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CS FOR SENATE BILL NO. 70(L&C)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SEVENTH LEGISLATURE - FIRST SESSION

BY THE SENATE LABOR AND COMMERCE COMMITTEE

Offered:
Referred:

Sponsor(s): SENATORS FRENCH, Davis

A BILL

FOR AN ACT ENTITLED

"An Act establishing the Alaska Health Benefit Exchange; and providing for an effective date."

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

*** Section 1.** The uncodified law of the State of Alaska is amended by adding a new section to read:

INTENT. It is the intent of the legislature in this Act

(1) to facilitate the purchase and sale of qualified health plans in the individual market in this state;

(2) to establish a small business health options program exchange to assist qualified small employers in the state in enrolling employees in qualified health plans offered in the small group market;

(3) to provide consumer education and assist individuals with access to programs, credits, and cost-sharing reductions;

(4) to reduce the number of uninsured Alaskans by creating an organized,

transparent, and easy-to-navigate health insurance marketplace that offers a choice of high value health plans with low administrative costs for individuals and employers; and

(5) that the Alaska Health Benefit Exchange Board recommend to the legislature and the Office of the Governor methods to keep premium costs low and risk pools strong in the health insurance market place.

*** Sec. 2.** AS 21.54 is amended by adding new sections to read:

Article 2A. Alaska Health Benefit Exchange.

Sec. 21.54.200. Alaska Health Benefit Exchange. The Alaska Health Benefit Exchange is established as a public corporation of the state in the Department of Commerce, Community, and Economic Development but with separate and independent legal existence.

Sec. 21.54.210. Alaska Health Benefit Exchange Board. (a) The Alaska Health Benefit Exchange Board is established to manage the exchange.

(b) The board consists of eight members, including six members appointed by the governor, the commissioner of health and social services or the commissioner's designee, serving ex officio, and the director, serving ex officio, without the power to vote. The members of the board appointed by the governor are

(1) a representative of small business employers;

(2) a representative of the health care insurance business;

(3) a person with expertise in health plan finance;

(4) a person with expertise in health plan administration;

(5) an actuary or a person with a background in health care actuarial or economic principles; and

(6) a health care consumer representative.

(c) Except for the commissioner or the commissioner's designee and the director, who serve ex officio, each board member serves for a term of three years beginning on January 1 and until a successor has been appointed. A member is eligible for reappointment.

(d) The board shall select a member to serve as chair and a member to serve as vice-chair for a term and with duties and powers necessary to perform their functions.

(e) A majority of the board constitutes a quorum for transacting business.

(f) If a vacancy occurs, the governor shall make an appointment, effective immediately, for the balance of the unexpired term.

(g) Board members and the executive director hired under (j) of this section shall comply with the requirements of AS 39.50 (public official financial disclosure) and shall disclose an affiliation with an insurer, agent, broker, or other representative of an insurer, a health care provider, or a health care facility.

(h) Members of the board are entitled to per diem and transportation costs under AS 39.20.180.

(i) A member of the board of directors of the exchange may not be held civilly or criminally liable for an act or omission if the act or omission was in good faith and within the scope of the director's duties.

(j) The board shall employ an executive director to administer the exchange. The executive director shall perform duties as prescribed by the board and may employ a staff to assist in the performance of the duties of the executive director. The executive director and staff employed under this subsection are in the partially exempt service under AS 39.25.120.

Sec. 21.54.220. Duties and powers of the Alaska Health Benefit Exchange; limitation. (a) The Alaska Health Benefit Exchange Board shall

(1) facilitate the purchase and sale of qualified health plans;

(2) establish a small business health options program exchange to assist qualified small employers in the state in enrolling employees in a qualified health plan;

(3) provide for the operation of a toll-free telephone hotline to respond to requests for assistance;

(4) provide for enrollment periods under sec. 1311(c)(6), P.L. 111-148 (Patient Protection and Affordable Care Act), as amended, and regulations adopted under that Act;

(5) maintain an Internet website through which enrollees and prospective enrollees of qualified health plans may obtain standardized comparative information on those plans;

(6) implement procedures for the certification, recertification, and

decertification of qualified health plans according to the determination of the division consistent with guidelines developed by the United States Secretary of Health and Human Services under sec. 1311(c), P.L. 111-148 (Patient Protection and Affordable Care Act), as amended, and regulations adopted under that Act;

(7) assign a rating to each qualified health plan offered through the exchange according to the determination of the division in accordance with the criteria developed by the United States Secretary of Health and Human Services under sec. 1311(c)(3), P.L. 111-148 (Patient Protection and Affordable Care Act), as amended, and regulations adopted under that Act;

(8) determine the level of coverage of each qualified health plan according to the determination of the division under regulations issued by the United States Secretary of Health and Human Services under sec. 1302(d)(2)(A), P.L. 111-148 (Patient Protection and Affordable Care Act), as amended, and regulations adopted under that Act;

(9) use a standardized format for presenting health benefit options in the exchange, including the use of the uniform outline of coverage established under 42 U.S.C. 300gg et seq. (sec. 2715, Part A, subpart II, title XXVII, Public Health Service Act);

(10) in accordance with sec. 1413, P.L. 111-148 (Patient Protection and Affordable Care Act), as amended, and regulations adopted under that Act, inform individuals of title XIX, Social Security Act eligibility requirements for the Medicaid program under 42 U.S.C. 1396 - 1396w-2, the Children's Health Insurance Program under 42 U.S.C. 1397aa - 1397mm (title XXI of the Social Security Act), or any applicable state or local public program; and, if the exchange determines that any individual is eligible for a program, enroll that individual in that program;

(11) establish and make available by electronic means a calculator to determine the actual cost of coverage after application of any premium tax credit under 26 U.S.C. 36B (Internal Revenue Code of 1986), and any cost-sharing reduction under sec. 1402, P.L. 111-148 (Patient Protection and Affordable Care Act), as amended, and regulations adopted under that Act;

(12) establish a small business health options program exchange

through which qualified employers may access coverage for their employees and which shall enable a qualified employer to specify a level of coverage so that any of its employees may enroll in any qualified health plan offered through the small business health options program exchange at the specified level of coverage;

(13) subject to sec. 1411, P.L. 111-148 (Patient Protection and Affordable Care Act), as amended, and regulations adopted under that Act, grant a certification attesting that, for purposes of the individual responsibility penalty under 26 U.S.C. 5000A (Internal Revenue Code of 1986), an individual is exempt from the individual responsibility requirement or from the penalty imposed by that section because

(A) an affordable qualified health plan covering the individual is not available through the exchange or through the individual's employer; or

(B) the individual meets the requirements for another exemption from the individual responsibility requirement or penalty;

(14) provide the following information to the United States Secretary of the Treasury:

(A) the name and taxpayer identification number of each individual issued a certification under (13) of this subsection;

(B) the name and taxpayer identification number of each individual who was an employee but who was determined to be eligible for the premium tax credit under 26 U.S.C. 36B (Internal Revenue Code of 1986) because

(i) the employer did not provide minimum essential coverage; or

(ii) the employer provided the minimum essential coverage, but it was determined under 26 U.S.C. 36B(c)(2)(C) (Internal Revenue Code of 1986), to be unaffordable to the employee or not to provide the required minimum actuarial value; and

(C) the name and taxpayer identification number of each individual who

(i) notifies the exchange under sec. 1411(b)(4), P.L.

111-148 (Patient Protection and Affordable Care Act), as amended, and regulations adopted under that Act, that the individual has changed employers; and

(ii) ceases coverage under a qualified health plan during a plan year and the effective date of that cessation;

(15) provide to each employer the name of each employee of the employer described in (14)(B) of this subsection who ceases coverage under a qualified health plan during a plan year and the effective date of the cessation;

(16) perform duties required of the exchange by the United States Secretary of Health and Human Services or the United States Secretary of the Treasury related to determining eligibility for premium tax credits, reduced cost-sharing, or individual responsibility requirement exemptions;

(17) select entities qualified to serve as navigators as determined by the division in accordance with sec. 1311(i), P.L. 111-148 (Patient Protection and Affordable Care Act), as amended, and regulations adopted under that Act, and standards developed by the United States Secretary of Health and Human Services and award grants to enable navigators to

(A) conduct public education activities to raise awareness of the availability of qualified health plans;

(B) distribute fair and impartial information concerning enrollment in qualified health plans, the availability of premium tax credits under 26 U.S.C. 36B (Internal Revenue Code of 1986), and the availability of cost-sharing reductions under sec. 1402, P.L. 111-148 (Patient Protection and Affordable Care Act), as amended, and regulations adopted under that Act;

(C) facilitate enrollment in qualified health plans;

(D) provide referrals to the division for consumer assistance for a person with a grievance, complaint, or question regarding the person's health benefit plan or coverage, or a determination under that plan or coverage; and

(E) provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the exchange;

(18) review the rate of premium growth within the exchange and outside the exchange as determined by the division and rely on the information developed by the division on whether to continue limiting qualified employer status to small employers;

(19) rely on policies and procedures developed by the division to minimize adverse selection among plans sold within the exchange and review policies within the exchange and outside the exchange to monitor the effect of adverse selection between the two marketplaces;

(20) credit the amount of any free choice voucher to the monthly premium of the plan in which a qualified employee is enrolled, in accordance with sec. 10108, P.L. 111-148 (Patient Protection and Affordable Care Act), as amended, and regulations adopted under that Act, and collect the amount credited from the offering employer;

(21) consult with persons having an interest in the activities of the exchange, including

(A) health care insurers;

(B) health care consumers who are enrollees in qualified health plans;

(C) individuals and entities with experience in facilitating enrollment in qualified health plans;

(D) representatives of small businesses and self-employed individuals;

(E) the division in the Department of Health and Social Services responsible for administering Medicaid; and

(F) advocates for enrolling hard-to-reach populations;

(22) establish one or more advisory groups to consult with the board to provide expertise on and input into operations of the exchange; the membership of an advisory group may include health care providers, hospitals, and persons identified in (21) of this subsection;

(23) maintain an accurate accounting of all activities, receipts, and expenditures;

(24) submit an annual accounting report to the United States Secretary of Health and Human Services, the governor, the director and the legislature; the report must include the following information described by insurer by benefit plan:

(A) the number of covered persons;

(B) the number of covered persons receiving free choice vouchers and the amount of free choice vouchers credited;

(C) the number of individuals exempted from individual responsibility requirements by reason;

(D) the number of individuals eligible for premium tax credit;

(E) the number of employees who terminated coverage and the number of individuals obtaining coverage through the exchange who were covered under an employer health plan in the preceding six months; and

(F) other data specified by the director;

(25) cooperate with an investigation conducted by the division or the United States Secretary of Health and Human Services under the Secretary's authority under P.L. 111-148 (Patient Protection and Affordable Care Act), as amended, and regulations adopted under that Act, and allow the division or the Secretary, in coordination with the Inspector General of the United States Department of Health and Human Services, to

(A) investigate the affairs of the exchange;

(B) examine the properties and records of the exchange;

(C) require periodic reports in relation to the activities undertaken by the exchange;

(26) allow a health care insurer to offer a plan that provides limited scope dental benefits under 26 U.S.C. 9832(c)(2)(A) (Internal Revenue Code of 1986), through the exchange, either separately or in conjunction with a qualified health plan, if the plan provides pediatric dental benefits under sec. 1302(b)(1)(J), P.L. 111-148 (Patient Protection and Affordable Care Act), as amended, and regulations adopted under that Act;

(27) apply for planning and establishment grants made available to the exchange under sec. 1311, P.L. 111-148 (Patient Protection and Affordable Care Act),

as amended, and regulations adopted under that Act;

(28) rely on the division's determination relating to the potential for interstate compacts that would permit the sale and purchase of health care insurance across state borders and recommend particular compact arrangements for legislative approval; and

(29) submit to the director a plan of operation to ensure the fair, reasonable, and equitable administration of the exchange; the plan of operation becomes effective on approval in writing by the director, subject to the following:

(A) if the exchange fails to submit a suitable plan under this paragraph, the director may adopt reasonable regulations necessary or advisable to carry out the provisions of AS 21.54.200 - AS 21.54.270; the regulations adopted by the director under this subparagraph must continue in force until modified by the director or superseded by a plan submitted by the exchange and approved by the director;

(B) the plan of operation must

(i) establish procedures for the performance of the duties and powers of the exchange;

(ii) establish procedures for handling assets of the exchange;

(iii) establish the amount and method of reimbursing members of the board of directors;

(iv) establish regular places and times for meetings of the board of directors;

(v) establish procedures for records to be kept of all financial transactions of the exchange, its agents, and the board of directors;

(vi) contain any additional provisions necessary or proper for the execution of the powers and duties of the exchange.

(b) The exchange may

(1) enter into a contract for the performance of the exchange's duties with the Department of Health and Social Services or another entity that has

experience in individual and small group health insurance or benefit administration, or other experience relevant to the responsibilities to be assumed by the entity, except that the exchange may not contract for the performance of its duties with a health care insurer or an affiliate of a health care insurer;

(2) enter into information-sharing agreements with federal and state agencies and other state exchanges to carry out its duties if the agreements include adequate protections with respect to the confidentiality of the information to be shared and comply with all state and federal laws and regulations; and

(3) apply for and receive grants or donations from federal, state, local government, foundation, or private entities.

(c) The exchange may not use money intended for the administrative and operational expenses of the exchange for staff retreats, promotional giveaways, or excessive executive compensation.

(d) Neither the exchange nor a health care insurer offering a health benefit plan through the exchange may charge an individual a fee or penalty for termination of coverage if the individual enrolls in another type of minimum essential coverage because

(1) the individual has become newly eligible for that coverage; or

(2) the individual's employer-sponsored coverage has become affordable under the standards of 26 U.S.C. 36B(c)(2)(C) (Internal Revenue Code of 1986).

Sec. 21.54.230. Health benefit plan certification. (a) The exchange may certify a health benefit plan as a qualified health plan if

(1) the plan provides the essential health benefits described in sec. 1302(a), P.L. 111-148 (Patient Protection and Affordable Care Act), as amended, and regulations adopted under that Act, except that the plan is not required to provide essential benefits that duplicate the minimum benefits of qualified dental plans if

(A) the exchange has determined that at least one qualified dental plan is available to supplement the plan's coverage; and

(B) the health care insurer makes prominent disclosure at the time it offers the plan, in a form approved by the exchange, that the plan does

not provide the full range of essential pediatric benefits, and that qualified dental plans providing those benefits and other dental benefits not covered by the plan are offered through the exchange;

(2) the premium rates and contract language have been approved by the director;

(3) the plan provides at least a bronze level of coverage under AS 21.54.220(a)(7) unless the plan is certified as a qualified catastrophic plan, meets the requirements of P.L. 111-148 (Patient Protection and Affordable Care Act), as amended, and regulations adopted under that Act, for catastrophic plans, and will only be offered to individuals eligible for catastrophic coverage;

(4) the cost-sharing requirements of the plan do not exceed the limits established under sec. 1302(c)(1), P.L. 111-148 (Patient Protection and Affordable Care Act), as amended, and regulations adopted under that Act, and, if the plan is offered through the small business health options program exchange, the deductible for the plan does not exceed the limits established under sec. 1302(c)(2), P.L. 111-148 (Patient Protection and Affordable Care Act), as amended, and regulations adopted under that Act;

(5) the health care insurer offering the plan

(A) is licensed and in good standing to offer health insurance coverage in the state;

(B) offers at least one qualified health plan that provides a silver level of coverage under AS 21.54.220(a)(7) and at least one plan that provides a gold level of coverage through each small business health options program exchange and exchange for individual coverage in which the health care insurer participates;

(C) charges the same premium rate for each qualified health plan without regard to whether the plan is offered through the exchange and without regard to whether the plan is offered directly from the health care insurer or through an insurance producer;

(D) does not charge cancellation fees or penalties in violation of AS 21.54.220(d); and

(E) complies with the regulations developed by the United States Secretary of Health and Human Services under sec. 1311(d), P.L. 111-148 (Patient Protection and Affordable Care Act), as amended, and regulations adopted under that Act, and other requirements the exchange establishes;

(6) the plan meets the requirements of certification as adopted by regulation under AS 21.54.250 and by the United States Secretary of Health and Human Services under sec. 1311(c), P.L. 111-148 (Patient Protection and Affordable Care Act), as amended, and regulations adopted under that Act, which include minimum standards in the areas of marketing practices, network adequacy, essential community providers in underserved areas, accreditation, quality improvement, uniform enrollment forms, and descriptions of coverage and information on quality measures for health benefit plan performance; and

(7) the exchange determines that making the plan available through the exchange is in the interest of qualified individuals and qualified employers in this state.

(b) The exchange may not exclude a health benefit plan

(1) because the plan is a fee-for-service plan;

(2) by imposing premium price controls; or

(3) because the plan provides treatments necessary to prevent patients' deaths that the exchange determines are inappropriate or too costly.

(c) The exchange shall require each health care insurer seeking certification of a plan as a qualified health plan to

(1) submit to the exchange a justification for any premium increase before implementation of that increase; the health care insurer shall prominently post the justification information on the health care insurer's Internet website; the exchange shall consider the information submitted, along with the information and the recommendations provided to the exchange by the director under 42 U.S.C. 300gg-94 (sec. 2794(b), Part C, title XXVII, Public Health Service Act) when determining whether to allow the health care insurer to make plans available through the exchange;

(2) make available to the public in plain language, as defined in sec. 1311(e)(3)(B), P.L. 111-148 (Patient Protection and Affordable Care Act), as

amended, and regulations adopted under that Act, and submit to the exchange, the United States Secretary of Health and Human Services, and the director accurate and timely disclosure of the following:

(A) claims payment policies and practices;

(B) periodic financial disclosures;

(C) data on enrollment;

(D) data on disenrollment;

(E) data on the number of claims that are denied;

(F) data on rating practices;

(G) information on cost-sharing and payments with respect to any out-of-network coverage;

(H) information on enrollee and participant rights under Title I of P.L. 111-148 (Patient Protection and Affordable Care Act), as amended, and regulations adopted under that Act; and

(I) other appropriate information as determined by the United States Secretary of Health and Human Services.

(3) permit individuals to learn, in a timely manner on the request of the individual, the amount of cost-sharing, including deductibles, copayments, and coinsurance, under the individual's plan or coverage that the individual would be responsible for paying with respect to the furnishing of a specific item or service by a participating provider; a minimum, that information must be made available to the individual through an Internet website and through other means for individuals without access to the Internet.

(d) The exchange may not exempt a health care insurer seeking certification of a qualified health plan from state licensure or solvency requirements, regardless of the type or size of the health care insurer, and shall apply the criteria of this section in a manner that ensures equality between or among health care insurers participating in the exchange.

(e) The provisions of AS 21.54.200 - 21.54.270 that are applicable to qualified health plans also apply, to the extent relevant, to qualified dental plans, except as modified under (1) - (3) of this subsection or by regulations adopted by the exchange.

Under this subsection,

(1) the health care insurer shall be licensed to offer dental coverage, but need not be licensed to offer other health benefits;

(2) the plan must be limited to dental and oral health benefits, without substantially duplicating the benefits typically offered by a health benefit plan without dental coverage and must include, at a minimum, the essential pediatric dental benefits prescribed by the United States Secretary of Health and Human Services under sec. 1302(b)(1)(J), P.L. 111-148 (Patient Protection and Affordable Care Act), as amended, and regulations adopted under that Act, and other dental benefits as the exchange or the Secretary may specify by regulation; and

(3) the health care insurer may jointly offer a comprehensive plan through the exchange in which the dental benefits are provided by a health care insurer through a qualified dental plan and the other benefits are provided by a health care insurer through a qualified health plan if the plans are priced separately and are also made available for purchase separately at the same price.

Sec. 21.54.240. Exchange funding; publication of costs of the exchange. (a) The exchange may charge assessments or user fees to a health care insurer offering a health benefit plan or otherwise generate funding necessary to support its operations provided under AS 21.54.200 - 21.54.270.

(b) The exchange shall publish the average costs of licensing, regulatory fees, and any other payments required by the exchange, and the administrative costs of the exchange, on its Internet website. That information must include information on money lost to waste, fraud, and abuse.

Sec. 21.54.250. Regulations. The division or the exchange may adopt regulations to implement their respective authority under the provisions of AS 21.54.200 - 21.54.270. Regulations adopted under this section may not conflict with or prevent the application of regulations adopted by the United States Secretary of Health and Human Services under P.L. 111-148 (Patient Protection and Affordable Care Act), as amended, and regulations adopted under that Act.

Sec. 21.54.260. Relation to other laws. Provisions of AS 21.54.200 - 21.54.270, and actions taken by the exchange under AS 21.54.200 - 21.54.270 may

not be construed to preempt or supersede the authority of the director to regulate the business of insurance in the state. Except as expressly provided to the contrary in AS 21.54.200 - 21.54.270, all health care insurers offering qualified health plans in the state shall comply fully with all applicable health insurance laws of the state and regulations adopted and orders issued by the director.

Sec. 21.54.270. Definitions. In AS 21.54.200 - 21.54.270,

(1) "board" means the Alaska Health Benefit Exchange Board established AS 21.54.210;

(2) "exchange" means the Alaska Health Benefit Exchange established under AS 21.54.200;

(3) "health benefit plan" has the meaning given in AS 21.54.500, except that, notwithstanding AS 21.54.500, it does not include

(A) coverage only for accident or disability income insurance, or any combination of accident or disability income insurance;

(B) coverage issued as a supplement to liability insurance;

(C) liability insurance, including general liability insurance and automobile liability insurance;

(D) workers' compensation insurance or similar insurance;

(E) automobile medical payment insurance;

(F) credit-only insurance;

(G) coverage for on-site medical clinics;

(H) insurance coverage specified in federal regulations issued under the P.L. 104-191 (Health Insurance Portability and Accountability Act of 1996), under which benefits for health care services are secondary or incidental to other insurance benefits;

(I) the following benefits if they are provided under a separate policy, certificate, or contract of insurance or are otherwise not an integral part of the plan:

(i) limited scope dental or vision benefits;

(ii) benefits for long-term care, nursing home care, home health care, community-based care, or any combination of long-

term care, nursing home care, home health care, or community based care;

(J) limited benefits specified in federal regulations issued under P. L. 104-191 (Health Insurance Portability and Accountability Act of 1996);

(K) the following benefits if the benefits are provided under a separate policy, certificate, or contract of insurance; there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor; and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to an event under any group health plan maintained by the same plan sponsor:

(i) coverage for only a specified disease or illness; or

(ii) hospital indemnity or other fixed indemnity insurance;

(L) the following benefits if offered as a separate policy, certificate, or contract of insurance:

(i) Medicare supplemental health insurance as defined in 42 U.S.C. 1395ss(g)(1) (sec. 1882(g)(1) ch. 7, Subchapter XVIII, Part E, Social Security Act);

(ii) coverage supplemental to the coverage provided 10 U.S.C. 1071 - 1110a (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)); or

(iii) similar supplemental coverage provided to coverage under a group health plan;

(4) "qualified dental plan" means a limited scope dental plan that has been certified under AS 21.54.230(e);

(5) "qualified employer" means a small employer that elects to make its full-time employees and, at the option of the employer, some or all of its part-time employees, eligible for one or more qualified health plans offered through the small business health options program exchange if the employer

(A) has its principal place of business in this state and elects to

provide coverage through the small business health options program exchange to all of its eligible employees, wherever employed; or

(B) elects to provide coverage through the small business health options program exchange to all of its eligible employees who are principally employed in this state;

(6) "qualified health plan" means a health benefit plan that has in effect a certification that the plan meets the criteria for certification described in sec. 1311(c), P.L. 111-148 (Patient Protection and Affordable Care Act), as amended, and regulations adopted under that Act, and AS 21.54.230;

(7) "qualified individual" means an individual, including a minor, who

(A) is seeking to enroll in a qualified health plan offered to individuals through the exchange;

(B) resides in this state;

(C) at the time of enrollment, is not incarcerated, other than incarceration pending the disposition of charges; and

(D) for the entire period for which enrollment is sought, is and is reasonably expected to be a citizen or national of the United States or an alien lawfully present in the United States;

(8) "small business health options program exchange" means the small business health options exchange under AS 21.54.220(a)(12) and sec. 1321, P.L. 111-148, (Patient Protection and Affordable Care Act), as amended, and regulations adopted under that Act;

(9) "small employer," notwithstanding AS 21.54.500, means an employer that employed an average of not more than 50 employees during the preceding calendar year; for purposes of this paragraph,

(A) a person treated as a single employer under 26 U.S.C. 414 (b), (c), (m), or (o) (Internal Revenue Code of 1986), shall be treated as a single employer;

(B) an employer and any predecessor employer shall be treated as a single employer;

(C) all employees shall be counted, including a part-time

employee and an employee who is not eligible for coverage through the employer;

(D) if an employer was not in existence throughout the preceding calendar year, the determination of whether that employer is a small employer shall be based on the average number of employees the employer is reasonably expected to employ on business days in the current calendar year; and

(E) an employer that makes enrollment in qualified health plans available to its employees through the small business health options program exchange and that would cease to be a small employer because of an increase in the number of its employees, shall continue to be treated as a small employer for purposes of AS 21.54.200 - 21.54.270 as long as the employer continuously makes enrollment through the small business health options program exchange available to its employees.

*** Sec. 3.** AS 39.25.120(c) is amended by adding a new paragraph to read:

(21) the executive director and employees of the Alaska Health Benefit Exchange Board employed under AS 21.54.210(j).

*** Sec. 4.** AS 39.50.200(a)(9) is amended to read:

(9) "public official" means

(A) a judicial officer;

(B) the governor or the lieutenant governor;

(C) a person hired or appointed in a department in the executive branch as

(i) the head or deputy head of the department;

(ii) the director or deputy director of a division;

(iii) a special assistant to the head of the department;

(iv) a person serving as the legislative liaison for the department;

(D) an assistant to the governor or the lieutenant governor;

(E) the chair or a member of a state commission or board;

(F) state investment officers and the state comptroller in the

Department of Revenue;

(G) the chief procurement officer appointed under AS 36.30.010;

(H) the executive director of the Alaska Workforce Investment Board;

(I) each appointed or elected municipal officer; [AND]

(J) the members of the board of trustees, the executive director, and the investment officers of the Alaska Permanent Fund Corporation; **and**

(K) the executive director of the Alaska Health Benefit Exchange employed under AS 21.54.210;

*** Sec. 5.** AS 39.50.200(b) is amended by adding a new paragraph to read:

(64) the Alaska Health Benefit Exchange Board (AS 21.54.210).

*** Sec. 6.** The uncodified law of the State of Alaska is amended by adding a new section to read:

TRANSITIONAL PROVISIONS. Notwithstanding AS 21.54.210(c), enacted by sec. 2 of this Act, the initial terms for members of the Alaska Health Benefit Exchange Board appointed by the governor are as follows:

(1) three members shall be appointed to serve for terms ending December 31, 2011;

(2) three members shall be appointed to serve for terms ending December 31, 2012.

*** Sec. 7.** The uncodified law of the State of Alaska is amended by adding a new section to read:

TRANSITION: REGULATIONS. The Alaska Health Benefit Exchange Board established under AS 21.54.200, enacted by sec. 2 of this Act, and the director of insurance may adopt regulations necessary to implement their respective powers and duties created by this Act under AS 21.54.250, enacted by sec. 2 of this Act. The regulations take effect under AS 44.62 (Administrative Procedure Act), but not before the effective date of the statutory changes.

*** Sec. 8.** AS 21.54.200, 21.54.210, 21.54.220, 21.54.250, and 21.54.270, enacted by sec. 2 of this Act, and secs. 3 - 6 of this Act take effect July 1, 2011.

* **Sec. 9.** Section 7 of this Act takes effect immediately under AS 01.10.070(c).

* **Sec. 10.** Except as provided in secs. 8 and 9 of this Act, this Act takes effect July 1, 2012.