INSTRUCTIONS FOR COMPLETING THE CALENDAR YEAR 2005 ANNUAL ALASKA HEALTH INSURANCE SURVEY

General

- 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.
- **Premium and claim totals should balance to the data reported in the NAIC Annual Statement State Page for Alaska, except as provided below in regard to trust and association group reporting.**
- If no health insurance is written in Alaska, simply respond to the survey by sending an e-mail that states "No health insurance written in Alaska" including the name and NAIC number of the company and contact information.
- Send your survey response by e-mail to the address insinfo@commerce.state.ak.us
- The survey is available in EXCEL formats on the division's Website at www.commerce.state.ak.us/insurance/bulletins/
- Do not complete shaded areas.

PART I

Individual means insurance issued to an individual covering the individual and/or their dependents **including insurance offered to an individual through an association or trust.** Individual insurance includes conversions from group insurance.

Group means insurance issued to an employer covering employees and/or their dependents **including insurance offered to an employer through an association or trust.**

> **Small Employer (2-50)** means health insurance offered, delivered, issued for delivery or renewed to small employers that employed an average of at least 2 but not more than 50 employees 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.
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> **Other Employer** means health insurance offered, delivered, issued for delivery or renewed to employers that are not small employers.
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> **Multiple Employer Assoc or Trust** means health insurance issued to an association or trust covering the employees and dependents of the employer members of the association or trust.
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> **Other Assoc or Trust** means health 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, specified accident.

Comprehensive Medical: coverage for hospital, medical, and surgical expenses (not supplemental coverage but may 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 limited benefit insurance in this line (include in the limited benefit 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.**

Limited Benefit: coverage that are not coordinated with other health coverage and that provide limited medical and/or hospital benefits such as medical expense, hospital expense, hospital indemnity, or short-term medical. Do not include specified disease insurance in this line (include in specified disease line).

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 1 year.

Specified Disease: coverage for diagnosis and treatment of a specifically named disease, such as cancer.

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's 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's health plan, in which claims are paid from the insurers own bank account and the insurer subsequently reserves reimbursement from the self-insured employer or association.

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.

Column Headings

In regard to group insurance:

- Number of policies is 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.
- Number of covered individuals is the number of employees, dependents/spouses, and other individuals covered under group policies.

 # New Policies Issued During the Year: number of policies newly issued during the reporting year not including renewed or reinstated policies.

 # Policies Terminated During the Year: number of policies terminated during the reporting year.

 # Policies In Force End of Year: number of 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: 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 in force in another state. For example, a family policy covering 2 parents and 2 children would count as 4 individuals covered and an employer health plan that covers 25 employees, 20 spouses and 20 children would count as 65 individuals covered (1 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.)

Earned Premium and Incurred Claims: premiums and claims incurred during the reporting year.

> **For Life and Health Insurance Companies:** earned premium and incurred claims total 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.
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> **For Property and Casualty Insurance Companies:** earned premium and incurred claims total 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 the liability lines and excluding credit and federal employee health benefits program.

PART II

Report data only for group comprehensive major 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, impropriety, or circumstance requiring special treatment that precludes timely payment on the claim. See AS 21.54.050(l)

Externally appealed: means a claim that is currently or was under review by an external appeal agency as required under AS 21.07.050, because of denial of a claim.

Internally appealed: means a claim that is currently or was under review by the company as required under AS 21.07.020, because of denial of a claim.