2020 ANNUAL ALASKA HEALTH INSURANCE SURVEY
REPORTING FOR CALENDAR YEAR 2019

GENERAL INSTRUCTIONS

- All companies with any health insurance in force in Alaska must submit a survey.
- **Premium and claim totals** should balance to the premium and claim totals reported in the 2019 NAIC Annual Statement State Page for Alaska, **except as described below with respect to employer, trust, and association group reporting**. *Note that companies must report in the survey all coverage provided to an Alaska resident through employer, trust, or association plans issued in another state regardless of whether the premiums and claims for that coverage are reported in the NAIC Annual Statement State Page for Alaska.*
- Contact information should identify the individual to contact if the division has questions about the information reported in the survey.
- Report dollar amounts and numerical counts accurately using whole numbers.
- If no health insurance is in force in Alaska, simply send an e-mail that states "NO DATA TO REPORT" in the body of the e-mail along with contact information. Include the full company name and NAIC number in the subject line. Do not include a blank survey or survey completed with NONE or zeros as an attachment.
- Certificates of Compliance required under 3 AAC 28.916 and 3 AAC 28.932(e)(1) may be submitted as attachments in response to the survey.
- Send your survey response by e-mail to:

insinfo@alaska.gov

- The survey is available in EXCEL on the division's website at:

https://www.commerce.alaska.gov/web/ins/Resources/Bulletins.aspx

- **Do not complete** shaded areas.

PART I – DEFINITIONS (for Individual and Group tabs)

- **Individual:** insurance issued to an individual covering the individual and/or their dependents including plans offered to an individual through an association or trust **and include** conversions from group insurance.
- **Group**: insurance issued to an employer covering employees and/or their dependents including insurance offered to an employer through an association or trust.
- **Employer (1-50 employees), Employer (51+ employees):** insurance offered, delivered, issued for delivery, or renewed to an employer that employed an average of at least [1, 51] but not more than [50, unlimited] on the business days during the preceding calendar year and that employ at least 2 employees on the first day of the health insurance plan year.
- **Multiple Employer Assoc or Trust:** insurance issued to an association or trust covering the employees and dependents of the employer members of the association or trust. If individual members (i.e., not employees or dependents of an employer member) are covered under the association or trust, report in the **Other Assoc or Trust** line.
- **Other Assoc or Trust:** insurance issued to an association or trust covering both employees and dependents of employer members as well as individual members. Health insurance issued to an association or trust covering only individuals should be reported in the Individual survey.

Row Headings

- **Accident or AD&D:** coverage, singly or in combination, for death, dismemberment, disability, or hospital and medical care caused by an accident, including accident only, travel accident, accidental death and dismemberment, student accident, blanket accident, or specified accident. Do not include combination accident and sickness policies in this line. These should be included in the comprehensive medical line or other appropriate line.
- **Comprehensive Medical:** coverage for hospital, medical, and surgical expenses (not supplemental coverage but include dental and vision benefits that are offered as part of the hospital, medical, and surgical coverage). Do not include hospital only, medical only, or other fixed indemnity insurance in this line (include in the fixed indemnity line.)
- **Dental:** stand-alone dental coverage. If dental benefits are part of a comprehensive medical plan, then include data under comprehensive major medical.
- **Disability Income:** loss of time coverage, but **does not include credit disability**.
- **Fixed Indemnity:** coverage that is not coordinated with other health insurance coverage and that provides a limited fixed dollar amount of benefit for medical care or hospital expenses and in which benefits are not related to expenses incurred, such as hospital confinement indemnity coverage**.**
- **Long Term Care:** coverage for at least 12 consecutive months for diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services provided in a setting other than an acute care unit of a hospital, including products that provide benefits for cognitive impairment or loss of functional capacity. This line should include products providing only nursing home care, home health care, community based care, or any combination.
- **Medicare Supplement:** coverage designed as a supplement to reimbursement under Medicare for hospital, medical, or surgical expenses of a person eligible for Medicare.
- **Short-term Medical:** comprehensive medical coverage for a short period of time, typically less than one year.
- **Specified Disease:** coverage for diagnosis and treatment of a specifically named disease, such as cancer.
- **Vision:** stand-alone vision coverage. If vision benefits are part of a comprehensive medical plan, then include data under comprehensive major medical.
- **Other:** health insurance coverage that does not meet one of the above product definitions. Provide a brief description of the product on survey. **Do NOT report credit insurance, Medicare Part D, Federal Employees Health Benefits Program, TRICARE, or Medicare Title XVIII.**
- **Stop Loss:** coverage purchased by a self-insured entity (such as an employer, association, or trust) to cover hospital, medical, or surgical expenses in excess of a specified amount.
- **Administrative Services Only:** administrative services for a self-insured employer or association health plan in which claims are paid from a bank account owned and funded directly by a self-insured employer or association, or claims are paid from a bank account owned by the administrator but only after receiving funds from the self-insured employer of association.
- **Administrative Services Contract:** administrative services for a self-insured employer or association health plan in which claims are paid from the insurer's own bank account and the insurer subsequently reserves reimbursement from the self-insured employer or association.

Column Headings

In regard to the **Group Tab:**

- **Policies:** The number of insurance contracts issued to employers, associations, and trusts in Alaska, not the number of employees, dependents/spouses, or other individuals covered under such policies.

- **Covered individuals:** The number of employees, dependents/spouses, and other individuals covered under group policies.
- **New Policies Issued During the Year:** The number of policies newly issued during the reporting year, not including renewed or reinstated policies.
- **Policies Terminated During the Year:** The number of policies terminated during the reporting year.
- **Policies In Force End of Year:** The number of GROUP policies in force on December 31 of the reporting year. In the case of employer, trust, or association health coverage*, if no policies are in force in Alaska, but individuals in Alaska are covered under an employer, trust, or association policy in force in another state, record 0 policies in force*.
- **Individuals Covered End of Year:** The number of people covered under policies in force on December 31 of the reporting year, *including those Alaskans covered under an employer, trust, or association policy issued or in force in another state*. For example, a family policy covering two parents and two children would count as four individuals covered and an employer health plan that covers 25 employees, 20 spouses, and 20 children would count as 65 individuals covered (one policy).
- **Member Months:** the sum of the number of covered lives on a specified day of each month during the calendar year (i.e. determine the number of covered lives on a particular day in each of the 12 months and add together).
- **Direct Premiums Paid/Written and Direct Losses Paid:** premiums and claims paid during the reporting year.

    - **For Life and Health Insurers:** These totals should balance to the Alaska State Page for the reporting year, Accident and Health Insurance Section Total excluding Credit and Federal Employee Health Benefits Program. Please explain if they do not.
    - **For Property and Casualty Insurers:** These totals should balance to the Alaska State Page for the reporting year, Accident and Health lines, including any Employer or Stop Loss that is reported in another line and excluding Credit and Federal Employee Health Benefits Program. Please explain if they do not.

- **Association/Trust (Y/N)** – If the company has any group policies that have been issued to any associations and/or trusts with enrollment in Alaska, please enter Y.

Claims Tab

REPORT DATA ONLY FOR INDIVIDUAL OR GROUP COMPREHENSIVE MEDICAL INSURANCE (AS DEFINED IN PART I).

- **Claim:** means a request for payment under an insurance contract. Count multiple requests for payment for the same health care service or supply as only one claim. Do not count a response to a request for additional clarification/information regarding an already submitted claim as another claim.
- **Clean claim:** means a claim that does not have a defect or impropriety, including a lack of any required substantiating documentation, or a particular circumstance requiring special treatment that prevents timely payment on the claim. See AS 21.36.495(i)(1)

Grievances – EHRs Tab

All Health Care Insurers

- **Number of Grievances:** means a grievance as defined by 3 AAC 28.989(28) was received during 2019 for the corresponding line of business
- **Synopsis:** means a summary of company's actions to remedy issues that the company has identified during a grievance

Dental and Comprehensive Major Medical Insurers

- **External healthcare reviews requested:** means a claim that was submitted by the consumer requesting for a review by an independent review organization, as required under 3 AAC 28.954, because of denial of a grievance.
- **External healthcare reviews adjudicated:** means a claim that is under review or was processed by an independent review organization, as required under 3 AAC 28.954, because of denial of a grievance.
- **Expedited:** means an appeal that meets the requirements under 3 AAC 28.960