$239
41	\$632	\$575	\$479	\$391	\$295	\$245
42	\$652	\$593	\$494	\$404	\$304	\$253
43	\$678	\$617	\$514	\$420	\$317	\$263
44	\$706	\$642	\$534	\$437	\$329	\$273
45	\$761	\$692	\$576	\$471	\$355	\$295
46	\$763	\$694	\$578	\$472	\$356	\$296
47	\$794	\$722	\$601	\$491	\$371	\$308
48	\$829	\$754	\$628	\$513	\$387	\$321
49	\$867	\$788	\$656	\$536	\$405	\$336
50	\$935	\$850	\$709	\$580	\$439	\$365
51	\$947	\$860	\$717	\$586	\$442	\$367
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56	\$1,162	\$1,057	\$880	\$719	\$543	\$450
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62	\$1,449	\$1,317	\$1,097	\$897	\$676	\$561
63	\$1,479	\$1,344	\$1,120	\$915	\$690	\$573
64	\$1,506	\$1,369	\$1,140	\$932	\$703	\$583

What were past Rates?

ALASKA COMPREHENSIVE HEALTH INSURANCE ASSOCIATION (ACHIA)
Premium Rates Effective January 1, 2004 through December 31, 2004

Medicare Supplement Plan		
Monthly Premium Rates		
Age	Plan A	Plan I
0-65	\$120	\$326
66	\$121	\$333
67	\$124	\$343
68	\$128	\$357
69	\$133	\$371
70	\$141	\$398
71	\$145	\$413
72	\$150	\$428
73	\$154	\$441
74	\$158	\$453
75	\$165	\$475
76	\$169	\$487
77	\$173	\$499
78	\$176	\$512
79	\$179	\$525
80+	\$189	\$569

ALASKA COMPREHENSIVE HEALTH INSURANCE ASSOCIATION (ACHIA)
Premium Rates Effective January 1, 2004 through December 31, 2004

Medicare Carveout Plan	
Deductible:	\$1,000
Coinsurance:	80%
Out of pocket maximum:	\$2,500
Lifetime Maximum:	\$1,000,000
Age	Monthly Premium Rates
0-18	\$144
19+	\$288

Financial

This section details the policy year financial experience for ACHIA. Exhibit 1 is the ACHIA balance sheet for years ended 2003 and 2004. Exhibit 2 shows the revenues, expenses and changes in the fund balance. ACHIA began 2004 with a balance of \$(948,799) and ended with a balance of \$1,463,783 net of reserves or \$3,071,170 in cash. Revenues for the year were \$8,608,200 and expenses were \$6,204,722. Exhibit 3 shows the cash flow for 2003 and 2004. It should be noted that in 2004, ACHIA received a total of \$969,110 through the Federal TAA grant monies to help offset losses for 2002 and 2003. It is expected that ACHIA will receive another small cleanup grant in 2005. Legislation is pending at the Federal level to increase the amounts and extent the program to 2009.

**Alaska Comprehensive Health Insurance Association
The Board of Directors for 2004 was:**

BOARD MEMBERS

Jeff Davis, **Chairperson**
Blue Cross/Blue Shield of Alaska
2550 Denali Street, Suite 1404
Anchorage, AK 99503
Ph: (907) 258-5065 x304
Fax: (907) 258-1619
e-mail: jeff.davis@premera.com

Chester Lozowski, **Vice Chairperson**
Ceres Group
613 Burno Drive
Palatine, IL 60067
Ph: (847) 934-0288, (913) 261-6615
e-mail: lozowski@earthlink.net

Shawn Pollock, **Secretary/Treasurer**
Physicians Mutual Insurance Company
2600 Dodge Street
Omaha, NE 68131
Ph: (402) 633-1686,
Fax: (402) 633-1096
e-mail: shawn.Pollock@pmic.com

Sandra Cole (Resigned August 2004)
7000 Wellington Drive
Wasilla, AK 99654

OTHERS

Cecil Bykerk, **Executive Director**
CDBykerk Consulting, LLC
9543 Oak Circle
Omaha, NE 68124-2767
Ph: (402) 501-8701
Fax: (402) 393-1645
e-mail: oakoffice1@a.com.net

BOARD MEMBERS

J. Brian Angel
AFLAC
1932 Wynnton Road
Columbus, GA 31999
Ph: (907) 596-3467
Fax: (907) 596-3908
e-mail: bangel@aflac.com

Robert Corn
Mutual of Omaha Insurance Company
Mutual of Omaha Plaza
Omaha, NE 68175
Ph: (402) 351-8160
Fax: (402) 351-5298
e-mail: bob.corn@mutualofomaha.com

Mona McAleese
12321 Heritage Road
Anchorage, AK 99516

OTHERS

Katherine Campbell (Katie), **Director's Designee**
Ex-officio Member
State of Alaska Division of Insurance
333 Willoughby
Juneau, AK 99801
Ph: (907) 465-4607
Fax: (907) 465-3422
e-mail: Katie.Campbell@dec.state.ak.us

2004-2005 COMMITTEES

ACTUARIAL COMMITTEE

Chet Lozowski, Chair
Katie Campbell
Peggy Onstott
Cecil Bykerk

ADVERTISING COMMITTEE

Mona McAleese, Chair
Chris Clasen
Julie Ratliff
Cecil Bykerk

AUDIT COMMITTEE

Chet Lozowski, Chair
Robert Corn

GRIEVANCE COMMITTEE

Brian Angel, Chair
Robert Corn
Mona McAleese
Cecil Bykerk
Jeff Davis (ex-officio)

POLICY COMMITTEE

Shawn Pollock, Chair
Robert Corn
Katie Campbell
Cecil Bykerk
Jeff Davis (ex-officio)

NOMINATING COMMITTEE

Chet Lozowski, Chair
Jeff Davis

Exhibit 1

BALANCE SHEETS

December 31, 2004 and 2003

Assets	2004	2003
Current assets:		
Cash	\$ 3,071,170	1,221,704
Claims refund receivable	67,664	--
Premiums receivable	21,540	--
	<u>\$ 3,160,374</u>	<u>1,221,704</u>
 Liabilities and Fund Balance		
Reserve for claims and claims adjustment expense	\$ 1,630,000	2,150,000
Unearned premiums	53,196	20,503
Other liabilities	1,921	--
	<u>1,685,117</u>	<u>2,170,503</u>
Total current liabilities	1,685,117	2,170,503
Net assets unrestricted	1,475,257	(948,799)
Commitments and contingencies		
	<u>\$ 3,160,374</u>	<u>1,221,704</u>

See accompanying notes to financial statements.

Exhibit 2

STATEMENTS OF REVENUES, EXPENSES AND CHANGES IN NET ASSETS

Years ended December 31, 2004 and 2003

	2004	2002
Operating revenues:		
Premiums earned	2,650,880	2,640,325
Operating expenses:		
Claims paid	6,333,543	6,657,608
Change in claims and claims adjustment expense reserves	(520,000)	1,100,000
Administrative services	263,241	254,358
Actuarial consulting Service	25,355	15,600
Management consulting Service	24,000	--
Board meetings	13,414	22,266
Accounting services	12,450	13,650
Case management fees	10,659	--
Telephone	3,078	2,283
Advertising	1,075	3,355
Agent commissions	450	2,600
Other	5,404	1,843
	6,172,669	8,073,563
Operating income (loss)	(3,521,789)	(5,433,238)
Nonoperating revenues:		
Member assessments (net of uncollectible amounts of \$32,053 and \$7,675 in 2004 and 2003, respectively)	\$ 4,967,631	4,551,599
Investment income	9,104	5,833
Grants	969,110	--
Increase (decrease) in net assets	2,424,056	(875,806)
Net assets at beginning of year	(948,799)	(72,993)
Net assets at end of year	\$ 1,475,257	(948,799)

See accompanying notes to financial statements.

Exhibit 3

STATEMENTS OF CASH FLOWS

**ALASKA COMPREHENSIVE HEALTH
INSURANCE ASSOCIATION**

Statements of Cash Flows

Years ended December 31, 2004 and 2003

	<u>2004</u>	<u>2003</u>
Cash flows from operating activities:		
Premiums collected from insureds	2,663,954	2,555,828
Other	(373)	--
Claims expenses paid	(6,333,543)	(6,593,811)
Cash paid to administrator and suppliers	(358,753)	(322,734)
Cash returned to administrator in excess of claims and other expenses paid by administrator	--	(220,299)
Net cash used by operating activities	<u>(4,028,715)</u>	<u>(4,581,016)</u>
Cash flows from noncapital financing activities:		
Grant Income	969,110	--
Assessments collected from members	\$ 4,899,967	4,551,599
Net cash provided by noncapital financing activities	<u>5,869,077</u>	<u>4,551,599</u>
Cash flows from investing activities:		
Interest receipts	9,104	5,833
Net increase (decrease) in cash	<u>1,849,466</u>	<u>(23,584)</u>
Cash at beginning of year	1,221,704	1,245,288
Cash at end of year	\$ <u>3,071,170</u>	<u>1,221,704</u>
Reconciliation of operating losses to net cash used by operating activities:		
Operating income	\$ (3,521,789)	(5,433,238)
Changes in assets and liabilities:		
Increase in premiums receivable	(21,540)	--
Decrease in funds due to administrator	--	(220,299)
Decrease in claims refund receivable	--	63,797
Increase (decrease) in reserve for claims and claims adjustment expenses	(520,000)	1,100,000
Increase (decrease) in unearned premiums	32,693	(84,497)
Increase (decrease) in other liabilities	1,921	(6,779)
Total adjustments	<u>(506,926)</u>	<u>852,222</u>
Net cash provided by (used by) operating activities	\$ <u>(4,028,715)</u>	<u>(4,581,016)</u>

See accompanying notes to financial statements.

(1) History

The Alaska Comprehensive Health Insurance Association (Association) was established by the Alaska State Health Insurance Act of 1992 (Act) to provide an individual state plan of health insurance to Alaska residents who are considered high risks and are otherwise unable to obtain health insurance.

The Association is a nonprofit organization whose membership consists by statute of all licensed hospital or medical service corporations in the state that offer subscriber contracts for major medical coverage, and all insurers licensed to transact health insurance in the state that offer policies for major medical coverage on an expense-incurred basis.

The Association is empowered by the statutes to assess its members amounts to cover underwriting losses of the state plans and amounts to cover the operating and administrative expenses incurred by the Association to conduct its affairs.

(2) Summary of Significant Accounting Policies

(a) Basis of Presentation

The Association adopted the provisions of Governmental Accounting Standards Board (GASB) Statement No. 34, *Basic Financial Statements – and Management’s Discussion and Analysis – for State and Local Governments* and GASB Statement No. 37, *Basic Financial Statements – and Management’s Discussion and Analysis – for State and Local Governments: Omnibus*. These standards and GASB Statement No. 38, *Certain Financial Statement Disclosures* were applied effective January 1, 2003.

As a result of GASB Statement No. 34, significant changes to the financial statements are as follows:

- Revenues and expenses are now categorized as either operating or nonoperating. Previously, a measure of operations was not presented.
- A statement of cash flows using the direct method is now presented.

GASB Statement No. 34 requires that resources be classified for accounting and reporting purposes into the following net asset categories:

- **Unrestricted Net Assets** – Assets, net of related liabilities, which are not subject to externally-imposed restrictions and are not considered invested in capital assets, net of related debt. Unrestricted net assets may be designated for specific purposes by action of management or the Board of Directors.
- **Restricted Net Assets** – Net assets whose use is constrained externally by creditors, grantors, contributors or laws and regulations of other governments or imposed by law through constitutional provisions or enabling legislation.
- **Invested in Capital Assets, Net of Related Debt** – Capital assets, net of accumulated depreciation and outstanding principal balances of debt attributable to the acquisition, construction or improvement of those assets.

All of the net assets of the Association are considered unrestricted.

The Association accounts for its activities as a special purpose government engaged in business – type activities which is reported similarly to an enterprise fund. Enterprise funds are accounted for using a flow of economic resources measurement focus. With this measurement focus, all assets and all liabilities associated with the activity of providing insurance services are included on the balance sheet.

An enterprise fund is accounted for using the accrual basis of accounting. Revenue is recognized when it is earned and expenses are recognized when they are incurred.

The Association applies all pronouncements of the GASB, as well as pronouncements of the Financial Accounting Standards Board (FASB) issued prior to November 30, 1989, that do not otherwise conflict with GASB pronouncements. The Association has the option to apply all FASB pronouncements issued after November 30, 1989, unless FASB conflicts with GASB. The Association has elected not to apply FASB pronouncements issued after the applicable date.

(b) Income Taxes

The Association is nontaxable for state income tax purposes under the provisions of the Act.

Effective January 1, 1997, the Association was granted federal tax exempt status under Section 501(c)(26) of the Internal Revenue Code. During 1997, the Association was also determined to be a federal taxable entity for the years prior to 1997. However, the Association had no net taxable income for 1996 and all prior years and does not anticipate that it will owe taxes for those years.

(c) Operating Revenues

Operating revenues consist of assessments, premiums and operating grants. All other revenues are considered nonoperating.

Assessments levied on all members are reported in the period for which such assessments are levied. Member assessments are charged to each member based on the ratio of the member's total fees for subscriber contracts or total health insurance premiums, received from or on behalf of state residents, as divided by the total subscriber fees and health insurance premiums received by all members from or on behalf of state residents. Premiums earned are recognized on a pro rata basis over the respective terms of the policies. Unearned premiums represent the portion of insureds' premiums written which relate to future periods. The Association recognizes grant revenue under the provisions of GASB Statement No. 33, *Accounting and Financial Reporting for Nonexchange Transactions*, whereby revenue is recognized when all applicable eligibility requirements, including time requirements, are met.

(d) Reserve for Claims and Claims Adjustment Expense

The reserve for claims and claims adjustment expense represents management's estimate of the ultimate settlement of reported and unreported claims. Management believes that such reserves are adequate to cover the ultimate net cost of claims expense incurred; however, reserves are necessarily based on estimates and the amount ultimately paid may be more or less than such estimates. Adjustments to reserves are charged or credited to expense in the period in which they are made.

(e) Estimates

In preparing the financial statements, management is required to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosures of contingent assets and liabilities as of the date of the financial statements and revenue and expenses for the period. Actual results could differ from those estimates. The more significant accounting and reporting policies and estimates applied in the preparation of the accompanying combined financial statements are discussed above.

(3) Cash

Cash consists of a demand deposit in the amount of \$3,071,170 and \$1,221,704 at December 31, 2004 and 2003, respectively. The bank balances were \$3,153,102 and \$998,022 at December 31,

2004 and 2003, respectively, \$100,000 of which was insured by the FDIC. Remaining amounts are uncollateralized.

(4) Member Assessments

In January 2003 and August 2003 the Association assessed members \$2,000,000 and \$2,500,000 to cover anticipated claims and expenses in 2003. In September 2003, an additional assessment of \$57,056 was made to carriers who had not returned their qualification letters to the Alaska Insurance Department to cover anticipated claims and expenses in 2003.

In May and September of 2004, the Association assessed members \$2,500,000 for a total of \$5,000,000 to cover anticipated claims and expenses in 2004.

(5) Reserve for Claims and Claims Adjustment Expense

A summary of the changes in reserves for claims and claims adjustment expense for the years ended December 31, 2004 and 2003 follows:

	<u>2004</u>	<u>2003</u>
Reserve for claims and claims adjustment expense at beginning of the year	\$ 2,150,000	1,050,000
Incurred claims and claims adjustment expense	5,813,543	7,757,608
Payments	<u>(6,333,543)</u>	<u>(6,656,608)</u>
Reserve for claims and claims adjustment expense at end of year	\$ <u>1,630,000</u>	<u>2,150,000</u>

(6) Related Party Transactions

Board meeting expense consists primarily of reimbursements to certain members of the Board of Directors of the Association for travel costs incurred on behalf of the Association.

Benefit Management, Inc. (BMI), the administrator, administer the plan by collecting the premium payments and adjusting and settling claims and are paid a fee by the Association for their services. Total fees paid to BMI were \$235,596 in 2004 and \$233,420 in 2003.

(7) Line of Credit

Through June 11, 2004 and at December 31, 2003, the Association had a line of credit with a bank that allowed the Association to borrow up to \$1,000,000 in 2004 and 2003 as needed to maintain working capital levels on a short-term basis. The Association did not renew the line of credit after it matured on June 11, 2004. The Association borrowed \$100,000 on the line in May of 2004 and paid it back in June of 2004 resulting in an interest expense of \$373. No borrowings were made on the line of credit during 2003. [A new line of credit has now been established.]

(8) High Risk Pool Operation Grant

During fiscal year 2004, the Association received a High Risk Pool Operation Grant from the Department of Health and Human Services in the amount of \$969,110. The funds provided by this grant were used to reduce the need for additional assessments.

HB

31



NATIONAL COUNCIL ON COMPENSATION INSURANCE, INC.

ANALYSIS OF ALASKA HOUSE BILL 31

The enactment of House Bill 31 could produce a significant increase in loss costs for the relatively few class codes directly impacted (particularly firefighters). Note that the proposed language allows for coverage of claims made after the effective date of the proposal, regardless of whether or not the exposure leading to the occupational disease occurred before the effective date. Therefore, it is expected that there would be a significant impact on total system costs due to the retroactive nature of this proposal.

Summary of Bill

HB 31 creates a presumption of workers compensation coverage for firefighters for the following occupational diseases:

Respiratory disease

Heart problems that are experienced within 72 hours after exposure to smoke, fumes, or toxic substances

After 10 years experience:

Primary brain cancer

Malignant melanoma

Leukemia

Non-Hodgkin's lymphoma

Bladder cancer

Ureter cancer

Kidney cancer

HB 31 would also create a presumption of workers compensation coverage for employees in occupations involving exposure to human blood or bodily fluids for the following diseases:

Human immunodeficiency virus

Acquired immunodeficiency syndrome

All strains of hepatitis

Meningococcal meningitis

Mycobacterium tuberculosis

Currently, the employee has the burden of proof for compensability of a workers compensation disability claim. This proposal establishes a presumption of coverage, which must be overcome by a preponderance of evidence to the contrary. This would now place the burden of proof on the employer (and insurer.)

Additionally, this proposal could increase the frequency and total cost of claims in some classes (i.e. firefighters) significantly. It should also be noted that much of the impact for some of these classes would be felt by governmental entities as the employer of many of those being impacted by this proposal.

Potential Impact

Information about Alaska cancer rates and research on the relationship between cancer rates and firefighters suggest that **cost of prospective claims in this classification could increase loss costs by 10% to 20%, with potentially greater impacts due to the retroactive nature of this proposal.** If HB 31 becomes law, respiratory diseases, heart problems, and cancer cases for firefighters previously covered under health insurance would more likely be covered under WC due to the exclusive remedy feature of WC, the lack of medical cost sharing under WC, and the proposed presumption of compensability for firefighters.

The above scenario assumes that current practice is not to provide WC coverage for such ailments (respiratory disease, heart ailments, certain cancers) for most claims. On the other hand, if most of the claimants with such ailments were currently being accepted for WC coverage, then the codification of this practice would not have much impact on system costs.

In situations where employees file claims as a result of their occupation and associated exposure to human blood or bodily fluids, the impact on WC costs for such classes is not expected to be significant. Such employees could include law enforcement officers, firefighters, nurses and emergency medical technicians, among others. Based on claims data available from NCCI's unit statistical plan (USP), there are several claims in Alaska that have resulted from exposure to AIDS or other contagious diseases. Thus, it appears that the enactment of HB 31 will result in the codification of current practice. Any additional impact will be reflected in subsequent data that is collected and used in future rate filings. However, due to the retroactive coverage provided by this proposal, the overall costs could be significant. Since coverage for such claims may not have been contemplated in previous loss cost filings, such retroactive costs would be unfunded.

Other potential impacts not explicitly priced but expected to offset one another to some degree are:

a) Decrease in attorney costs due to fewer cases where an attorney needs to be involved as a result of the presumptive clause for firefighters, emergency responders, which could be easily offset or more by...

b) Additional claim filings and disputes over other related diseases or occupations, filed in the spirit of this proposal.

ALASKA PROFESSIONAL FIRE FIGHTERS LEGISLATIVE FACT SHEET

Released 1/27/2005

HB 31

FIRE FIGHTER PRESUMPTIVE DISABILITY LAW

BACKGROUND

Fire fighters are exposed on a daily basis to stress, smoke, heat, and various toxic substances. As a result, fire fighters are far more likely to contract heart disease and cancer than other workers. And as fire fighters increasingly assume the role of the state's leading providers of emergency medical services, they are also exposed to infectious diseases. Heart disease, lung disease, cancer and infectious disease are now among the leading causes of death and disability for fire fighters, and numerous studies have found that these illnesses are occupational hazards of fire fighting.

In recognition of this linkage, 38 states have enacted "presumptive disability" laws, which presume that cardiovascular diseases, certain cancers and infectious diseases are job related for purposes of workers compensation and disability retirement unless proven otherwise. No such law covers firefighters employed in Alaska.

Under Alaska workers compensation laws, fire fighters must be able to pinpoint the precise incident or exposure that caused a disease in order for it to be considered job-related. This burden of proof is extraordinarily difficult for fire fighters to meet because they respond to a wide variety of emergency calls, constantly working in uncontrolled environments under difficult conditions. As a result, very few cases of occupational disease contracted by fire fighters have been deemed to be service-connected.

HB 31, sponsored by Representative Tom Anderson (R) has been introduced that will amend workers compensation law so the cardiovascular disease, certain cancers and infectious diseases are presumed to be job related for purposes of workers compensation and disability retirement, and places the burden on the employer to prove otherwise.

APFF POSITION

The APFF supports HB 31 which provides a disability presumption for Alaska's fire fighters

APFF ARGUMENTS

- Most states have acknowledged the occupational hazards attributed to fire fighting and have presumptive disability laws for fire fighters because it is difficult for fire fighters to identify when and where they contracted an occupational disease.
- Alaska fire fighters regularly respond to HAZMAT incidents involving chemical, radiological and biological hazards. Working in such a hazardous environment, it is virtually impossible to precisely identify when and where a fire fighter contracted a disease.
- Alaska fire fighters do not have the benefit of a presumptive disability law. Instead they are faced with a burden of proof that is nearly impossible to meet and only in extraordinary cases do fire fighters, suffering from occupational diseases, receive fair and just compensation benefits.

CURRENT STATUS

HB 31 was referred to the Labor and Commerce Committee; Other referrals – HES and Finance Committees

ALASKA PROFESSIONAL FIRE FIGHTERS
International Association of Fire Fighter, AFL-CIO, CLC
1120 E. Huffman Road, Suite 23, PMB 556 • Anchorage, Alaska 99516

Enk Tuott, Anchorage Local Rep.
907-250-2311 E_tuott@hotmail.com

What is Presumptive Legislation?

What is presumptive legislation? As its name implies, presumptive legislation presumes for the purpose of worker compensation that a fire fighter's brain cancer, for example, is the result of their employment as a career fire fighter, if they have been a fire fighter for a certain number of years.

Typically, presumptive legislation amends a state's workplace compensation legislation to state that if a career fire fighter develops a certain form of cancer, it is presumed that the cancer is a direct result of their occupation as a fire fighter, and that compensation will be granted.

In the absence of presumptive legislation, the onus is on the worker to prove their illness is a result of their occupation. Presumptive legislation changes that onus; the claim is approved automatically if the appropriate criteria are met, unless the employer can demonstrate that the illness is not a result of the fire fighter's occupation.

Without presumptive legislation, a worker who contracts an illness as the result of their job must file a worker's compensation claim, and endure the uncertainties of the claim process. This system of claims and appeals can take years to produce a final decision. Even so, there is still no guarantee the worker's compensation claim system will recognize an occupational disease and award appropriate compensation. There are cases where a fire fighter who contracted cancer as the result of years of toxic exposures and filed a claim was asked, "At which fire did you contract this cancer?"

The latent nature of the disease poses other considerations. Many fire fighters who are currently battling cancer suffered their exposures decades ago, when less was known about the importance of respiratory and other protections and when protective equipment was built to lower standards than today. In some cases, individual fire departments didn't provide enough SCBAs to equip everyone at the scene of a fire; some were lucky to get one while others entered a fire without any respiratory protection. They may have made it home safely at the end of their shift, week after week, month after month; not knowing the seeds of a brain cancer or a leukemia that developed 20 years later had been irrevocably planted.

The days of entering fires without respiratory protection are over, and fire departments across the country are implementing comprehensive fitness and wellness programs. Most fire departments require annual medical examinations that include screening for cancers and infectious diseases. Fire fighters have better understanding of the products of combustion and the adverse effects upon their health, yet, in spite of these improvements fire fighting is still one of the most dangerous occupations in the United States. For example, one in three fire fighters in Los Angeles is expected to develop cancer by the age of 60. The introduction of new chemicals, plastics, and building materials continue to contribute to the myriad of toxins that fire fighters will encounter in their career. As long as fire fighters are exposed to these toxins while serving the public, some will contract job-related diseases as a direct result. This makes it all the more important to pass presumptive legislation; to protect Alaska's fire fighters and their survivors.

Why Do Alaskan Fire Fighters need Presumptive Legislation?

Presumptions giving the benefit of the doubt to Alaskan fire fighters are justified because they are subjected to an occupational risk that would be intolerable in other lines of work. The nature of the work calls for fire fighters to mitigate emergencies in less than ideal conditions, including but not limited to extreme weather, natural disasters, acts of terrorism, and toxic environments. As of 2005, 38 states as well as the federal government have enacted some sort of presumptive legislation to protect their emergency responders. The men and women serving as Alaska's fire fighters need the same protection as their peers in other locations.

Fire Fighters and Lung Disease

There are 70,000 various toxins on file with the EPA, but in reality, when these toxins burn together, they can create more than 70 million possible combinations, the effects of which are not fully understood. Studies have shown that these toxins cause irreversible pulmonary changes and lung disease in fire fighters. (1, 2) In spite of improvements to safety gear and training, fire fighters are still regularly exposed to these toxic environments when protecting lives and property.

Fire fighters also have an increased risk of dying from non-malignant respiratory diseases. (3)

Fire Fighters and Heart Disease

Fire fighters exposed to carbon monoxide have increased cardiac arrhythmias during exercise. (4)

There is strong evidence of an increased risk of death overall from heart disease among fire fighters. This is particularly true because of the strong selection criteria for health in recruitment of fire fighters and, especially regarding diabetes-free individuals. (5)

Fire Fighters and Cancer

Statistically speaking, fire fighters have been shown to be at increased risk of numerous cancers, chief among them brain, kidney, colon, bladder, bone marrow, melanoma, urinary tract, leukemia, prostate, and non-Hodgkin's lymphoma. (6)

The relationship between cancer deaths and fire fighting is expressed by the Standard Mortality Ratio (SMR). An SMR greater than 100 indicates that the observed portion of deaths from a specific cancer is greater than the expected proportion. Fire fighters experience significantly elevated SMR's of 417 for benign neoplasms, 184 for colon cancer, 316 for bladder cancer (8) as well as 218 for brain cancer (9), to name a few.

Fire Fighters and Infectious Diseases

Fire fighters and emergency responders routinely respond to medical calls without warning, time, or medical knowledge of their patients. Because of this, fire fighters are not afforded the same precautions as other health care professionals. Compounding emergency situations are other hazards such as broken glass, sharp objects, and poor scene lighting, to name a few. These problems place fire fighters and emergency responders at an elevated risk of being exposed to infectious diseases.

24-LS0225\F
Craver
2/18/05

**SPONSOR SUBSTITUTE FOR HOUSE BILL NO. 31
IN THE LEGISLATURE OF THE STATE OF ALASKA
TWENTY-FOURTH LEGISLATURE - FIRST SESSION**

BY REPRESENTATIVES ANDERSON, Lynn, Gatto

Introduced:

Referred:

A BILL

FOR AN ACT ENTITLED

1 **"An Act relating to the presumption of coverage for a workers' compensation claim for**
2 **disability as a result of certain diseases for certain occupations."**

3 **BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

4 *** Section 1.** AS 23.30 is amended by adding a new section to read:

5 **Sec. 23.30.121. Presumption of coverage for disability from diseases for**
6 **certain occupations.** (a) There is a presumption that a claim for compensation for
7 disability as a result of the diseases described in (b) and (c) of this section for the
8 occupations listed under (b) and (c) of this section are within the provisions of this
9 chapter. This presumption of coverage may be rebutted by a preponderance of the
10 evidence. The evidence may include the use of tobacco products, physical fitness and
11 weight, lifestyle, hereditary factors, and exposure from other employment or
12 nonemployment activities.

13 (b) For a fire fighter covered under AS 23.30.243,

14 (1) there is a presumption that a claim for compensation for disability

1 as a result of the following diseases is within the provisions of this chapter:

2 (A) respiratory disease;

3 (B) heart problems that are experienced within 72 hours after
4 exposure to smoke, fumes, or toxic substances; and

5 (C) the following cancers:

6 (i) primary brain cancer;

7 (ii) malignant melanoma;

8 (iii) leukemia;

9 (iv) non-Hodgkin's lymphoma;

10 (v) bladder cancer;

11 (vi) ureter cancer; and

12 (vii) kidney cancer;

13 (2) notwithstanding AS 23.30.100(a), following termination of service,
14 the presumptions established in (1) of this subsection extend to the fire fighter for a
15 period of three calendar months for each year of requisite service but may not extend
16 more than 60 calendar months following the last date of employment;

17 (3) the presumption established in (1)(C) of this subsection applies
18 only to an active or former fire fighter who has cancer that develops or manifests itself
19 after the fire fighter has served at least 10 years and who was given a qualifying
20 medical examination upon becoming a fire fighter or during employment as a fire
21 fighter that did not show evidence of cancer.

22 (c) The presumption in this subsection applies to fire fighters covered under
23 AS 23.30.243, peace officers, and emergency medical and rescue personnel. In this
24 subsection, "emergency medical and rescue personnel" means a trauma technician,
25 emergency medical technician, rescuer, or mobile intensive care paramedic who is a
26 paid employee of a first responder service, a rescue service, an ambulance service, or a
27 fire department that provides emergency medical or rescue services as part of its
28 duties. There is a presumption that a claim for compensation for disability as a result
29 of the following contagious diseases is within the provisions of this chapter:

30 (1) human immunodeficiency virus;

31 (2) acquired immunodeficiency syndrome;

- 1 (3) all strains of hepatitis;
2 (4) meningococcal meningitis; and
3 (5) mycobacterium tuberculosis.

4 (d) The provisions of (b)(1) of this section do not apply to a fire fighter who
5 develops a heart or lung condition and who has a history of tobacco product use as
6 established under (e)(2) of this section.

7 (e) The department shall, by regulation, define

8 (1) for purposes of (b)(3) of this section, the type and extent of the
9 medical examination that is needed to eliminate evidence of cancer in an active or
10 former fire fighter; and

11 (2) for purposes of (d) of this section, the nature and quantity of a
12 person's tobacco product use; the standards adopted under this paragraph shall use or
13 be based on existing medical research.

14 * **Sec. 2.** The uncodified law of the State of Alaska is amended by adding a new section to
15 read:

16 **APPLICABILITY.** The presumption of coverage established by this Act applies to
17 claims made on or after the effective date of this Act, even if the exposure leading to the
18 occupational disease occurred before the effective date of this Act.

ALASKA STATE HOUSE OF REPRESENTATIVES

Labor & Commerce Committee, Chair
Administrative Regulation Review, Chair
Judiciary Committee, Vice-Chair
Health, Education and Social Services



State Capitol Suite 408
Juneau, AK 99508
Phone (907) 465-4939
Fax (907) 465-2418

Representative Tom Anderson

Email: Representative_Tom_Anderson@legis.state.ak.us

MEMORANDUM

Date: March 3, 2005
To: House Labor and Commerce Committee Members
From: Representative Tom Anderson
Re: Changes made in the Sponsor Substitute to HB 31

There were two changes made to HB 31 as a result of requests made at the last L&C hearing.

The first change was to include the language notwithstanding as 23.30.100(a) to page 2 line 13. This addresses a concern that existing statutes might interfere with the extension of presumption of illness coverage for certain cancers to retired firefighters.

The second change was made on page 2 lines 22-29. Subsection (c) was rewritten to narrow the scope of who is covered under the presumptive illness clause for blood borne pathogens. The original language included **"persons exposed to human bodily fluids on a regular basis"**. The new language limits the coverage to firefighters, peace officers, emergency medical and rescue personnel.

Please see the attached word document for the actual language before and after the changes were made.

Original language Page 2 lines 13-16:

- (2) following termination of service, the presumptions established in (1) of this subsection extend to the fire fighter for a period of three calendar months for each year of requisite service but may not extend more than 60 calendar months following the last date of employment;

New language in SS to HB 31:

- (2) **notwithstanding AS 23.30.100(a)**, following termination of service, the presumptions established in (1) of this subsection extend to the fire fighter for a period of three calendar months for each year of requisite service but may not extend more than 60 calendar months following the last date of employment;

Original language Page 2 lines 22-24:

- (c) For an employee in an occupation involving exposure to human blood or bodily fluids, there is a presumption that a claim for compensation for disability as a result of the following contagious diseases is within the provisions of this chapter:

New language in SS to HB 31:

- (c) The presumption in this subsection applies to fire fighters covered under AS 23.30.243, peace officers, and emergency medical and rescue personnel. In this subsection, "emergency medical and rescue personnel" means a trauma technician, emergency medical technician, rescuer, or mobile intensive care paramedic who is a paid employee of a first responder service, a rescue service, an ambulance service, or a fire department that provides emergency medical or rescue services as part of its duties. There is a presumption that a claim for compensation for disability as a result of the following contagious diseases is within the provisions of this chapter:

Alaska State Legislature

Interim:
716 W. 4th Ave.
Anchorage, AK 99501-2133

Phone: (907) 269-0265
Fax: (907) 269-0264



Session:
Alaska State Capitol, Rm 408
Juneau, AK 99801-1182

Phone: (907) 465-4939
Fax: (907) 465-2418
Toll Free: (800) 465-4939
Rep. Tom Anderson@legis.state.ak.us

Representative Tom Anderson
District 19 - Anchorage

Sponsor Statement HB 31

Title: "An Act relating to the presumption of coverage for a workers' compensation claim for disability as a result of certain diseases for certain occupations"

Firefighters and emergency response professionals are regularly exposed to dangerous chemicals, fumes and blood borne pathogens. Nationwide, emergency personnel suffer from an increased probability of contracting certain cancers and illnesses. It has been shown that after exposure to a toxic substance many of the resulting illnesses can take years to manifest.

Firefighter and emergency personnel are a valuable and necessary part of any community. They risk their lives on a regular basis in order to ensure the safety and well being of their community.

Their sacrifice, which ends up costing them so dearly, demands action on our parts. By assuming a "presumption of illness" for certain professions such as firefighters and EMTs HB 31 is just such an action. This bill would make them eligible for health benefits in the case that they are diagnosed with certain cancers or illnesses described in the bill.

By enacting HB 31 we will provide coverage and security for our at risk emergency personnel. This legislation is necessary and urgent in order to protect and preserve our State's brave men and women of the emergency response profession.

I urge your support for this bill.

HOUSE BILL NO. 31

IN THE LEGISLATURE OF THE STATE OF ALASKA
TWENTY-FOURTH LEGISLATURE - FIRST SESSION

BY REPRESENTATIVE ANDERSON

Introduced: 1/10/05

Referred: Labor and Commerce, Health, Education and Social Services, Finance

A BILL

FOR AN ACT ENTITLED

1 "An Act relating to the presumption of coverage for a workers' compensation claim for
2 disability as a result of certain diseases for certain occupations."

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

4 * Section 1. AS 23.30 is amended by adding a new section to read:

5 Sec. 23.30.121. Presumption of coverage for disability from diseases for
6 certain occupations. (a) There is a presumption that a claim for compensation for
7 disability as a result of the diseases described in (b) and (c) of this section for the
8 occupations listed under (b) and (c) of this section are within the provisions of this
9 chapter. This presumption of coverage may be rebutted by a preponderance of the
10 evidence. The evidence may include the use of tobacco products, physical fitness and
11 weight, lifestyle, hereditary factors, and exposure from other employment or
12 nonemployment activities.

13 (b) For a fire fighter covered under AS 23.30.243,

14 (1) there is a presumption that a claim for compensation for disability

clear & convincing

1 as a result of the following diseases is within the provisions of this chapter:

2 (A) respiratory disease;

3 (B) heart problems that are experienced within 72 hours after
4 exposure to smoke, fumes, or toxic substances; and

5 (C) the following cancers:

6 (i) primary brain cancer;

7 (ii) malignant melanoma;

8 (iii) leukemia;

9 (iv) non-Hodgkin's lymphoma;

10 (v) bladder cancer;

11 (vi) ureter cancer; and

12 (vii) kidney cancer;

13 (2) following termination of service, the presumptions established in
14 (1) of this subsection extend to the fire fighter for a period of three calendar months
15 for each year of requisite service but may not extend more than 60 calendar months
16 following the last date of employment;

17 (3) the presumption established in (1)(C) of this subsection applies
18 only to an active or former fire fighter who has cancer that develops or manifests itself
19 after the fire fighter has served at least 10 years and who was given a qualifying
20 medical examination upon becoming a fire fighter or during employment as a fire
21 fighter that did not show evidence of cancer.

22 (c) For an employee in an occupation involving exposure to human blood or
23 bodily fluids, there is a presumption that a claim for compensation for disability as a
24 result of the following contagious diseases is within the provisions of this chapter:

25 (1) human immunodeficiency virus;

26 (2) acquired immunodeficiency syndrome;

27 (3) all strains of hepatitis;

28 (4) meningococcal meningitis; and

29 (5) mycobacterium tuberculosis.

30 (d) The provisions of (b)(1) of this section do not apply to a fire fighter who
31 develops a heart or lung condition and who has a history of tobacco product use as

for a firefighter, emergency medical services worker or a peace officer
NOTWITHSTANDING 23.30.120 WORKERS COMP

1 established under (e)(2) of this section.

2 (e) The department shall, by regulation, define

3 (1) for purposes of (b)(3) of this section, the type and extent of the
4 medical examination that is needed to eliminate evidence of cancer in an active or
5 former fire fighter; and

6 (2) for purposes of (d) of this section, the nature and quantity of a
7 person's tobacco product use; the standards adopted under this paragraph shall use or
8 be based on existing medical research.

9 * Sec. 2. The uncoded law of the State of Alaska is amended by adding a new section to
10 read:

11 **APPLICABILITY.** The presumption of coverage established by this Act applies to
12 claims made on or after the effective date of this Act, even if the exposure leading to the
13 occupational disease occurred before the effective date of this Act.

Alaska State Legislature

House of Representatives



Official Business

State Capitol
Juneau, AK
99801-1182

Sectional Analysis for HB 31 BY: Representative Tom Anderson

Section 1. Adds a new section to AS 23.30

- (a) Outlines the fact that there is a presumption that the illnesses listed in (b)(1)(C) and (c) are attributed to the occupations listed in other subsections of this bill. Further, the presumption may be rebutted if certain evidence is found such as tobacco use or weight problems.
- (b) Deals with the coverage specific to fire fighters
 - (1) Lists the diseases for which firefighters are covered including respiratory diseases, heart problems experienced within 72 hours of exposure to smoke, fumes or toxic substances and certain cancers.
 - (2) Extends the coverage under the presumptions of this bill for retired fire fighters for three calendar months for each year of service up to 60 calendar months after the last day of their employment
 - (3) The coverage for cancers listed under (1)(C) of this subsection apply only to firefighters with 10 or more years of service who were given a qualifying medical exam upon becoming a fire fighter that showed no evidence of cancer.
- (c) Deals with the coverage for employees whose occupations expose them to human blood or bodily fluids
 - (1) - (5) Lists the contagious diseases this section applies to including HIV, AIDS and hepatitis
- (d) Denies the coverage provided for under (b)(1) of this section to firefighters who smoke that develop a heart or lung condition
- (e) Directs the department to define through regulation
 - (1) The type and extent of the medical examination needed to comply with (b)(3)

(2) The nature and quantity of a person's tobacco use based on medical research that will make them ineligible for coverage under (1)

Section 2. Amends the uncodified law of the State of Alaska by adding a new subsection

Stating that the coverage established by this act applies to claims made on or before the effective date of this Act even if the exposure happened prior to the effective date.

IAFF LEGISLATIVE FACT SHEET

Revised: 4/11/2003

FEDERAL FIRE FIGHTERS PRESUMPTIVE LAW

BACKGROUND

Fire fighters are exposed on a daily basis to stress, smoke, heat, and various toxic substances. As a result, fire fighters are far more likely to contract heart disease, lung disease and cancer than other workers. And as fire fighters increasingly assume the role of the nation's leading providers of emergency medical services, they are also exposed to infectious diseases. Heart disease, lung disease, cancer and infectious disease are now among the leading causes of death and disability for fire fighters, and numerous studies have found that these illnesses are occupational hazards of fire fighting.

In recognition of this linkage, 38 states have enacted "presumptive disability" laws, which presume that cardiovascular diseases, certain cancers and infectious diseases are job related for purposes of workers compensation and disability retirement unless proven otherwise. No such law covers fire fighters employed by the federal government.

Under the Federal Employee Compensation Act (FECA), federal fire fighters must be able to pinpoint the precise incident or exposure that caused a disease in order for it to be considered job-related. This burden of proof is extraordinarily difficult for fire fighters to meet because they respond to a wide variety of emergency calls, constantly working in different environments under different conditions. As a result, very few cases of occupational disease contracted by fire fighters have been deemed to be service-connected.

CURRENT LEGISLATION

H.R. 1101, sponsored by Reps. Rodriguez (D-TX) and JoAnn Davis (R-VA), and **S. 530**, sponsored by Sen. Kerry (D-MA), have been introduced that will amend the FECA so that cardiovascular disease, certain cancers and infectious diseases are presumed to be job related for purposes of workers compensation and disability retirement, and places the burden on the employer to prove otherwise.

IAFF POSITION

The IAFF **supports** H.R. 1101 and S. 530 which provide a disability presumption for federal fire fighters.

IAFF ARGUMENTS

- Federal fire fighters, like all fire fighters, regularly respond to HAZMAT incidents involving chemical, radiological, and biological hazards. Working in such a hazardous environment, it is virtually impossible to precisely identify when and where a fire fighter contracted a disease.
- Most states have acknowledged the occupational hazards attributed to fire fighting and have presumptive disability laws for fire fighters because it is so difficult for fire fighters to identify when and where they contracted an occupational disease.
- Federal fire fighters do not have the benefit of a presumptive disability law. Instead they are faced with a burden of proof that is nearly impossible to meet and only in extraordinary cases do federal fire fighters, suffering from occupational diseases, receive fair and just compensation or retirement benefits.
- It is only fair that the federal government should provide parity for federal fire fighters who are exposed to the same occupational hazards as other professional fire fighters. There is no legal or rational reason why federal fire fighters do not have the same right as fire fighters in 38 states.

CURRENT STATUS

On 3/5/2003 H.R. 1101 was introduced and referred to the House Committee on Education and the Workforce.

On 3/5/2003 S. 530 was introduced and referred to the Senate Committee on Governmental Affairs.



Occupational Cancer and the Fire Fighter

Harold A. Schaitberger
General President

Vincent J. Bollon
General Secretary-Treasurer

Richard M. Duffy
Director of Occupational Health and Safety

Compiled by:

Department of Occupational Health and Safety
International Association of Fire Fighters, AFL-CIO, CLC
1750 New York Avenue, NW
Washington, DC 20006

Office: (202) 737-8484

FAX: (202) 737-8418

IAFF DEPARTMENT OF OCCUPATIONAL HEALTH AND SAFETY

**SUMMARY OF THE VIEWS ON OCCUPATIONAL CANCER
IN FIRE FIGHTERS**

Thank you for requesting information on Occupational Cancer in Fire Fighters. This document will serve to summarize and interpret the contents of the informational packet enclosed, as well as briefly state the views of the IAFF Department of Occupational Health and Safety on this matter.

I. Summary of Cancer in Fire Fighters

(1) It has been documented in scientific studies that fire fighters are exposed to thousands of different chemical agents during the course of their duties. Many **industrial hygiene** studies performed in fire fighters have actually measured exposures at real and simulated fires.

(2) Some of these chemicals are known to be carcinogens (cancer-causing agents). Most of the studies that have suggested that certain chemicals can cause cancer have been performed in animals, but some human epidemiologic studies do exist.

(3) Some of the chemicals to which fire fighters are exposed have been documented in epidemiologic studies to increase the risk of cancer in working populations (such as workers manufacturing or applying the agent). These include **vinyl chloride, asbestos, benzene, and polycyclic aromatic hydrocarbons (tars)**. These have been shown to cause liver cancer, lung and lung lining cancer, leukemia, and skin and lung cancer, respectively. These studies have not been performed in fire fighters, however.

(4) Several **mortality studies** have been performed in fire fighters (some of the reports are enclosed in this packet). When combining these studies, it appears that fire fighters have an increased risk (or incidence) of several types of cancer, including cancer of the **brain, rectum and colon, skin, and leukemia**. Other cancers, such as bladder cancer, have been found to be elevated in some studies but there is a lack of consistency in the findings.

The position of the IAFF Department of Occupational Health and Safety is that there is an increased incidence of some specific cancers in fire fighters.