

SENATE BILL NO. 351

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTIETH LEGISLATURE - SECOND SESSION

BY THE SENATE RULES COMMITTEE BY REQUEST

Introduced: 4/9/98

Referred: HESS, Labor and Commerce

A BILL

FOR AN ACT ENTITLED

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

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

4 * **Section 1.** AS 21.55.020 is repealed and reenacted to read:

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

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

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

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

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

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

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

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

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

29 (c) The association may not refuse to offer coverage under a state plan to
 30 residents [WHO ARE HIGH RISKS, OR TO FEDERALLY DEFINED ELIGIBLE
 31 INDIVIDUALS,] who are eligible under this chapter. The association may not refuse

1 coverage under a state plan to residents who [ARE HIGH RISKS, OR TO
 2 FEDERALLY DEFINED ELIGIBLE INDIVIDUALS, WHO] are eligible under this
 3 chapter, apply for coverage, and pay the required premium.

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

5 (d) The association may make available to residents who are high risks and to
 6 federally defined eligible individuals coverage through a health maintenance
 7 organization or other managed care arrangement **if** [AS] approved by the director.

8 **Deductible, copayment, and calendar year maximum limits provided through an**
 9 **organization or arrangement are not subject to the limits described in**
 10 **AS 21.55.120, but the limits must be approved by the director.**

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

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

20 (1) hospital services;

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

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

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

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

30 (6) home health agency services up to a maximum of 270 visits in a
 31 calendar year if the services commence within seven days following confinement in

1 a hospital or skilled nursing facility of at least three consecutive days for the same
 2 condition, except that in the case of an individual diagnosed by a physician as
 3 terminally ill with a prognosis of six months or less to live, the home health agency
 4 services may commence irrespective of whether the covered person was previously
 5 confined or, if the covered person was confined, irrespective of the seven-day period,
 6 and the yearly benefit for medical social services may not exceed \$200;

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

8 (8) use of radium or other radioactive materials;

9 (9) outpatient chemotherapy;

10 (10) oxygen;

11 (11) anesthetics;

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

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

18 (14) diagnostic x-rays and laboratory tests;

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

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

23 (17) transportation by a local ambulance operated by licensed or
 24 certified personnel to the nearest health care institution for treatment of the illness or
 25 injury and round trip transportation by air to the nearest health care institution for
 26 treatment of the illness or injury if the treatment is not available locally; if the patient
 27 is a child under 12 years of age, the transportation charges of a parent or legal
 28 guardian accompanying the child may be paid if the attending physician certifies the
 29 need for the accompaniment;

30 (18) confinement in a licensed or certified facility established primarily
 31 for the treatment of alcohol or drug abuse, or in a part of a hospital used primarily for

1 this treatment, for a period of at least 45 days within any calendar year;

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

4 (20) second surgical opinions;

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

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

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

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

22 (c) **The** [EXCEPT AS PROVIDED IN (e) OF THIS SECTION, THE] sum of
23 the deductible and copayments required in any calendar year under a plan may not
24 exceed a maximum limit of **\$2,500 plus the deductible** [\$2,000 PER COVERED
25 INDIVIDUAL]. Covered expenses incurred after the applicable maximum limit has
26 been reached shall be paid at the rate of 100 percent of usual, customary, reasonable,
27 or prevailing charges, except that expenses incurred for treatment of mental and
28 nervous conditions shall be paid at the rate of 50 percent. [THE \$2,000 MAXIMUM
29 SHALL BE ADJUSTED YEARLY TO CORRESPOND WITH THE CHANGE IN
30 THE MEDICAL CARE COMPONENT OF THE CONSUMER PRICE INDEX
31 AS ADJUSTED BY THE DIRECTOR.]

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

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

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

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

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

20 (c) **The board shall determine standard risk premium rates by considering**
21 **the premium rates charged by members of the association offering, to residents**
22 **of the state, health insurance** [THE FIVE MEMBERS OF THE ASSOCIATION
23 THAT INSURE, OR HAVE SUBSCRIBER CONTRACTS WITH, THE LARGEST
24 NUMBER OF INDIVIDUALS IN THE STATE UNDER PLANS WITH] benefits
25 substantially equivalent to **benefits under** the state plan [BENEFITS SHALL SUBMIT
26 TO THE ASSOCIATION AN ESTIMATE OF THE RATE THAT WOULD BE
27 ACTUARIALLY SOUND FOR A PERSON WHO IS A STANDARD RISK FOR
28 COVERAGE SUBSTANTIALLY EQUIVALENT TO THE STATE PLAN]. The
29 premium for a state plan may not exceed 200 percent of the **standard risk premium**
30 **rates determined by the board** [AVERAGE OF THOSE FIVE ESTIMATES].

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

1 **Sec. 21.55.200. Selection of a plan administrator** [WRITING CARRIERS].

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

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

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

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

28 (c) The plan administrator shall submit to the board and the director on a
 29 regular basis a report on the operation of the state plans. Specific information to be
 30 contained in the report shall be determined by the board and shall be specified in the
 31 contract between the association and the plan administrator.

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

4 (e) The plan administrator shall

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

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

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

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

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

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

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

18 (d) The **board** [ASSOCIATION] shall make an annual determination of each
19 member's liability, if any, and may make an annual fiscal year end assessment if
20 necessary. The **board** [ASSOCIATION] may also, subject to the approval of the
21 director, provide for interim assessments against the members as may be necessary to
22 assure the financial capability of the association in meeting the incurred or estimated
23 claims expenses of the state plans and operating and administrative expenses of the
24 association until the association's next annual fiscal year end assessment. Payment of
25 an assessment is due within 30 days of receipt by a member of written notice of a
26 fiscal year end or interim assessment. Failure by a member to tender to the association
27 the assessment within 30 days shall be grounds for revocation of a member's certificate
28 of authority. A member that ceases to do health insurance business in the state, or
29 ceases to offer subscriber contracts in the state, due to revocation, suspension, or
30 voluntary surrender of its certificate of authority, remains liable for assessments
31 through the calendar year that the health insurance business ceased. The **board**

1 [ASSOCIATION] may decline to levy an assessment against a member if the
 2 assessment would **be minimal** [NOT EXCEED \$10]. Assessments paid by a member
 3 are a general expense of the member.

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

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

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

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

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

13 (4) payment of the first premium.

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

15 **Sec. 21.55.320. Plan administrator's [WRITING CARRIER'S] response.**

16 Within 30 days after receiving the certificate described in AS 21.55.310, the **plan**
 17 **administrator** [WRITING CARRIER] shall either reject the application for failing to
 18 comply with the requirements of AS 21.55.300 and 21.55.310 or forward the eligible
 19 person a notice of acceptance.

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

21 **Sec. 21.55.330. Effective date of policies.** (a) Except as provided in (b) of
 22 this section and AS 21.55.130(c), insurance under a state plan is effective immediately
 23 upon receipt of the first [QUARTERLY] premium, and is retroactive to the date of the
 24 application, if the applicant otherwise complies with the requirements of this chapter.

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

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

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

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

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

1 **Sec. 21.55.400. Duties of director.** The director may

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

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

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

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

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

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

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

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

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

22 (B) whose most recent prior creditable coverage was under a
23 health benefit plan or health care insurance plan offered in the **large employer**
24 **group market or the small employer group market;**

25 (C) who is not eligible for coverage under a health benefit plan,
26 42 U.S.C. 1395c or 42 U.S.C. 1395j (Part A or Part B of Title XVIII of the
27 Social Security Act), or a state plan under 42 U.S.C. 1396 (Title XIX of the
28 Social Security Act), and who does not have other health care insurance
29 coverage;

30 (D) whose most recent coverage within the period of aggregate
31 creditable coverage as provided under AS 21.54.110(b) was not terminated

1 based on a factor relating to nonpayment of premiums or fraud;

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

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

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

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

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

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

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

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

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

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

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