



# LAWS OF ALASKA

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**Chapter No.**  
31

## AN ACT

Relating to health insurance provided by and provisions relating to the Comprehensive Health Insurance Association.

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

THE ACT FOLLOWS ON PAGE 1

**Approved by the Governor:** May 27, 1999

**Actual Effective Date:** August 25, 1999

AN ACT

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

3

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 AS 21.55.020 is repealed and reenacted to read: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 consists of seven individuals. Five board members shall be selected  
7 by association members, subject to approval by the director of the division of  
8 insurance, and two board members shall be consumers selected by the director of the  
9 division of insurance. The director or the director's designee is a nonvoting ex officio  
10 member of the board. A member of the board serves for a term of three years and  
11 may be reappointed to an unlimited number of terms. The term of a board member  
12 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.

## Chapter 31

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.

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

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

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

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

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

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

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

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

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

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

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

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

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

25 (1) hospital services;

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

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

## Chapter 31

- 1 (4) legend drugs requiring a physician's prescription;
- 2 (5) services of a skilled nursing facility for not more than 120 days in
- 3 a policy year;
- 4 (6) home health agency services up to a maximum of 270 visits in a
- 5 calendar year if the services commence within seven days following confinement in
- 6 a hospital or skilled nursing facility of at least three consecutive days for the same
- 7 condition, except that in the case of an individual diagnosed by a physician as
- 8 terminally ill with a prognosis of six months or less to live, the home health agency
- 9 services may commence irrespective of whether the covered person was previously
- 10 confined or, if the covered person was confined, irrespective of the seven-day period,
- 11 and the yearly benefit for medical social services may not exceed \$200;
- 12 (7) hospice services for up to six months in a calendar year;
- 13 (8) use of radium or other radioactive materials;
- 14 (9) outpatient chemotherapy;
- 15 (10) oxygen;
- 16 (11) anesthetics;
- 17 (12) nondental prosthesis and maxillo-facial prosthesis used to replace
- 18 any anatomic structure lost during treatment for head and neck tumors or additional
- 19 appliances essential for the support of the prosthesis;
- 20 (13) rental, or purchase if purchase is more cost effective than rental,
- 21 of durable medical equipment that has no personal use in the absence of the condition
- 22 for which it was prescribed;
- 23 (14) diagnostic x-rays and laboratory tests;
- 24 (15) oral surgery for excision of partially or completely unerupted
- 25 impacted teeth or excision of a tooth root without the extraction of the entire tooth;
- 26 (16) services of a licensed physical therapist rendered under the
- 27 direction of a physician;
- 28 (17) transportation by a local ambulance operated by licensed or
- 29 certified personnel to the nearest health care institution for treatment of the illness or
- 30 injury and round trip transportation by air to the nearest health care institution for
- 31 treatment of the illness or injury if the treatment is not available locally; if the patient

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

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

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

9 (20) second surgical opinions;

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

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

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

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

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

Chapter 31

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

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

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

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

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

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

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

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

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

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

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

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

19 **Sec. 21.55.210. Duties of plan administrator.** (a) The plan administrator

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

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

## Chapter 31

1 association.

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

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

9 (e) The plan administrator shall

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

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

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

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

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

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

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

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

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

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

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

- 17 (1) name, address, age, and length of residency of the applicant;  
 18 (2) a designation of the plan desired, including deductible option  
 19 chosen;  
 20 (3) information relevant to whether the person is a high risk or a  
 21 federally defined eligible individual; and  
 22 (4) payment of the first premium.

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

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

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

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

## Chapter 31

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3 (C) who is not eligible for coverage under a health benefit plan,  
4 42 U.S.C. 1395c or 42 U.S.C. 1395j (Part A or Part B of Title XVIII of the  
5 Social Security Act), or a state plan under 42 U.S.C. 1396 (Title XIX of the  
6 Social Security Act), and who does not have other health care insurance  
7 coverage;

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

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

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

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

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

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

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

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

**Chapter 31**

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

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

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

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