

SENATE BILL NO. 325

IN THE LEGISLATURE OF THE STATE OF ALASKA

NINETEENTH LEGISLATURE - SECOND SESSION

BY THE SENATE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

Introduced: 4/19/96

Referred: HES, FIN

A BILL

FOR AN ACT ENTITLED

1 "An Act relating to state health insurance."

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

3 * **Section 1.** AS 21.36.095(e) is amended to read:

4 (e) In this section, "insurer" includes

5 (1) an insurer, as defined in AS 21.90.900;

6 (2) a group health plan, as defined in 29 U.S.C. 1167(l) (Employee
7 Retirement Income Security Act of 1974);

8 (3) a health maintenance organization, as defined in AS 21.86.900;

9 (4) a hospital service corporation or medical service corporation, as
10 defined in AS 21.87.330;

11 (5) a plan administrator [WRITING CARRIER], as defined in
12 AS 21.55.500; and

13 (6) an entity offering a service benefit plan, as referred to in 42 U.S.C.
14 1396g.

15 * **Sec. 2.** AS 21.55.020 is repealed and reenacted to read:

1 Sec. 21.55.020. BOARD OF DIRECTORS; ORGANIZATION. (a) The board
2 of directors of the association shall be made up of seven individuals. Five board
3 members shall be selected by association members, subject to approval by the director
4 of the division of insurance, and two board members shall be consumers selected by
5 the director of the division of insurance. The director or the director's designee shall
6 serve as a nonvoting ex officio member of the board. A member of the board serves
7 for a term of three years and may be reappointed to an unlimited number of terms.
8 The term of a board member shall continue until a successor is appointed.

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

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

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

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

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

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

31 (a) The association shall make available to residents who are high risks an

1 individual state plan of health insurance. The association shall offer **at least one plan**
2 **related to the deductible, copayment, and calendar year maximums** [THREE
3 ALTERNATIVES RELATED TO DEDUCTIBLES AS] described in AS 21.55.120 and
4 may offer additional deductible, **copayment, and calendar year maximum**
5 alternatives **as approved by the director.**

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

7 (d) The association may make available to residents who are high risks
8 coverage through a health maintenance organization or other managed care
9 arrangement **if** [AS] approved by the director. **Deductible, copayment, and calendar**
10 **year maximum limits provided through an organization or arrangement are not**
11 **subject to the limits described in AS 21.55.120, but the limits must be approved**
12 **by the director.**

13 * **Sec. 5.** AS 21.55.120(a) is amended to read:

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

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

28 (b) A state plan other than a Medicare supplement plan **must** [SHALL] require
29 a maximum copayment of **40** [20] percent for charges for all types of health care in
30 excess of the deductible and 50 percent for services described in AS 21.55.110(3) in
31 excess of the deductible.

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

2 (c) **The** [EXCEPT AS PROVIDED IN (e) OF THIS SECTION, THE] sum of
3 the deductible and copayments required in any calendar year under a plan may not
4 exceed a maximum limit of **five times the deductible as determined by the board**
5 **and approved by the director** [\$2,000 PER COVERED INDIVIDUAL]. Covered
6 expenses incurred after the applicable maximum limit has been reached shall be paid
7 at the rate of 100 percent of usual, customary, reasonable, or prevailing charges, except
8 that expenses incurred for treatment of mental and nervous conditions shall be paid at
9 the rate of 50 percent. [THE \$2,000 MAXIMUM SHALL BE ADJUSTED YEARLY
10 TO CORRESPOND WITH THE CHANGE IN THE MEDICAL CARE COMPONENT
11 OF THE CONSUMER PRICE INDEX AS ADJUSTED BY THE DIRECTOR.]

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

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

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

23 Sec. 21.55.150. STATE PLAN PREMIUMS. (a) The association may not
24 charge a rate for coverage issued by or through the association that is [EXCESSIVE,
25 INADEQUATE, OR] unfairly discriminatory. **Premium rates shall be submitted to**
26 **the director for approval before use.**

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

31 (c) **The board shall determine standard risk premium rates by considering**

1 the premium rates charged by members of the association offering, to residents
2 of the state, health insurance [THE FIVE MEMBERS OF THE ASSOCIATION
3 THAT INSURE, OR HAVE SUBSCRIBER CONTRACTS WITH, THE LARGEST
4 NUMBER OF INDIVIDUALS IN THE STATE UNDER PLANS WITH] benefits
5 substantially equivalent to benefits under the state plan [BENEFITS SHALL SUBMIT
6 TO THE ASSOCIATION AN ESTIMATE OF THE RATE THAT WOULD BE
7 ACTUARIALLY SOUND FOR A PERSON WHO IS A STANDARD RISK FOR
8 COVERAGE SUBSTANTIALLY EQUIVALENT TO THE STATE PLAN]. The
9 premium for a state plan may not exceed 200 percent of the standard risk premium
10 rates determined by the board [AVERAGE OF THOSE FIVE ESTIMATES].

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

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

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

25 Sec. 21.55.210. DUTIES OF PLAN ADMINISTRATORS. (a) The plan
26 administrator shall perform the administrative and claims payment functions required
27 by this section. The plan administrator shall provide these services for a period
28 specified in the contract between the association and the plan administrator subject to
29 removal for cause and subject to the terms, conditions, and limitations of the contract
30 between the association and the plan administrator. At least six months before the
31 expiration of each contract period, the board shall invite eligible entities, including the

1 plan administrator, to submit bids to serve as the plan administrator. The board shall
2 follow the provisions of this section in selecting a plan administrator for the
3 subsequent contract period.

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

9 (c) The plan administrator shall submit to the board and the director on a
10 quarterly basis a report on the operation of the state plans. Specific information to be
11 contained in the report shall be determined by the board and shall be specified in the
12 contract between the association and the plan administrator.

13 (d) Claims shall be paid by the plan administrator and must indicate that the
14 claim was paid under a state plan. A claim payment must include a telephone number
15 that can be used for inquiries regarding the claim.

16 (e) The plan administrator shall be reimbursed from the state plan premiums
17 received for its direct and indirect expenses for administering the plan. Direct and
18 indirect expenses must include a pro rata reimbursement for that portion of the plan
19 administrator's administrative, printing, claims administration, management, and
20 building overhead expenses that are assignable to the maintenance and administration
21 of the state plans. The board shall approve cost accounting methods to substantiate
22 the plan administrator's cost reports consistent with generally accepted accounting
23 principles. Direct and indirect expenses may not include costs directly related to the
24 original submission of bids before selection as the plan administrator.

25 (f) The plan administrator shall at all times when carrying out its duties under
26 this chapter be considered an agent of the association.

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

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

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

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

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

5 (d) The **board** [ASSOCIATION] shall make an annual determination of each
6 member's liability, if any, and may make an annual fiscal year end assessment if
7 necessary. The **board** [ASSOCIATION] may also, subject to the approval of the
8 director, provide for interim assessments against the members as may be necessary to
9 assure the financial capability of the association in meeting the incurred or estimated
10 claims expenses of the state plans and operating and administrative expenses of the
11 association until the association's next annual fiscal year end assessment. Payment of
12 an assessment is due within 30 days of receipt by a member of written notice of a
13 fiscal year end or interim assessment. Failure by a member to tender to the association
14 the assessment within 30 days shall be grounds for revocation of a member's certificate
15 of authority. A member that ceases to do health insurance business in the state, or
16 ceases to offer subscriber contracts in the state, due to revocation, suspension, or
17 voluntary surrender of its certificate of authority, remains liable for assessments
18 through the calendar year that the health insurance business ceased. The **board**
19 [ASSOCIATION] may decline to levy an assessment against a member if the
20 assessment would **be minimal** [NOT EXCEED \$10]. Assessments paid by a member
21 are a general expense of the member.

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

23 Sec. 21.55.310. ENROLLMENT BY AN ELIGIBLE PERSON. A person may
24 enroll in a state plan by applying to the **plan administrator** [WRITING CARRIER].
25 The application must include the following:

- 26 (1) name, address, age, and length of residency of the applicant;
27 (2) a designation of the plan desired, including deductible option
28 chosen;
29 (3) information relevant to whether the person is a high risk; and
30 (4) payment of the first premium.

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

1 Sec. 21.55.320. **PLAN ADMINISTRATOR'S** [WRITING CARRIER'S]
2 RESPONSE. Within 30 days after receiving the certificate described in AS 21.55.310,
3 the **plan administrator** [WRITING CARRIER] shall either reject the application for
4 failing to comply with the requirements of AS 21.55.300 and 21.55.310 or forward the
5 eligible person a notice of acceptance.

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

7 Sec. 21.55.330. EFFECTIVE DATE OF POLICIES. (a) Except as provided
8 in (b) of this section and AS 21.55.130(c), insurance under a state plan is effective
9 immediately upon receipt of the first [QUARTERLY] premium, and is retroactive to
10 the date of the application, if the applicant otherwise complies with the requirements
11 of this chapter.

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

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

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

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

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

19 Sec. 21.55.400. DUTIES OF DIRECTOR. The director may

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

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

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

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

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

31 Sec. 21.55.410. STATE NOT LIABLE. The state is not liable for acts or

1 omissions of the association or a **plan administrator** [WRITING CARRIER] under
2 this chapter, nor is the state liable for payment of a claim under a state plan issued by
3 a **plan administrator** [WRITING CARRIER].

4 * **Sec. 20.** AS 21.55.500(11) is amended to read:

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

7 * **Sec. 21.** AS 21.55.500(13) is amended to read:

8 (13) "**plan administrator** [WRITING CARRIER]" means the **eligible**
9 **entity or entities** [INSURER OR INSURERS] selected by the **board**
10 [ASSOCIATION] and approved by the director to administer a state plan.

11 * **Sec. 22.** AS 21.55.120(d) and 21.55.120(e) are repealed.