

**SENATE BILL NO. 70**

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SEVENTH LEGISLATURE - FIRST SESSION

**BY SENATORS FRENCH, Davis**

**Introduced: 1/26/11**

**Referred: Labor and Commerce, Finance**

**A BILL**

**FOR AN ACT ENTITLED**

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

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

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

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

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

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

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

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

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

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

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

7 **Article 2A. Alaska Health Benefit Exchange.**

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

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

14 (b) The board consists of 13 members, including 12 members appointed by the  
15 governor, and the commissioner of health and social services or the commissioner's  
16 designee, serving ex officio. The members of the board appointed by the governor are

17 (1) one representative who is a licensed insurance producer;

18 (2) one representative from a health insurance company licensed to  
19 transact health care insurance in the state;

20 (3) two representatives of the business community other than health  
21 care insurers, one representing large businesses, and one representing small  
22 businesses;

23 (4) two representatives from two separate hospitals located in the state;

24 (5) one representative of a labor organization;

25 (6) two physicians licensed in the state;

26 (7) two health care consumer advocates; and

27 (8) one registered nurse.

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

31 (d) The board shall select a member to serve as chair and a member to serve as

1 vice-chair for a term and with duties and powers necessary to perform their functions.

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

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

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

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

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

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

18 (1) make qualified health plans available to qualified individuals and  
19 qualified employers;

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

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

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

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

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

1 (7) implement procedures for the certification, recertification, and  
2 decertification of qualified health plans consistent with guidelines developed by the  
3 United States Secretary of Health and Human Services under sec. 1311(c), P.L. 111-  
4 148 (Patient Protection and Affordable Care Act), as amended, and regulations  
5 adopted under that Act;

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

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

14 (10) use a standardized format for presenting health benefit options in  
15 the exchange, including the use of the uniform outline of coverage established under  
16 42 U.S.C. 300gg et seq. (sec. 2715, Part A, subpart II, title XXVII, Public Health  
17 Service Act);

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

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

30 (13) establish a small business health options program exchange  
31 through which qualified employers may access coverage for their employees and

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

4 (14) subject to sec. 1411, P.L. 111-148 (Patient Protection and  
 5 Affordable Care Act), as amended, and regulations adopted under that Act, grant a  
 6 certification attesting that, for purposes of the individual responsibility penalty under  
 7 26 U.S.C. 5000A (Internal Revenue Code of 1986), an individual is exempt from the  
 8 individual responsibility requirement or from the penalty imposed by that section  
 9 because

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

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

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

16 (A) the name and taxpayer identification number of each  
 17 individual issued a certification under (14) of this subsection;

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

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

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

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

30 (i) notifies the exchange under sec. 1411(b)(4), P.L.  
 31 111-148 (Patient Protection and Affordable Care Act), as amended, and

1 regulations adopted under that Act, that the individual has changed  
2 employers; and

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

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

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

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

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

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

23 (C) facilitate enrollment in qualified health plans;

24 (D) provide referrals to any applicable office of health  
25 insurance consumer assistance or health insurance ombudsman established  
26 under 42 U.S.C. 300gg-93 (sec. 2793, Part C, title XXVII, Public Health  
27 Service Act), or any other appropriate state agency or agencies, for any  
28 enrollee with a grievance, complaint, or question regarding the enrollee's  
29 health benefit plan or coverage, or a determination under that plan or coverage;  
30 and

31 (E) provide information in a manner that is culturally and

1 linguistically appropriate to the needs of the population being served by the  
2 exchange;

3 (19) review the rate of premium growth within the exchange and  
4 outside the exchange and consider the information in developing recommendations on  
5 whether to continue limiting qualified employer status to small employers;

6 (20) develop policies and procedures to minimize adverse selection  
7 among plans sold within the exchange and review policies within the exchange and  
8 outside the exchange to monitor the effect of adverse selection between the two  
9 marketplaces;

10 (21) credit the amount of any free choice voucher to the monthly  
11 premium of the plan in which a qualified employee is enrolled, in accordance with sec.  
12 10108, P.L. 111-148 (Patient Protection and Affordable Care Act), as amended, and  
13 regulations adopted under that Act, and collect the amount credited from the offering  
14 employer;

15 (22) consult with persons having an interest in the activities of the  
16 exchange, including

17 (A) health care insurers;

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

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

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

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

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

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

29 (24) submit an annual accounting report to the United States Secretary  
30 of Health and Human Services, the Governor, the director and the legislature;

31 (25) cooperate with an investigation conducted by the United States

1 Secretary of Health and Human Services under the Secretary's authority under P.L.  
 2 111-148 (Patient Protection and Affordable Care Act), as amended, and regulations  
 3 adopted under that Act, and allow the Secretary, in coordination with the Inspector  
 4 General of the United States Department of Health and Human Services, to

5 (A) investigate the affairs of the exchange;

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

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

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

15 (27) apply for planning and establishment grants made available to the  
 16 exchange under sec. 1311, P.L. 111-148 (Patient Protection and Affordable Care Act),  
 17 as amended, and regulations adopted under that Act; and

18 (28) study the potential for interstate compacts that would permit the  
 19 sale and purchase of health care insurance across state borders and recommend  
 20 particular compact arrangements for legislative approval.

21 (b) The exchange may

22 (1) enter into a contract for the performance of the exchange's duties  
 23 with the Department of Health and Social Services or another entity that has  
 24 experience in individual and small group health insurance or benefit administration, or  
 25 other experience relevant to the responsibilities to be assumed by the entity, except  
 26 that the exchange may not contract for the performance of its duties with a health care  
 27 insurer or an affiliate of a health care insurer;

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

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

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

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

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

11 (2) the individual's employer-sponsored coverage has become  
12 affordable under the standards of 26 U.S.C. 36B(c)(2)(C) (Internal Revenue Code of  
13 1986).

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

16 (1) the plan provides the essential health benefits described in sec.  
17 1302(a), P.L. 111-148 (Patient Protection and Affordable Care Act), as amended, and  
18 regulations adopted under that Act, except that the plan is not required to provide  
19 essential benefits that duplicate the minimum benefits of qualified dental plans if

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

22 (B) the health care insurer makes prominent disclosure at the  
23 time it offers the plan, in a form approved by the exchange, that the plan does  
24 not provide the full range of essential pediatric benefits, and that qualified  
25 dental plans providing those benefits and other dental benefits not covered by  
26 the plan are offered through the exchange;

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

29 (3) the plan provides at least a bronze level of coverage under  
30 AS 21.54.220(a)(8) unless the plan is certified as a qualified catastrophic plan, meets  
31 the requirements of P.L. 111-148 (Patient Protection and Affordable Care Act), as

1 amended, and regulations adopted under that Act, for catastrophic plans, and will only  
2 be offered to individuals eligible for catastrophic coverage;

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

10 (5) the health care insurer offering the plan

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

13 (B) offers at least one qualified health plan that provides a  
14 silver level of coverage under AS 21.54.220(a)(8) and at least one plan that  
15 provides a gold level of coverage through each small business health options  
16 program exchange and exchange for individual coverage in which the health  
17 care insurer participates;

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

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

24 (E) complies with the regulations developed by the United  
25 States Secretary of Health and Human Services under sec. 1311(d), P.L. 111-  
26 148 (Patient Protection and Affordable Care Act), as amended, and regulations  
27 adopted under that Act, and other requirements the exchange establishes;

28 (6) the plan meets the requirements of certification as adopted by  
29 regulation under AS 21.54.250 and by the United States Secretary of Health and  
30 Human Services under sec. 1311(c), P.L. 111-148 (Patient Protection and Affordable  
31 Care Act), as amended, and regulations adopted under that Act, which include

1 minimum standards in the areas of marketing practices, network adequacy, essential  
 2 community providers in underserved areas, accreditation, quality improvement,  
 3 uniform enrollment forms, and descriptions of coverage and information on quality  
 4 measures for health benefit plan performance; and

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

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

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

10 (2) by imposing premium price controls; or

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

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

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

22 (2) make available to the public in plain language, as defined in sec.  
 23 1311(e)(3)(B), P.L. 111-148 (Patient Protection and Affordable Care Act), as  
 24 amended, and regulations adopted under that Act, and submit to the exchange, the  
 25 United States Secretary of Health and Human Services, and the director accurate and  
 26 timely disclosure of the following:

27 (A) claims payment policies and practices;

28 (B) periodic financial disclosures;

29 (C) data on enrollment;

30 (D) data on disenrollment;

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

- 1 (F) data on rating practices;
- 2 (G) information on cost-sharing and payments with respect to  
3 any out-of-network coverage;
- 4 (H) information on enrollee and participant rights under Title I  
5 of P.L. 111-148 (Patient Protection and Affordable Care Act), as amended, and  
6 regulations adopted under that Act; and
- 7 (I) other appropriate information as determined by the United  
8 States Secretary of Health and Human Services.

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

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

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

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

27 (2) the plan must be limited to dental and oral health benefits, without  
28 substantially duplicating the benefits typically offered by a health benefit plan without  
29 dental coverage and must include, at a minimum, the essential pediatric dental benefits  
30 prescribed by the United States Secretary of Health and Human Services under sec.  
31 1302(b)(1)(J), P.L. 111-148 (Patient Protection and Affordable Care Act), as amended,

1 and regulations adopted under that Act, and other dental benefits as the exchange or  
2 the Secretary may specify by regulation; and

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

8 **Sec. 21.54.240. Exchange funding; publication of costs of the exchange.** (a)  
9 The exchange may charge assessments or user fees to health care insurers or otherwise  
10 generate funding necessary to support its operations provided under AS 21.54.200 -  
11 21.54.270.

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

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

22 **Sec. 21.54.260. Relation to other laws.** Provisions of AS 21.54.200 -  
23 21.54.270, and actions taken by the exchange under AS 21.54.200 - 21.54.270 may  
24 not be construed to preempt or supersede the authority of the director to regulate the  
25 business of insurance in the state. Except as expressly provided to the contrary in  
26 AS 21.54.200 - 21.54.270, all health care insurers offering qualified health plans in the  
27 state shall comply fully with all applicable health insurance laws of the state and  
28 regulations adopted and orders issued by the director.

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

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

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

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

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

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

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

10 (D) workers' compensation insurance or similar insurance;

11 (E) automobile medical payment insurance;

12 (F) credit-only insurance;

13 (G) coverage for on-site medical clinics;

14 (H) insurance coverage specified in federal regulations issued  
15 under the P.L. 104-191 (Health Insurance Portability and Accountability Act of  
16 1996), under which benefits for health care services are secondary or incidental  
17 to other insurance benefits;

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

21 (i) limited scope dental or vision benefits;

22 (ii) benefits for long-term care, nursing home care,  
23 home health care, community-based care, or any combination of long-  
24 term care, nursing home care, home health care, or community based  
25 care;

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

28 (K) the following benefits if the benefits are provided under a  
29 separate policy, certificate, or contract of insurance; there is no coordination  
30 between the provision of the benefits and any exclusion of benefits under any  
31 group health plan maintained by the same plan sponsor; and the benefits are

1 paid with respect to an event without regard to whether benefits are provided  
 2 with respect to an event under any group health plan maintained by the same  
 3 plan sponsor:

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

5 (ii) hospital indemnity or other fixed indemnity  
 6 insurance;

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

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

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

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

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

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

23 (A) has its principal place of business in this state and elects to  
 24 provide coverage through the small business health options program exchange  
 25 to all of its eligible employees, wherever employed; or

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

29 (6) "qualified health plan" means a health benefit plan that has in effect  
 30 a certification that the plan meets the criteria for certification described in sec.  
 31 1311(c), P.L. 111-148 (Patient Protection and Affordable Care Act), as amended, and

1 regulations adopted under that Act, and AS 21.54.230;

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

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

5 (B) resides in this state;

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

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

11 (8) "small business health options program exchange" means the small  
12 business health options exchange under AS 21.54.220(a)(13) and sec. 1321, P.L. 111-  
13 148, (Patient Protection and Affordable Care Act), as amended, and regulations  
14 adopted under that Act;

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

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

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

23 (C) all employees shall be counted, including a part-time  
24 employee and an employee who is not eligible for coverage through the  
25 employer;

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

31 (E) an employer that makes enrollment in qualified health plans

1 available to its employees through the small business health options program  
 2 exchange and that would cease to be a small employer because of an increase  
 3 in the number of its employees, shall continue to be treated as a small  
 4 employer for purposes of AS 21.54.200 - 21.54.270 as long as the employer  
 5 continuously makes enrollment through the small business health options  
 6 program exchange available to its employees.

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

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

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

11 (9) "public official" means

12 (A) a judicial officer;

13 (B) the governor or the lieutenant governor;

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

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

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

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

19 (iv) a person serving as the legislative liaison for the

20 department;

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

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

23 (F) state investment officers and the state comptroller in the  
 24 Department of Revenue;

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

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

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

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

1 **(K) the executive director of the Alaska Health Benefit**

2 **Exchange employed under AS 21.54.210;**

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

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

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

7 TRANSITIONAL PROVISIONS. Notwithstanding AS 21.54.210(c), enacted by sec.  
8 2 of this Act, the initial terms for members of the Alaska Health Benefit Exchange Board,  
9 except for the commissioner of health of social services who serves ex officio, are as follows:

10 (1) four members shall be appointed to serve for terms ending December 31,  
11 2011;

12 (2) four members shall be appointed to serve for terms ending December 31,  
13 2012; and

14 (3) the remaining members shall be appointed to serve for terms ending  
15 December 31, 2013.

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

18 TRANSITION: REGULATIONS. The Alaska Health Benefit Exchange Board  
19 established under AS 21.54.200, enacted by sec. 2 of this Act, may adopt regulations  
20 necessary to implement this Act under AS 21.54.250, enacted by sec. 2 of this Act. The  
21 regulations take effect under AS 44.62 (Administrative Procedure Act), but not before the  
22 effective date of the statutory changes.

23 \* **Sec. 8.** AS 21.54.200, 21.54.210, 21.54.220, 21.54.250, and 21.54.270, enacted by sec. 2  
24 of this Act, and secs. 3 - 5 of this Act take effect July 1, 2011.

25 \* **Sec. 9.** Sections 6 and 7 of this Act take effect immediately under AS 01.10.070(c).

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