CS FOR SENATE BILL NO. 48(HES)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FIRST LEGISLATURE - FIRST SESSION

BY THE SENATE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

Offered: 2/25/99
Referred: Labor and Commerce

Sponsor(s): SENATOR MACKIE

A BILL

FOR AN ACT ENTITLED

"An Act relating to health insurance provided by and provisions relating to the Comprehensive Health Insurance Association."

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

*** Section 1.** AS 21.55.020 is repealed and reenacted to read:

Sec. 21.55.020. Board of directors; organization. (a) The board of directors of the association consists of seven individuals. Five board members shall be selected by association members, subject to approval by the director of the division of insurance, and two board members shall be consumers selected by the director of the division of insurance. The director or the director's designee is a nonvoting ex officio member of the board. A member of the board serves for a term of three years and may be reappointed to an unlimited number of terms. The term of a board member shall continue until a successor is appointed.

(b) In approving members of the board, the director shall consider, among other things, whether all types of association members are fairly represented.

(c) In determining voting rights at association meetings, an association member is entitled to vote in person or by proxy. The vote shall be a weighted vote based on the association member's premiums for health insurance for major medical coverage on an expense incurred basis, or the association member's subscriber fees, derived from or on behalf of state residents in the previous calendar year, as determined by the director.

(d) At board meetings, a board member is entitled to one vote in person or by proxy.

(e) A member of the board may be reimbursed from the association for expenses incurred as a result of board activities, but may not otherwise be compensated for services by the association. The costs of conducting meetings of the association and its board of directors shall be the responsibility of the members of the association.

(f) The board shall study and prepare a report at least once every three years on the effectiveness of this chapter. The report must include an analysis of the effectiveness of this chapter in promoting rate stability, product availability, and affordability of coverage. The report may contain recommendations for legislative or other regulatory action. The board shall notify the legislature that the report is available.

(g) In this section, "board" means the board of directors of the association.

*** Sec. 2.** AS 21.55.100(a) is amended to read:

(a) The association shall make available to **a person who is eligible for coverage under this chapter at least one** [RESIDENTS WHO ARE HIGH RISKS OR TO FEDERALLY DEFINED ELIGIBLE INDIVIDUALS AN] individual state plan of health insurance. The association shall offer **a plan with the deductible, copayment, and calendar year maximum limits** [THREE ALTERNATIVES RELATED TO DEDUCTIBLES] as described in AS 21.55.120 and may offer additional deductible**, copayment, and calendar year maximum limits as approved by the director** [ALTERNATIVES].

*** Sec. 3.** AS 21.55.100(c) is amended to read:

(c) The association may not refuse to offer coverage under a state plan to **a**

person who is [RESIDENTS WHO ARE HIGH RISKS, OR TO FEDERALLY DEFINED ELIGIBLE INDIVIDUALS, WHO ARE] eligible under this chapter. The association may not refuse coverage under a state plan to **a person who is** [RESIDENTS WHO ARE HIGH RISKS, OR TO FEDERALLY DEFINED ELIGIBLE INDIVIDUALS, WHO ARE] eligible under this chapter, **applies** [APPLY] for coverage, and **pays** [PAY] the required premium.

*** Sec. 4.** AS 21.55.100(d) is amended to read:

(d) The association may make available to **a person eligible under this chapter** [RESIDENTS WHO ARE HIGH RISKS AND TO FEDERALLY DEFINED ELIGIBLE INDIVIDUALS] coverage through a health maintenance organization or other managed care arrangement **if** [AS] approved by the director. **Deductible, copayment, and calendar year maximum limits provided through an organization or arrangement are not subject to the limits described in AS 21.55.120, but the limits must be approved by the director.**

*** Sec. 5.** AS 21.55.110 is amended to read:

Sec. 21.55.110. Minimum benefits of state health insurance plan. Except as provided in AS 21.55.120 - 21.55.140, the minimum standard benefits of a health insurance plan offered under AS 21.55.100(a) shall be benefits with a lifetime maximum of $1,000,000 **for each** [PER] individual for usual, customary, reasonable, or prevailing charges or, when applicable, the allowance agreed upon between a provider and the **plan administrator** [WRITING CARRIER] for charges**. The minimum standard benefits of the plan must cover** [, FOR] the following medical services performed for an individual covered by the plan for the diagnosis or treatment of nonoccupational disease or nonoccupational injury:

(1) hospital services;

(2) subject to the limitations of AS 21.36.090(d), professional services that are rendered by a physician or by a registered nurse at the physician's direction, other than services for mental or dental conditions;

(3) the diagnosis or treatment of mental conditions, as defined in regulations of the director, rendered during the year on other than an inpatient basis, up to a yearly maximum benefit of $4,000;

(4) legend drugs requiring a physician's prescription;

(5) services of a skilled nursing facility for not more than 120 days in a policy year;

(6) home health agency services up to a maximum of 270 visits in a calendar year if the services commence within seven days following confinement in a hospital or skilled nursing facility of at least three consecutive days for the same condition, except that in the case of an individual diagnosed by a physician as terminally ill with a prognosis of six months or less to live, the home health agency services may commence irrespective of whether the covered person was previously confined or, if the covered person was confined, irrespective of the seven-day period, and the yearly benefit for medical social services may not exceed $200;

(7) hospice services for up to six months in a calendar year;

(8) use of radium or other radioactive materials;

(9) outpatient chemotherapy;

(10) oxygen;

(11) anesthetics;

(12) nondental prosthesis and maxillo-facial prosthesis used to replace any anatomic structure lost during treatment for head and neck tumors or additional appliances essential for the support of the prosthesis;

(13) rental, or purchase if purchase is more cost effective than rental, of durable medical equipment that has no personal use in the absence of the condition for which it was prescribed;

(14) diagnostic x-rays and laboratory tests;

(15) oral surgery for excision of partially or completely unerupted impacted teeth or excision of a tooth root without the extraction of the entire tooth;

(16) services of a licensed physical therapist rendered under the direction of a physician;

(17) transportation by a local ambulance operated by licensed or certified personnel to the nearest health care institution for treatment of the illness or injury and round trip transportation by air to the nearest health care institution for treatment of the illness or injury if the treatment is not available locally; if the patient

is a child under 12 years of age, the transportation charges of a parent or legal guardian accompanying the child may be paid if the attending physician certifies the need for the accompaniment;

(18) confinement in a licensed or certified facility established primarily for the treatment of alcohol or drug abuse**,** or in a part of a hospital used primarily for this treatment, for a period of at least 45 days within any calendar year;

(19) alternatives to inpatient services as defined by the association in the state plan benefits;

(20) second surgical opinions;

(21) other services that are medically necessary in the treatment or diagnosis of an illness or injury as may be designated or approved by the director.

*** Sec. 6.** AS 21.55.120(a) is amended to read:

(a) A state plan other than a Medicare supplement plan may require **a deductible** [DEDUCTIBLES] of **not less than** [$200 A PERSON,] $500 a person **as determined by the board and approved by the director** [, OR $1,000 A PERSON]. The amount of the deductible may not be greater when a service is rendered on an outpatient basis than when that service is offered on an inpatient basis. Expenses incurred during the last three months of a calendar year and actually applied to an individual's deductible for that year shall also be applied to that individual's deductible in the following calendar year. [THE $200 MAXIMUM, THE $500 MAXIMUM, AND THE $1,000 MAXIMUM MAY BE ADJUSTED YEARLY TO CORRESPOND WITH THE CHANGE IN THE MEDICAL CARE COMPONENT OF THE CONSUMER PRICE INDEX, AS ADJUSTED BY THE DIRECTOR. THE BASE YEAR FOR THE COMPUTATION SHALL BE THE FIRST FULL CALENDAR YEAR OF OPERATION OF THE ASSOCIATION.]

*** Sec. 7.** AS 21.55.120(c) is amended to read:

(c) **The** [EXCEPT AS PROVIDED IN (e) OF THIS SECTION, THE] sum of the deductible and copayments required in any calendar year under a plan may not exceed a maximum limit of **$1,500 plus the deductible** [$2,000 PER COVERED INDIVIDUAL]. Covered expenses incurred after the applicable maximum limit has been reached shall be paid at the rate of 100 percent of usual, customary, reasonable,

or prevailing charges, except that expenses incurred for treatment of mental and nervous conditions shall be paid at the rate of 50 percent. [THE $2,000 MAXIMUM SHALL BE ADJUSTED YEARLY TO CORRESPOND WITH THE CHANGE IN THE MEDICAL CARE COMPONENT OF THE CONSUMER PRICE INDEX AS ADJUSTED BY THE DIRECTOR.]

*** Sec. 8.** AS 21.55.130(c) is amended to read:

(c) A state plan issued to a person whose previous subscriber contract, health policy, or Medicare supplement policy was involuntarily terminated shall credit the time covered under the previous contract or policy toward an exclusion for preexisting conditions under the state plan if the previous contract or policy had a similar preexisting condition exclusion and the person applies for a state plan within 31 days after termination of the previous contract or policy. If a person covered by this subsection is accepted by the **plan administrator** [WRITING CARRIER] and pays a specified premium for retroactive coverage, the state plan is effective retroactively to the date that the person's previous contract or policy terminated.

*** Sec. 9.** AS 21.55.150 is amended to read:

Sec. 21.55.150. State plan premiums. (a) The association may not charge a rate for coverage issued by or through the association that is [EXCESSIVE, INADEQUATE, OR] unfairly discriminatory. **The board shall submit premium rates to the director for approval before use.**

(b) The association **may** [SHALL] use separate scales of premium rates based on age and geographic location of the insured. The association may use separate scales of premium rates based on other factors, including use or nonuse of tobacco, if approved by the director.

(c) **The board shall determine standard risk premium rates by considering the premium rates charged by members of the association offering, to residents of the state, health insurance** [THE FIVE MEMBERS OF THE ASSOCIATION THAT INSURE, OR HAVE SUBSCRIBER CONTRACTS WITH, THE LARGEST NUMBER OF INDIVIDUALS IN THE STATE UNDER PLANS WITH] benefits substantially equivalent to **benefits under** the state plan [BENEFITS SHALL SUBMIT TO THE ASSOCIATION AN ESTIMATE OF THE RATE THAT WOULD BE

ACTUARIALLY SOUND FOR A PERSON WHO IS A STANDARD RISK FOR COVERAGE SUBSTANTIALLY EQUIVALENT TO THE STATE PLAN]. The premium for a state plan may not exceed 200 percent of the **standard risk premium rates determined by the board** [AVERAGE OF THOSE FIVE ESTIMATES].

*** Sec. 10.** AS 21.55.200 is amended to read:

Sec. 21.55.200. Selection of a plan administrator [WRITING CARRIERS]. The **board** [ASSOCIATION] shall develop bid specifications **and select a plan administrator through a competitive bidding process** [FOR MEMBERS THAT WISH TO BE SELECTED AS A WRITING CARRIER TO ADMINISTER A STATE PLAN]. The selection of the **plan administrator** [WRITING CARRIER] shall be based upon criteria including the **plan administrator's** [MEMBER'S] proven ability to handle [A LARGE NUMBER OF] health insurance **coverage for individuals** [CASES OR SUBSCRIBER CONTRACTS], efficient claim paying capacity, [AND] the estimate of total charges for administering the plan**, the plan administrator's ability to apply effective cost containment programs and procedures and to administer the plan in a cost efficient manner, and the financial condition and stability of the plan administrator**.

*** Sec. 11.** AS 21.55.210 is repealed and reenacted to read:

Sec. 21.55.210. Duties of plan administrator. (a) The plan administrator shall perform the administrative and claims payment functions required by this section. The plan administrator shall provide these services for a period specified in the contract between the association and the plan administrator subject to the terms, conditions, and limitations of the contract between the association and the plan administrator. At least six months before the expiration of each contract period, the board shall invite eligible entities, including the plan administrator, to submit bids to serve as the plan administrator. The board shall follow the provisions of this subsection in selecting a plan administrator for the subsequent contract period.

(b) The plan administrator shall provide to all eligible persons enrolled in a state plan an individual policy setting out a statement of the insurance protection to which the person is entitled, with whom claims are to be filed, and to whom benefits are payable. The policy must indicate that coverage was obtained through the

association.

(c) The plan administrator shall submit to the board and the director on a regular basis a report on the operation of the state plans. The board shall determine the specific information to be contained in the report and that information shall be specified in the contract between the association and the plan administrator.

(d) The plan administrator shall pay claims and shall indicate when a claim is paid under a state plan. A claim payment must include a telephone number that can be used for inquiries regarding the claim.

(e) The plan administrator shall

(1) be reimbursed from the state plan receipts for services rendered in connection with administering the plan; and

(2) at all times when carrying out its duties under this chapter be considered an agent of the association.

*** Sec. 12.** AS 21.55.220(a) is amended to read:

(a) Upon notification of eligibility under AS 21.55.320, a person may enroll in a state plan by payment of the appropriate state plan premium to the **plan administrator** [WRITING CARRIER].

*** Sec. 13.** AS 21.55.220(b) is amended to read:

(b) An employer that has in its employ one or more eligible persons enrolled in a state plan may make all or a portion of a state plan premium payment directly to the **plan administrator** [WRITING CARRIER].

*** Sec. 14.** AS 21.55.220(d) is amended to read:

(d) The **board** [ASSOCIATION] shall make an annual determination of each member's liability, if any, and may make an annual fiscal year end assessment if necessary. The **board** [ASSOCIATION] may also, subject to the approval of the director, provide for interim assessments against the members as may be necessary to assure the financial capability of the association in meeting the incurred or estimated claims expenses of the state plans and operating and administrative expenses of the association until the association's next annual fiscal year end assessment. Payment of an assessment is due within 30 days of receipt by a member of written notice of a fiscal year end or interim assessment. **A member who fails to pay a fiscal year end**

or interim assessment as required in this subsection (1) shall pay a civil penalty to the director in the amount of $100 for each day the member fails to pay the required assessment, and (2) may have the [FAILURE BY A MEMBER TO TENDER TO THE ASSOCIATION THE ASSESSMENT WITHIN 30 DAYS SHALL BE GROUNDS FOR REVOCATION OF A] member's certificate of authority **revoked by the director**. A member that ceases to do health insurance business in the state, or ceases to offer subscriber contracts in the state, due to revocation, suspension, or voluntary surrender of its certificate of authority**,** remains liable for assessments through the calendar year that the health insurance business ceased. The **board** [ASSOCIATION] may decline to levy an assessment against a member if the assessment would **be minimal** [NOT EXCEED $10]. Assessments paid by a member are a general expense of the member.

*** Sec. 15.** AS 21.55.310 is amended to read:

Sec. 21.55.310. Enrollment by an eligible person. A person may enroll in a state plan by applying to the **plan administrator** [WRITING CARRIER]. The application must include the following:

(1) name, address, age, and length of residency of the applicant;

(2) a designation of the plan desired, including deductible option chosen;

(3) information relevant to whether the person is a high risk or a federally defined eligible individual; and

(4) payment of the first premium.

*** Sec. 16.** AS 21.55.320 is amended to read:

Sec. 21.55.320. Plan administrator's [WRITING CARRIER'S] response. Within 30 days after receiving the **application** [CERTIFICATE] described in AS 21.55.310, the **plan administrator** [WRITING CARRIER] shall either reject the application for failing to comply with the requirements of AS 21.55.300 and 21.55.310 or forward the eligible person a notice of acceptance.

*** Sec. 17.** AS 21.55.330 is amended to read:

Sec. 21.55.330. Effective date of policies. (a) Except as provided in (b) of this section and AS 21.55.130(c), insurance under a state plan is effective immediately

upon receipt of the first [QUARTERLY] premium, and is retroactive to the date of the application, if the applicant otherwise complies with the requirements of this chapter.

(b) Insurance under a state plan is effective retroactively to the date that the person's previous contract or policy terminated if the person

(1) applies for a state plan within 60 days after the previous contract or policy terminated;

(2) is accepted by the **plan administrator** [WRITING CARRIER]; and

(3) pays a specified premium for the period of retroactive coverage.

*** Sec. 18.** AS 21.55.400 is amended to read:

Sec. 21.55.400. Duties of director. The director may

(1) approve the selection of the **plan administrator** [WRITING CARRIER] by the association and approve the association's contract with the **plan administrator** [WRITING CARRIER], including the coverages and premiums to be charged;

(2) contract with the federal government or another unit of government to ensure coordination of the state plans with other governmental assistance programs;

(3) undertake directly or through contracts with other persons studies or demonstration programs to develop awareness of the benefits of this chapter; and

(4) formulate general policy and adopt regulations that are reasonably necessary to administer this chapter.

*** Sec. 19.** AS 21.55.410 is amended to read:

Sec. 21.55.410. State not liable. The state is not liable for acts or omissions of the association or a **plan administrator** [WRITING CARRIER] under this chapter, nor is the state liable for payment of a claim under a state plan issued by a **plan administrator** [WRITING CARRIER].

*** Sec. 20.** AS 21.55.500(6) is amended to read:

(6) "federally defined eligible individual" means an individual

(A) with an aggregate of all periods of creditable coverage as provided under AS 21.54.110(b) **of** [THAT IS GREATER THAN] 18 **or more** months as of the date that the individual seeks coverage under this chapter;

(B) whose most recent prior creditable coverage was under a

health benefit plan or health care insurance plan offered in the **large employer** group market **or the small employer group market**;

(C) who is not eligible for coverage under a health benefit plan, 42 U.S.C. 1395c or 42 U.S.C. 1395j (Part A or Part B of Title XVIII of the Social Security Act), or a state plan under 42 U.S.C. 1396 (Title XIX of the Social Security Act), and who does not have other health care insurance coverage;

(D) whose most recent coverage within the period of aggregate creditable coverage as provided under AS 21.54.110(b) was not terminated based on a factor relating to nonpayment of premiums or fraud;

(E) who, having been offered and having elected continuation coverage under a federal continuation provision or a similar state program, has exhausted coverage under the continuation provision or program;

*** Sec. 21.** AS 21.55.500(18) is amended to read:

(18) "residents who are high risks" means residents who

(A) have been rejected for medical reasons after applying for a subscriber contract, a policy of health insurance, or a Medicare supplement policy by at least **one** [TWO] association **member** [MEMBERS] within the six months immediately preceding the date of application for a state plan; medical reasons may include preexisting medical conditions, a family history that predicts future medical conditions, or an occupation that generates a frequency or severity of injury or disease that results in coverage not being generally available;

(B) have had a restrictive rider placed on a subscriber contract, a health insurance policy, or a Medicare supplement policy that substantially reduces coverage; or

(C) meet other requirements adopted by regulation by the director that are consistent with this chapter and that indicate that a person is unable to obtain coverage substantially similar to that which may be obtained by a person who is considered a standard risk;

*** Sec. 22.** AS 21.55.500(19) is amended to read:

(19) "state plan" means a policy of insurance offered by the association through a **plan administrator** [WRITING CARRIER];

*** Sec. 23.** AS 21.55.500 is amended by adding a new paragraph to read:

(22) "plan administrator" means the eligible entity selected by the board and approved by the director to administer a state plan.

*** Sec. 24.** AS 21.55.120(d), 21.55.120(e), and 21.55.500(21) are repealed.