

ANNUAL REPORT
OF
ALASKA COMPREHENSIVE
HEALTH INSURANCE ASSOCIATION

JANUARY 1, 1999 - DECEMBER 31, 1999



ACHIA ANNUAL REPORT

Introduction

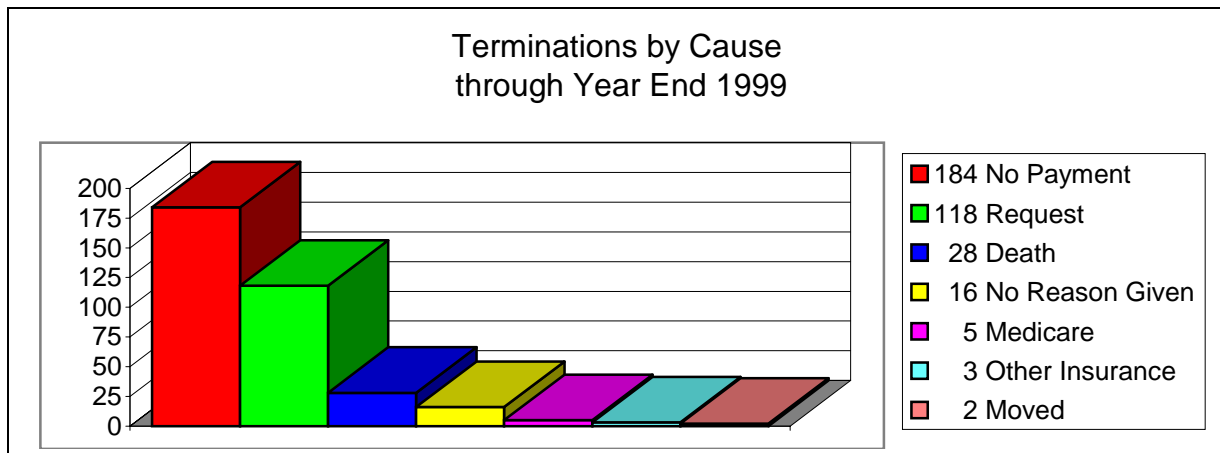
The Alaska Comprehensive Health Insurance Association (ACHIA) was established by the Alaska Legislature to provide access to health insurance to all residents of the state who are denied adequate health insurance or who are considered uninsurable. During 1997, legislation was passed that also made ACHIA coverage available to individuals who are considered 'federally eligible individuals' under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Additional legislation was introduced in late 1998 and was subsequently passed in 1999.

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.

Since the implementation date of the Plan, January 1, 1993, Aetna Insurance Company has served as the administrator of the Plan. As such Aetna processes applications for coverage under the plan, collects premium, pays claims on behalf of the association and performs other administrative functions as provided in the administrative contract.

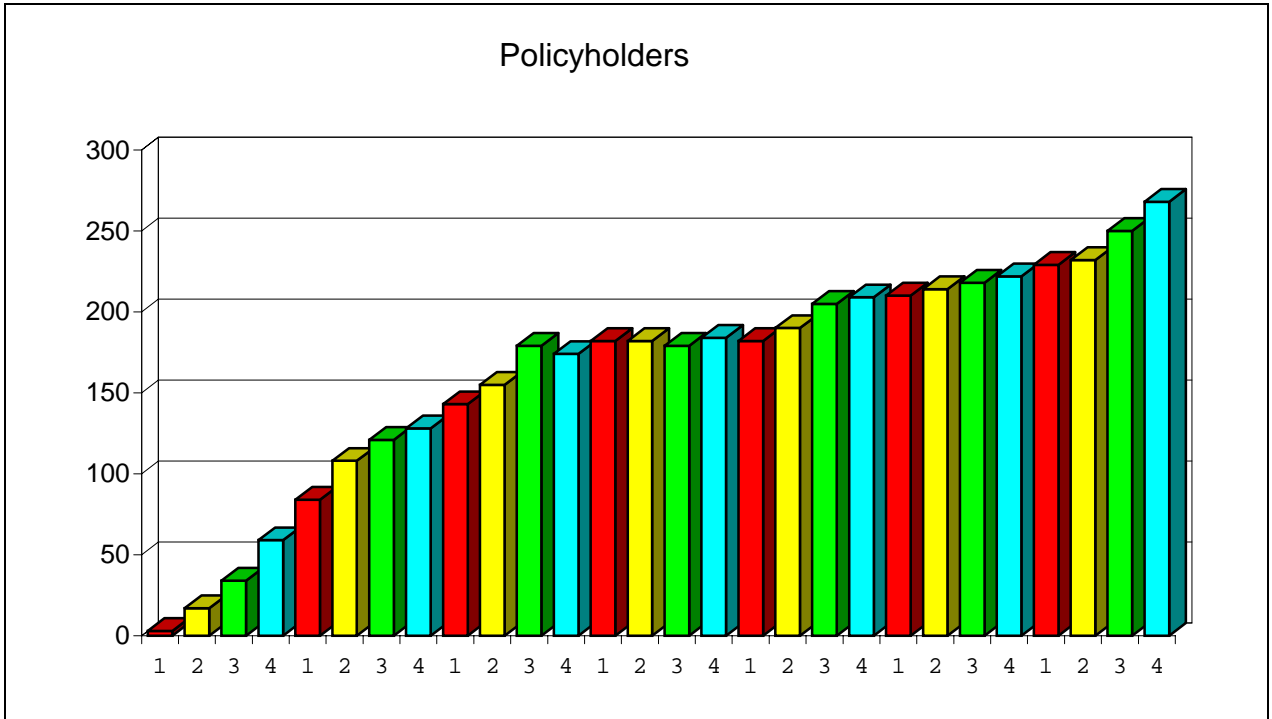
The Plan is funded through premiums collected from insureds and assessments received from health insurers transacting business in Alaska.

At the beginning of 1999, there were 222 insureds on the plan. As of December 31, 1999, there were 268 insureds. During the year, there were 109 new issues and 63 terminations. Terminations were due to many reasons including the 1993 Alaska Small Group Reform law and insureds leaving the state. Since inception, 356 terminations have occurred. The following chart shows the distribution for reason for termination.



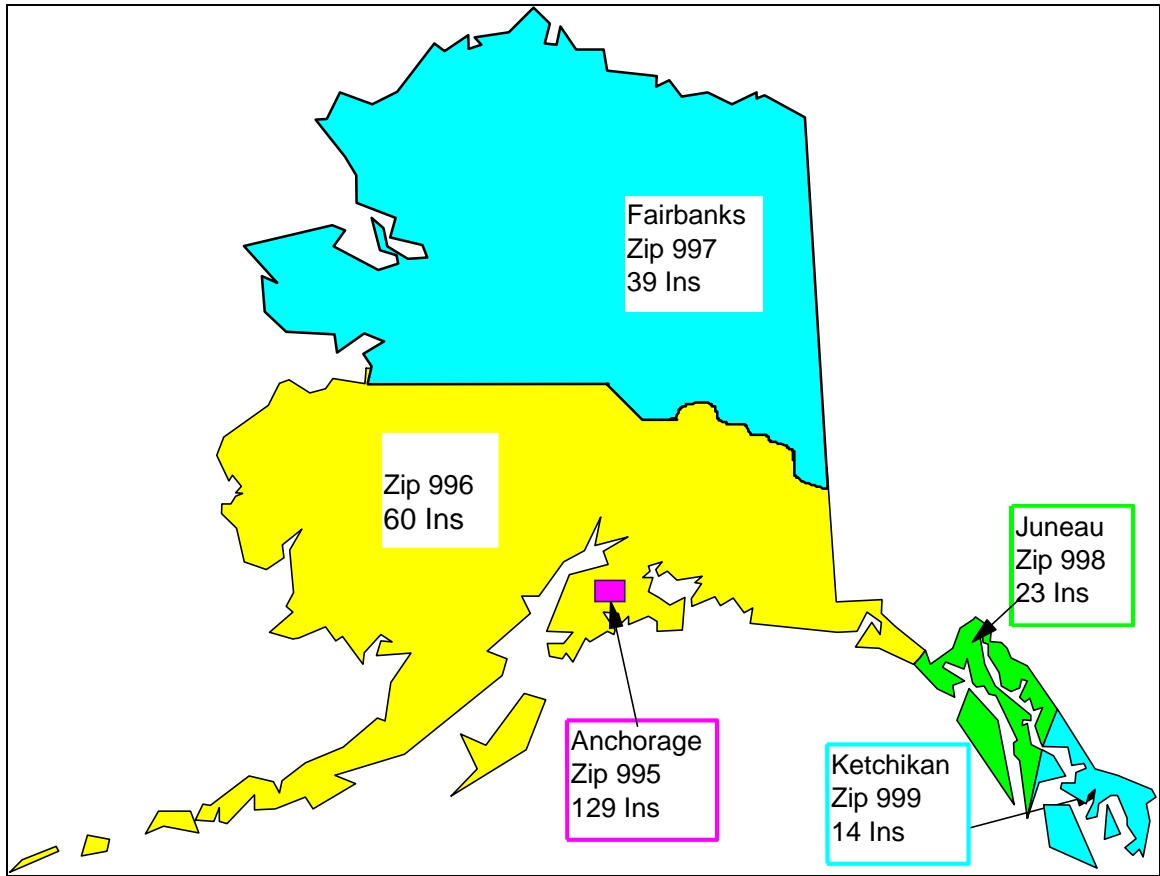
In 1999, 109 policies were issued. 93 of these policies were still in force and active on December 31, 1999.

Inforce by Quarter



Historical inforce counts reported in the current annual report are lower than historical inforce counts reported in previous annual reports. The reduction in counts came from more completely reported terminations of insureds in the current data than had been reported in previous years. Such differences are largely due to grace periods.

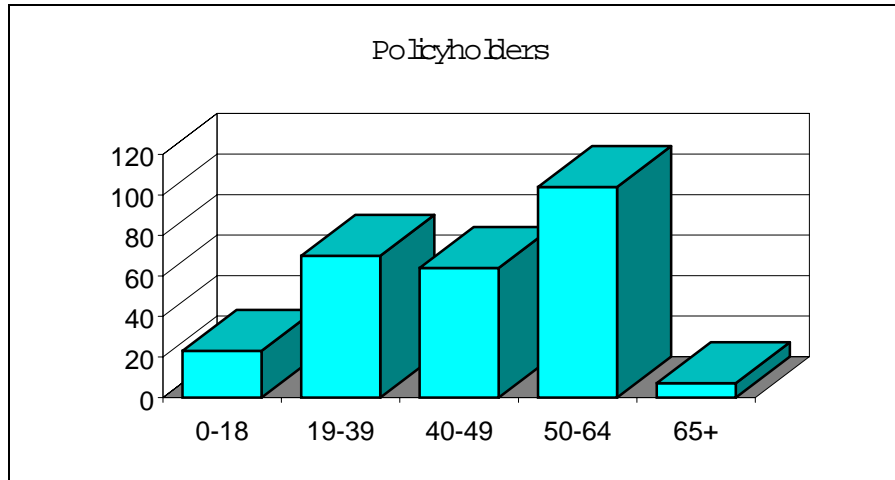
ACTIVE POLICYHOLDERS BY GEOGRAPHIC AREA



Note: Three Billing Addresses are Outside Alaska

**Policyholders by
Issue Age at
Year End 1999**

<u>Ages</u>	<u>19-39</u>	<u>40-49</u>	<u>50-64</u>	<u>65+</u>
0-18	70	64	104	7



Observations & Recommendations

During 1999, the number of policyholders covered by ACHIA continued to increase ending the year with 268 individuals covered. The year ending totals from 1993, 1994, 1995, 1996, 1997 and 1998 were 59, 128, 174, 184, 209 and 222, respectively. On the other hand, incurred claim totals for the seven years reflect a considerably different pattern; namely, \$244,758 in 1993, \$805,642 in 1994, \$2,157,549 in 1995, \$1,323,651 in 1996, \$1,610,300 in 1997, \$1,934,665 in 1998 and \$2,943,692 in 1999. Claims peaked in 1995, and declined in 1996 assuaging concerns which had resulted from the rapidly increasing claim amounts. The increase in the incurred claim amounts for 1997 and 1998 reflected the increase in the number of insureds for 1997 and 1998, and continued the stability first observed in 1996. However, the 1999 claim amounts showed a significant increase over the amount that might be expected due to the increase in policyholders.

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. 1999 showed several very large individual claims including one transplant case that totaled \$587,000. This case and six others over \$100,000 each could be the main reason for the unexpected increase and could be an aberration.

As a result of the poor experience in 1995, it was necessary for the Board to accelerate assessments against the member companies. An initial assessment of \$250,000 was made in September 1993 to establish operating capital. This assessment gave credit for the seed money assessment that had been made early in 1993, but which was based solely on a set level of \$5,000 per company for each of the top twenty companies. Because paid claims were so modest during 1993 and early 1994, and since the Board had little upon which to estimate or project, it was difficult to anticipate the timing and level of the next assessment following

September 1993. Additional problems complicated the process of establishing the next assessment. It is important to note that the assessments are paid by the insurance carriers operating in Alaska based on their proportionate share of insured medical premium. First, the companies to be assessed had to be determined. Many companies are licensed in Alaska to write health insurance but do not actually write health insurance and must be excluded from the assessment calculations. Second, the premium upon which each company's assessment is based is determined based on annual statement data which includes amounts that are not assessable and therefore must be excluded from the calculations. Additional difficulty was encountered in establishing the necessary reports and the timing of those reports so that determination of the necessary assessments could be made by the Board. In more recent years, this process has been streamlined considerably.

Following a discussion between the Board and the Administrator that lasted for eight months, the Board ordered that a \$600,000 assessment be made in April 1995. This assessment was followed in October 1995 by an assessment for \$1,200,000. Thus, by year-end 1995, the pool had a positive cash balance of \$86,017. However, claims for the first two months of 1996 eroded the cash balance and on May 9, 1996, a new assessment for \$1,500,000 was mailed to member companies. With the stabilization of the pool and the peaking of claims in 1995, assessment needs can be anticipated far enough in advance to prevent negative cash positions. In line with that, the Board ordered an assessment for \$1,200,000 in late October 1996. It was anticipated that this assessment would be needed to cover shortfalls during 1997. The next assessment was made in February, 1998 for \$1,000,000. It also should be noted that the Board arranged for a \$1,000,000 line of credit with the First National Bank of Anchorage for use in the case of a temporary shortfall in funds. During December 1998, the Board ordered the next assessment in the amount of \$1,500,000. It was anticipated that amount would cover the needs until late in 1999. The next assessment for \$1,500,000 was made in November, 1999. Due to the sharp increase in claims during 1999 another assessment for \$1,800,000 was administered during March, 2000.

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

The rapid increase in the claim to premium ratio (loss ratio) of the pool was very distressing to everyone connected with the pool, particularly those not familiar with this type of legislation. Normally, such a result would indicate the need to raise the premiums as that is the most direct way to reduce the loss ratio.

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 2.00. The Board initially set the premiums at 1.75 times that average which is less than the maximum allowed. In early 1996, the Board decided to increase the rates in order to reflect inflation in claim levels and standard risk premium rates in the Alaska market. The Board chose to set the premium at 1.75 rather than 2.00 because they felt that the 200% level would drive away the individuals who were healthier and result in a loss ratio that would be unimproved or worsened. This premium increase which averaged around 25% to 30% was effective July 1, 1996. This was the first increase since the initial rates were determined in April 1993. Rates were not increased during 1997 or 1998, and an increase is not expected in 1999. However, an increase which averaged 7 to 8% was put into effect July 1, 2000. In making this increase, 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.

The Board devoted a great deal of time in late 1995 and early 1996 developing strategy for managing ACHIA's financial condition in order to limit losses and resulting future assessments. However, the Board's flexibility has been, and remains, limited because (1) the policy benefits are restricted by statute, (2) the premiums are limited by statute (and by practical affordability levels), (3) newer techniques being used elsewhere in the insurance industry, like managed care, are limited by statute and the nature of Alaska's health care market, and (4) statute allows only an ACHIA member to administer the pool which may not allow for the most efficient and effective administration of ACHIA.

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

On March 7, 1996, Cecil Bykerk, Chairperson, testified in Juneau before a joint Senate and House hearing concerning the status of ACHIA. Following that hearing, the Board worked with the Division to draft legislation that addresses the limitations mentioned above. This draft legislation addressed the following issues: (1) technical corrections regarding representation on the Board which will allow proper input from consumer representatives and smaller member companies, (2) flexibility to allow development of cost containment methods including incentives to use PPO networks, (3) technical adjustments to the language to allow reduced complexity more appropriate in the determination of premium rates, (4) creating more competitive bidding on the administration of the plan by allowing entities other than member companies to administer ACHIA and (5) additional technical corrections that have become apparent over the early years of operation of the pool.

While these legislative changes were introduced, they did not progress to enactment during 1996. However, in 1996, ACHIA did contract with the administrator to provide a full-time case manager, Ellen Vickrey. Ellen has been extremely helpful in working with policyowners in an effort to provide them proper care. She contacts each new policyowner and discusses their situation. She has also worked with hospitals in an effort to hold down costs.

In 1997, the Board strongly recommended enactment of the legislation. However, an additional need for legislation was created by the enactment at the Federal level of the Health Insurance

Portability and Accountability Act of 1996 (HIPAA). This Act requires that states enforce certain portability and renewability standards. The states had several options in meeting these standards. One option is met through having a pool in place much like ACHIA. However, in order for ACHIA to satisfy the necessary requirements, the statute had to be amended to include automatic eligibility for individuals 'who are considered eligible for coverage under HIPAA.' Any individual who purchases coverage through this eligibility route will not be required to serve a pre-existing condition period. Such individuals are referred to as being Federally "Eligible Individuals" which is defined as individuals "for whom, as of the date on which the individual seeks coverage under this section, the aggregate of the periods of creditable coverage . . . is 18 or more months and . . . whose most recent prior creditable coverage was under a group health plan, governmental plan, or church plan (or health insurance coverage offered in connection with any such plan)" as well as meeting certain other criteria. The Board strongly recommended enactment of these necessary changes.

At first, it appeared that the necessary changes required by HIPAA and the changes previously described might be combined into one piece of legislation. However, because HIPAA required legislation that was beyond the scope of the ACHIA statute, it was determined that the bills should be split into two separate pieces of legislation. Because the Alaska HIPAA legislation had extremely tight time deadlines as mandated under HIPAA, focus was given to passage of this legislation and not to the Board sponsored legislation. The Board sponsored legislation did not get introduced. On April 2, 1997, Cecil Bykerk again testified before a joint Senate and House hearing concerning ACHIA and the potential impact of HIPAA on ACHIA. Ultimately, the bill was enacted and signed by the Governor. The Board again sought a sponsor for the bill in 1998. Late in the session, Senator Kelly agreed to introduce the bill but it died with the session. The bill was reintroduced in 1999 and was passed. Changes as a result of passage of the legislation will not occur until at least 2000.

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. In response to the HIPAA legislation in 1997, the ACHIA Board will revised the Plan of Operation, application, contracts and other support information. However, with additional changes enacted into statute in 1999, provisions have been created that will allow the Board, with approval and input from the Director of Insurance, to better manage ACHIA.

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, 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 60 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 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 coverages; **or**
- has any of the conditions listed below:

**Acquired Immune Deficiency
Syndrome (AIDS)**

Alzheimer's

Angina Pectoris

Anorexia Nervosa

Arteriosclerosis Obliteran

Artificial Heart Valve

Ascites

Brain Tumors

Cardiomyopathy

Cerebral Palsy

Chronic Pancreatitis

Cirrhosis of the Liver

Coronary Insufficiency

Coronary Occlusion

Crohn's Disease

Cystic Fibrosis

Dermatomyositis

Diabetes

Epilepsy

Friederich's Disease

Heart Disorders

Hemophilia

Hepatitis C (Active) (1998)

HIV+

Hodgkin's Disease

Huntington's Chorea

Hydrocephalus

Intermittent Claudication

Kidney Failure

**Lead Poisoning with Cerebral
Involvement**

Leukemia

Lupus Erythematosus Disseminate

**Malignant Tumor (if treated or has
occurred within last 4 yrs)**

Mental Retardation

Metastatic Cancer

Motor or Sensory Aphasia

Multiple or Disseminated

Sclerosis

Muscular Atrophy or Dystrophy

Myasthenia Gravis

Myotonia

Obesity - Morbid

Open Heart Surgery

Paraplegia or Quadriplegia

Parkinson's Disease

**Peripheral Arteriosclerosis (if
treatment within last 3 yrs)**

Poliomyelitis

Polyarteritis (Periarteritis Nodosa)

Polysystic Kidney

Postero-lateral Sclerosis

Psychotic Disorders

Rheumatoid Arthritis

Sickle Cell Anemia

Silicosis

**Splenic Anemia (True Banti's
Syndrome)**

Still's Disease

Stroke (CVA)

Syringomyelia

Tabes Dorsalis (Locomotor Ataxia)

**Thalassemia (Cooley's or
Mediterranean Anemia)**

Topectomy and Lobotomy

Ulcerative Colitis

Wilson's Disease

Individuals covered by Medicare may still be eligible for coverage under this plan.

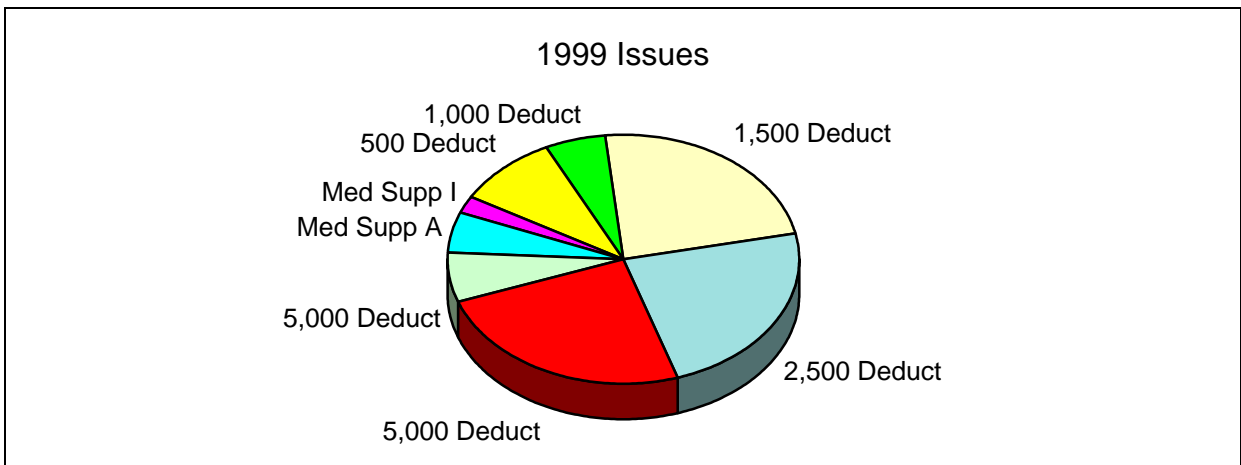
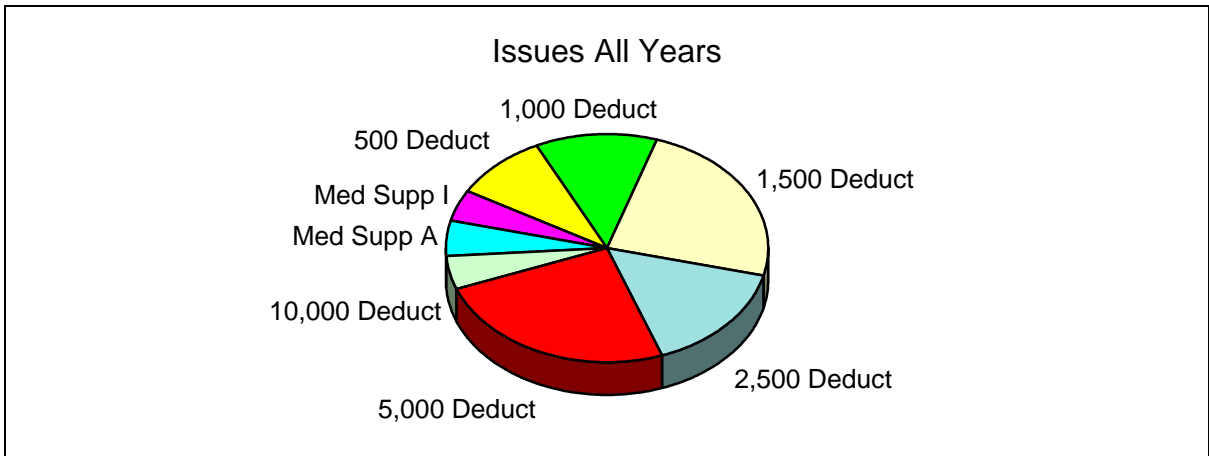
Additionally, effective July 1, 1997, a 'federally eligible individual' may purchase ACHIA coverage provided they are a resident of Alaska at the time of application (see page 8 of this report).

What Deductible Options are Available?

Six deductible options were available during 1999, \$500, \$1,000, \$1,500, \$2,500, \$5,000, and \$10,000. As of December 31, 1999, the plan insured the following:

1999 Year End Active Policyholders by Plan Type

Issues	Deductible						A	Medicare Supplement	
	500	1,000	1,500	2,500	5,000	10,000		I	Total
All	25	33	64	42	66	13	13	12	268
1999	9	5	22	22	23	6	5	1	93



What were the Rates?

Major Medical Rates, 1993 – June 30, 1996

Deductible:		\$ 500		\$1,000		\$1,500	
Out of Pocket							
Maximum :		\$2,000		\$2,000		\$2,000	
Age	Mon	Qrtly	Mon	Qrtly	Mon	Qrtly	
-18	135.00	405.00	98.00	294.00	89.00	267.00	
19-24	240.00	720.00	175.00	525.00	159.00	477.00	
25-29	243.00	729.00	180.00	540.00	163.00	489.00	
30-34	289.00	867.00	212.00	616.00	193.00	579.00	
35-39	306.00	918.00	225.00	675.00	204.00	612.00	
40-44	363.00	1,089.00	268.00	804.00	243.00	729.00	
45-49	418.00	1,254.00	308.00	924.00	279.00	837.00	
50-54	510.00	1,530.00	380.00	1,140.00	344.00	1,032.00	
55-59	586.00	1,758.00	438.00	1,314.00	397.00	1,191.00	
60-64	694.00	2,082.00	520.00	1,560.00	471.00	1,413.00	

Deductible:		\$2,500		\$5,000		\$10,000	
Out of Pocket							
Maximum :		\$3,500		\$7,500		\$10,000	
Age	Mon	Qrtly	Mon	Qrtly	Mon	Qrtly	
-18	74.00	222.00	52.00	156.00	38.00	114.00	
19-24	131.00	393.00	92.00	276.00	67.00	201.00	
25-29	135.00	405.00	94.00	282.00	68.00	204.00	
30-34	159.00	477.00	112.00	336.00	81.00	243.00	
35-39	169.00	507.00	118.00	354.00	86.00	258.00	
40-44	201.00	603.00	141.00	423.00	102.00	306.00	
45-49	230.00	690.00	162.00	486.00	118.00	354.00	
50-54	284.00	852.00	199.00	597.00	145.00	435.00	
55-59	328.00	984.00	230.00	690.00	167.00	501.00	
60-64	389.00	1,167.00	273.00	819.00	198.00	594.00	

Medicare Supplement Rates, 1993 - June 30, 1996

Age	Plan A		Plan I	
	Monthly	Quarterly	Monthly	Quarterly
-69	79.00	237.00	182.00	546.00
70-74	90.00	270.00	205.00	615.00
75-79	96.00	288.00	222.00	666.00
80+ .	102.00	306.00	236.00	708.00

Major Medical Rates, July 1, 1996 - June 30, 2000

Deductible:		<u>\$ 200</u>		<u>\$ 500</u>		<u>\$1,000</u>		<u>\$1,500</u>	
Out of Pocket									
Maximum :		<u>\$2,000</u>		<u>\$2,000</u>		<u>\$2,000</u>		<u>\$2,000</u>	
<u>Age</u>	<u>Mon</u>	<u>Qrtly</u>	<u>Mon</u>	<u>Qrtly</u>	<u>Mon</u>	<u>Qrtly</u>	<u>Mon</u>	<u>Qrtly</u>	
-18	285.25	855.75	182.00	546.00	141.75	425.25	117.25	351.75	
19-24	425.25	1,275.75	273.00	819.00	211.75	635.25	175.00	525.00	
25-29	484.75	1,454.25	309.75	929.25	243.25	729.75	201.25	603.75	
30-34	540.75	1,622.25	344.75	1,034.25	269.50	808.50	224.00	672.00	
35-39	609.00	1,827.00	388.50	1,165.50	306.25	918.75	253.75	761.25	
40-44	705.25	2,115.75	449.75	1,349.25	353.50	1,060.50	292.25	876.75	
45-49	826.00	2,478.00	526.75	1,580.25	414.75	1,244.25	344.75	1,034.25	
50-54	987.00	2,961.00	630.00	1,890.00	497.00	1,491.00	413.00	1,239.00	
55-59	1,172.50	3,517.50	745.50	2,236.50	595.00	1,785.00	495.25	1,485.75	
60-64	1,394.75	4,184.25	885.50	2,656.50	708.75	2,216.25	595.00	1,785.00	

Deductible:		<u>\$2,500</u>		<u>\$5,000</u>		<u>\$10,000</u>	
Out of Pocket							
Maximum :		<u>\$3,500</u>		<u>\$7,500</u>		<u>\$10,000</u>	
<u>Age</u>	<u>Mon</u>	<u>Qrtly</u>	<u>Mon</u>	<u>Qrtly</u>	<u>Mon</u>	<u>Qrtly</u>	
-18	99.75	299.25	66.50	199.50	57.75	173.25	
19-24	148.75	446.25	99.75	299.25	89.25	267.75	
25-29	171.50	514.50	115.50	346.50	103.25	309.75	
30-34	190.75	572.25	129.50	388.50	113.75	341.25	
35-39	215.25	645.75	143.50	430.50	129.50	388.50	
40-44	248.50	745.50	168.00	504.00	148.75	446.25	
45-49	292.25	876.75	196.00	588.00	175.00	525.00	
50-54	350.00	1,050.00	234.50	703.50	208.25	624.75	
55-59	420.00	1,260.00	283.50	850.50	250.25	750.75	
60-64	502.25	1,506.75	341.25	1,023.75	299.25	897.75	

Current Medicare Supplement Rates, first effective July 1, 1996

<u>Age</u>	<u>Plan A</u>		<u>Plan I</u>	
	<u>Monthly</u>	<u>Quarterly</u>	<u>Monthly</u>	<u>Quarterly</u>
-69	110.25	330.75	288.75	866.25
70-74	124.25	372.75	316.75	950.25
75-79	136.50	409.50	343.00	1,029.00
80+ .	147.00	441.00	388.50	1,165.50

What are the Rates?

Current Major Medical Rates, first effective July 1, 2000

<u>Deductible:</u>		<u>\$ 500</u>		<u>\$1,000</u>		<u>\$1,500</u>	
<u>Out of Pocket</u>							
<u>Maximum :</u>		<u>\$2,000</u>		<u>\$2,000</u>		<u>\$2,000</u>	
<u>Age</u>	<u>Mon</u>	<u>Qrtly</u>	<u>Mon</u>	<u>Qrtly</u>	<u>Mon</u>	<u>Qrtly</u>	
-18	206.00	618.00	160.00	546.00	132.00	425.25	
19-24	322.55	967.65	257.16	819.00	217.70	635.25	
25-29	350.00	1,050.00	275.00	929.25	227.00	729.75	
30-34	390.00	1,170.00	312.66	1,034.25	265.00	808.50	
35-39	445.91	1,337.73	360.03	1,165.50	303.87	918.75	
40-44	529.10	1,587.30	428.73	1,349.25	361.93	1,060.50	
45-49	629.13	1,887.39	510.99	1,580.25	431.81	1,244.25	
50-54	751.92	2,255.76	611.25	1,890.00	516.15	1,491.00	
55-59	874.11	2,622.33	711.02	2,236.50	598.05	1,785.00	
60-64	1,015.69	3,047.07	826.58	2,656.50	692.35	2,216.25	

<u>Deductible:</u>		<u>\$2,500</u>		<u>\$5,000</u>		<u>\$10,000</u>	
<u>Out of Pocket</u>							
<u>Maximum :</u>		<u>\$3,500</u>		<u>\$7,500</u>		<u>\$10,000</u>	
<u>Age</u>	<u>Mon</u>	<u>Qrtly</u>	<u>Mon</u>	<u>Qrtly</u>	<u>Mon</u>	<u>Qrtly</u>	
-18	113.00	339.00	79.66	238.98	68.93	206.79	
19-24	183.97	551.91	135.15	405.45	116.15	348.45	
25-29	194.00	582.00	140.73	422.19	120.56	361.68	
30-34	225.05	675.15	163.04	489.12	139.78	419.34	
35-39	259.07	777.21	187.06	561.18	160.14	480.42	
40-44	307.49	922.47	221.07	663.21	188.84	566.52	
45-49	368.88	1,106.64	263.09	789.27	224.70	674.10	
50-54	441.93	1,325.79	311.33	933.99	266.27	798.81	
55-59	512.65	1,537.95	360.19	1,080.57	308.37	925.11	
60-64	594.02	1,782.06	416.04	1,248.12	356.79	1,070.37	

Current Medicare Carveout Rates, first effective July 1, 2000

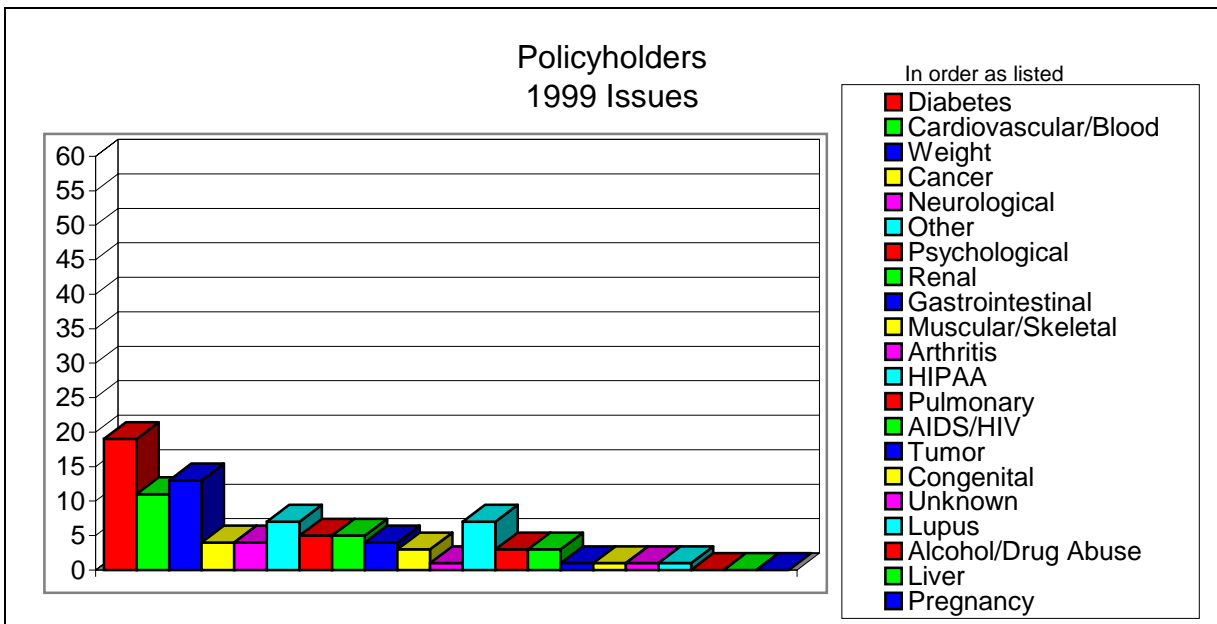
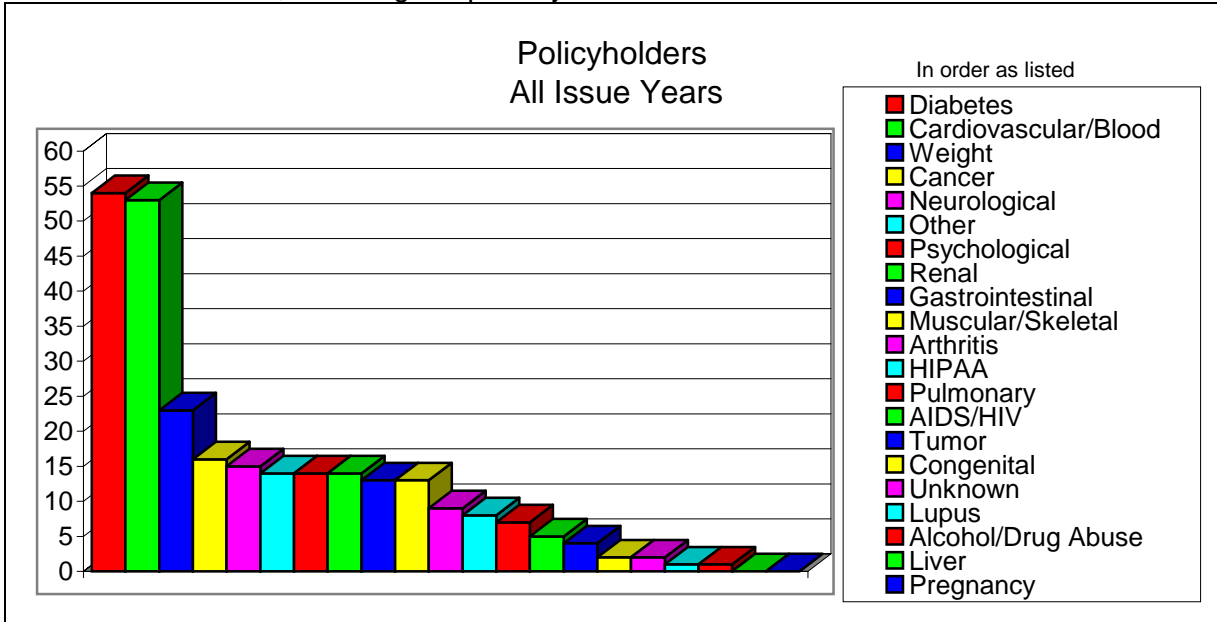
<u>Age</u>	<u>Monthly</u>	<u>Quarterly</u>
-18	126.53	379.59
19-64	253.05	759.15

Current Medicare Supplement Rates, first effective July 1, 1996

<u>Age</u>	<u>Plan A</u>		<u>Plan I</u>	
	<u>Monthly</u>	<u>Quarterly</u>	<u>Monthly</u>	<u>Quarterly</u>
-69	110.25	330.75	288.75	866.25
70-74	124.25	372.75	316.75	950.25
75-79	136.50	409.50	343.00	1,029.00
80+ .	147.00	441.00	388.50	1,165.50

Primary Medical Condition

Applicants for ACHIA coverage are asked to identify their primary medical condition. The most frequently listed category includes conditions related to a history of cardiovascular conditions. The next most frequently listed conditions include diabetes, cancer, and weight problems, followed by pulmonary, renal, neurological, gastrointestinal, psychological, and arthritis conditions. 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 two rejections for coverage in the last six months. Insureds who qualified for ACHIA coverage through HIPAA eligibility provisions are counted in the tables and charts, including the primary medical condition chart.



Financial

This section details the policy year financial experience for ACHIA. Exhibit 1 is the ACHIA balance sheet for years ended 1998 and 1999. Exhibit 2 shows the revenues, expenses and changes in the fund balance. ACHIA began 1999 with a deficit of \$80,618, and ended with a balance of \$38,293. Revenues for the year were \$3,387,594 and expenses were \$3,268,683. Exhibit 3 shows the cash flow for 1998 and 1999.

Board of Directors

The Board of Directors for 1999 was:

Cecil D. Bykerk, Chair
Executive VP & Chief Actuary
Mutual of Omaha Insurance Company
Mutual of Omaha Plaza
Omaha, NE 68175
Phone: (402) 351-2534
Fax: (402) 351-2465
Email:
cecil.bykerk@mutualofomaha.com

Robert Niebrugge, Vice-Chair
Consumer Representative
3521 Sky Ranch Loop – Box 4187
Palmer, AK 99645

Ross Blaker, CEBS
Aetna Life & Casualty
4300 B Street, Suite 205
Anchorage, AK 99503
Phone: (907) 563-0433
Fax: (907) 561-2362
Email: ross.blaker@aetna.com

Sandra Cole
Consumer Representative
2700 Teeland – Box 874165
Wasilla, AK 99687

Jeff Davis (new 1998)
Blue Cross/Blue Shield of Alaska
2550 Denali Street
Anchorage, AK 99503
Phone: (907) 258-5065 x304
Fax: (907) 258-1619

Chet Lozowski
Conseco Services
222 Merchandise Mart Plaza
Chicago, IL 60654-2001
Phone: (312) 396-7651
Fax: (312) 396-5903
Email: c.lozowski@banklife.com

Mark Wernicke
Humana
1100 Employers Blvd.
Green Bay, WI 54344
Phone: (920) 337-7656
Email: rperock@humana.com

Katie Campbell, Director's Designee
Ex-officio Member
State of Alaska Division of Insurance
333 Willoughby
Juneau, AK 99801
Phone: (907) 465-4607
Fax: (907) 465-3422
Email: katie.campbell@commerce.state.com

1999 COMMITTEES

ACTUARIAL COMMITTEE

Chet Lozowski, Chair
Cecil Bykerk
Katie Campbell
Mark Wernicke

ADVERTISING COMMITTEE

Sandra Cole, Chair
Gloria Chauvin
Ellen Vickrey

AUDIT COMMITTEE

Chet Lozowski, Chair
Bob Niebrugge
Mark Wernicke

GRIEVANCE COMMITTEE

Bob Niebrugge, Chair
Cecil Bykerk
Sandra Cole

POLICY COMMITTEE

Jeff Davis, Chair
Ross Blaker
Katie Campbell
Mark Wernicke
Cecil Bykerk (ex-officio)

NOMINATING COMMITTEE

Ross Blaker, Chair
Cecil Bykerk

Exhibit 1
BALANCE SHEETS

December 31, 1998 and 1999

Assets

	<u>1999</u>	<u>1998</u>
Cash	\$1,109,867	\$ 358,952
Funds held by (due to) administrator (note 4)	(224,223)	198,054
Assessments receivable (note 3)	<u>84,745</u>	<u>--</u>
	<u>970,389</u>	<u>557,006</u>

Liabilities and Fund Balance (Deficit)

	<u>1999</u>	<u>1998</u>
Reserve for claims and claim adjustment expenses	\$ 880,000	\$ 455,448
Unearned premiums	52,096	27,977
Assessments collected in advance (note 3)	-	154,199
Fund balance (deficit) (<u>Note</u> : In a subsequent event, the Board approved an assessment for \$1,000,000 in January, 1998)	<u>38,293</u>	<u>(80,618)</u>
	<u>\$ 970,389</u>	<u>557,006</u>

See accompanying notes to financial statements.

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

Years ended December 31, 1999 and 1998

	<u>1999</u>	<u>1998</u>
Revenues:		
Member assessments (note 3)	\$2,498,300	\$1,484,432
Premiums earned	863,966	759,686
Interest income (note 4)	<u>25,328</u>	<u>18,862</u>
	<u>3,387,594</u>	<u>2,262,980</u>
Expenses:		
Claims paid	\$2,519,140	\$1,840,192
Change in claims and claim adjustment expense reserves	424,552	94,474
Administrative services (note 4)	295,675	298,813
Board meetings	11,688	11,916
Accounting services	7,200	14,950
Telephone	3,242	3,441
Bank Fees	500	781
Postage	83	78
Other	<u>6,603</u>	<u>5,839</u>
	<u>\$3,268,683</u>	<u>\$2,270,483</u>
Excess (deficit) of revenues over expenses	118,911	(7,503)
Fund balance (deficit) at beginning of year	<u>(80,618)</u>	<u>(73,115)</u>
Fund balance (deficit) at end of year	<u>\$ 38,293</u>	<u>\$ (80,618)</u>

See accompanying notes to financial statements.

Exhibit 3
STATEMENTS OF CASH FLOWS

Years ended December 31, 1999 and 1998

	<u>1999</u>	<u>1998</u>
Cash flows from operating activities:		
Assessments collected from members	\$2,259,356	\$1,638,631
Premiums collected from insureds	888,085	743,607
Interest received	25,328	18,862
Claims expenses paid	(2,519,140)	(1,840,192)
Cash paid to administrators and suppliers	(324,991)	(335,817)
Cash advanced from (transferred to) administrators in excess of claims and other expenses paid by Administrator	<u>422,277</u>	<u>(335,577)</u>
Net cash provided (used) by operating activities and net increase (decrease) in cash	<u>750,915</u>	<u>(110,486)</u>
Cash at beginning of year	<u>358,952</u>	<u>469,438</u>
Cash at end of year	<u>1,109,867</u>	<u>358,952</u>
Reconciliation of deficiency of revenues over expenses to net cash provided (used) by operating activities:		
Excess (deficiency) of revenues over expenses	<u>118,911</u>	<u>(7,503)</u>
Adjustments:		
Decrease (increase) in assessments receivable	(84,745)	--
Decrease (increase) in funds held by administrator	422,277	(335,577)
Increase (decrease) in reserve for claims and claim adjustment expenses	424,552	94,474
Increase (decrease) in unearned premiums	24,119	(16,079)
Increase (decrease) in assessments collected in advance	<u>(154,199)</u>	<u>154,199</u>
Total adjustments	<u>632,004</u>	<u>(102,983)</u>
Net cash provided (used) by operating activities	<u>\$ 750,915</u>	<u>\$ (110,486)</u>

See accompanying notes to financial statements.

Notes to Financial Statements

December 31, 1999 and 1998

(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.

In preparing the financial statements, management is required to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure 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 financial statements are discussed below.

(2) Summary of Significant Accounting Policies

(a) *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.

(b) *Member Assessments*

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.

Notes to Financial Statements

(c) 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.

(d) Premiums

Premium income is recognized on a pro rata basis over the respective terms of the policies. Unearned premiums represent the portion of premiums written which relate to future periods.

(3) Member Assessments

In November 1999, the Association assessed members \$1,500,000 to cover anticipated claims and expenses in 1999.

In December 1998, the Association assessed its members \$1,500,000 of which \$1,000,000 was to cover anticipated claims and expenses in 1999. Of this assessment, \$154,199 was received in 1998 and recorded as assessments collected in advance.

(4) Related Party Transactions

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

Aetna Life Insurance Company (Aetna) administers the state plan by collecting the premium payments and adjusting and settling claims. Aetna is paid a fee by the Association for administering the plan. Total fees paid to Aetna were \$295,034 in 1999 and \$297,845 in 1998.

Funds owed to Aetna by the Association were \$224,223 at December 31, 1999. Funds owed by Aetna to the Association were \$198,054 at December 31, 1998. Aetna charges or pays interest to the Association on balances held by or owing to Aetna during the year. Interest paid by Aetna was \$3,842 and \$5,007, respectively, in 1999 and 1998.

(5) Line of Credit

At December 31, 1999 and 1998, the Association had a line of credit with a bank which allowed the Association to borrow up to \$1,000,000 as needed on a short-term basis.