

Introduced: 3/27/80
Referred: Health, Education &
Social Services and Finance

1 IN THE HOUSE

BY THE HEALTH, EDUCATION AND
SOCIAL SERVICES COMMITTEE

2 HOUSE BILL NO. 977

3 IN THE LEGISLATURE OF THE STATE OF ALASKA

4 ELEVENTH LEGISLATURE - SECOND SESSION

5 A BILL

6 For an Act entitled: "An Act relating to the health of residents of the
7 state; and providing for an effective date."

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

9 * Section 1. AS 18 is amended by adding a new chapter to read:

10 CHAPTER 12. PREPAID HEALTH CARE.

11 Sec. 18.12.010. COVERAGE OF REGULAR EMPLOYEES BY GROUP PREPAID
12 HEALTH CARE PLAN. (a) An employer who pays to a regular employee
13 monthly wages amounting to 86.67 times the minimum hourly wage estab-
14 lished in AS 23.10.065 or more shall provide coverage for the regular
15 employee with a prepaid health care plan contractor in accordance with
16 this chapter. The coverage shall be under a prepaid group health care
17 plan or combination of plans which have been certified under AS 21.50.-
18 030 as a number two qualified plan which includes coverage for
19 dependents.

20 (b) If the plan of health coverage provided to regular employees
21 does not meet the requirements of AS 21.50.030 for a number two
22 qualified plan, the employer shall make available a supplemental plan of
23 health benefits which, when combined with the existing plan of health
24 benefits, constitutes a number two coverage plan.

25 Sec. 18.12.020. TYPE OF PLAN AND SELECTION OF CONTRACTOR. (a) An
26 employer who employs an average of fewer than 100 regular employees
27 during a calendar quarter for whom he is required to provide coverage
28 through a prepaid group health care plan under this chapter shall choose
29 whether coverage is provided by

1 (1) a plan which obligates the prepaid health care plan
2 contractor to furnish the required health care benefits;

3 (2) a plan which obligates the prepaid health care plan
4 contractor to defray or reimburse the expenses of health care.

5 (b) A choice made under (a) of this section is binding for one
6 year from the date coverage begins under the chosen plan.

7 (c) An employer who employs an average of 100 or more regular
8 employees during a calendar quarter for whom he is required to provide
9 coverage through a prepaid group health care plan under this chapter
10 shall offer his employees an option to obtain health benefits through
11 either a plan type described in (a)(1) of this section or a plan type
12 described in (a)(2) of this section, if both are available. An option
13 need not be provided under this subsection if fewer than 25 employees
14 select that option.

15 (d) The employer may elect the particular contractor but the
16 covered employee is not obligated to contribute a greater amount to the
17 premium than he would have to contribute had the employer elected
18 coverage with the contractor providing the prevailing coverage of the
19 respective type in the state.

20 (e) An employer may provide coverage through an insurer, a health
21 maintenance organization, or on a self-insured basis. If coverage is
22 provided on a self-insured basis, the accident and health insurance
23 coverage or health maintenance organization coverage shall meet the
24 requirements of state law as to the services covered or benefits
25 provided but is not required to be approved by the director.

26 (f) An insurer may not make acceptance of its offer to provide
27 insurance coverage contingent on acceptance by the employer of health
28 maintenance organization coverage by a particular health maintenance
29 organization. A health maintenance organization may not make acceptance

1 of its offer to provide health maintenance organization coverage con-
2 tingent on acceptance by the employer of insurance coverage by a par-
3 ticular insurer. An offer to provide an accident and health insurance
4 policy and the health maintenance organization contract may not combine
5 the two offers at a single price.

6 (g) The employer shall provide coverage with the prepaid health
7 care plan contractor selected for all his regular employees covered by
8 the provisions of this chapter and electing that type of coverage.
9 Coverage under this section does not have to be provided for employees
10 covered by the health care provisions of an applicable collective
11 bargaining agreement and as provided in AS 18.12.090.

12 Sec. 18.12.030. LIABILITY FOR PAYMENT OF PREMIUM AND FOR WITH-
13 HOLDING. (a) Unless an applicable collective bargaining agreement
14 provides otherwise, an employer shall contribute at least one-half of
15 the premium for the coverage required by this chapter and the covered
16 employee shall contribute the balance. The covered employee may not be
17 required to contribute more than 1.5 percent of his wages under this
18 section. If the amount of the employee's contribution is less than
19 one-half of the premium, the employer is liable for the remaining
20 portion of the premium.

21 (b) The employer shall withhold the covered employee's share of
22 the premium from the employee's wages.

23 Sec. 18.12.040. COMMENCEMENT OF COVERAGE. An employer shall
24 provide the coverage required by this chapter for a regular employee who
25 has been in his employ for four consecutive weeks. Coverage shall begin
26 at the earliest time after the fourth week at which coverage may be
27 provided with the prepaid health care plan contractor selected in
28 accordance this chapter.

29 Sec. 18.12.050. CONTINUATION OF COVERAGE. If a regular employee

1 is prevented by sickness from working, the employer shall enable the
2 employee to continue the coverage required by this chapter by con-
3 tributing to the premium the amount paid by the employer toward the
4 premium before the employee's sickness. This contribution shall be made
5 for the period that the regular employee is prevented by sickness from
6 working. The obligation established by this section may not exceed
7 three months following the month during which the regular employee
8 became disabled from working or the period for which the employer has
9 paid regular wages to the regular employee, whichever is longer.

10 Sec. 18.12.060. PRINCIPAL AND SECONDARY EMPLOYERS. (a) If an
11 individual is concurrently a regular employee of two or more employers,
12 the principal employer is the employer who pays him the most wages. If
13 the employer who does not pay the most wages employs the regular em-
14 ployee for at least 35 hours per week, the employee shall determine
15 which of the employers is his principal employer and his other employers
16 are secondary employers. An employer designated as the principal
17 employer remains the principal employer for one year or until change of
18 employment, whichever occurs first.

19 (b) If an individual is concurrently a regular employee of a
20 public entity which is not an employer under this chapter and of an
21 employer under this chapter, the latter is a secondary employer.

22 (c) An employer who directly or indirectly interferes with or
23 coerces or attempts to coerce an employee in making a determination
24 under this section is guilty of a class B misdemeanor.

25 Sec. 18.12.070. CERTAIN EMPLOYEES EXCLUDED FROM COVERAGE. (a) An
26 employer is relieved of his obligations under AS 18.12.010 to a regular
27 employee who has notified him on a form specified by the commissioner
28 that the employee is

29 (1) provided with prepaid health coverage satisfying the

1 requirements of this chapter by another employer who is his principle
2 employer;

3 (2) protected by health insurance or a prepaid health care
4 plan established under a law of the United States;

5 (3) covered as a dependent under a prepaid health care plan,
6 entitling him to the health benefits required by this chapter; or

7 (4) a recipient of state medical assistance or covered by a
8 prepaid health care plan established under the laws of the state.

9 (b) An employer receiving notice of a claim of exemption under
10 this section or of any change in that status shall notify the commis-
11 sioner of the claim or the change in status on a form prescribed by the
12 commissioner.

13 Sec. 18.12.080. TERMINATION OF EXEMPTION. (a) If a principal
14 employer becomes a secondary employer or a secondary employer becomes
15 the principal employer because of a change in the employment situation
16 of a regular employee or a redetermination by an employee under
17 AS 18.12.060, the regular employee shall promptly notify the employers
18 affected of the change and the new principal employer shall provide
19 coverage required by this chapter.

20 (b) If an exemption claimed by a regular employee under AS 18.12.-
21 070 terminates, the regular employee shall notify the principal employer
22 promptly of the termination of the exemption and the employer shall
23 provide coverage as required by this chapter.

24 Sec. 18.12.090. FREEDOM OF COLLECTIVE BARGAINING. (a) This
25 chapter may not be construed to limit the freedom of employees to bar-
26 gain collectively for different prepaid health care plan coverage or for
27 a different allocation of the costs of the coverage. A collective
28 bargaining agreement may provide that the employer will provide the
29 health care specified in an agreement.

1 (b) If certain regular employees are not covered by the health
2 care provisions of an applicable collective bargaining agreement to
3 which their employer is a party, this chapter applies to them. An
4 employer or group of employers has complied with this chapter if the
5 employer or group of employers undertakes to provide health care
6 services under a collective bargaining agreement and the services are
7 available to all regular employees not covered by the agreement.

8 Sec. 18.12.100. INDIVIDUAL WAIVERS PROHIBITED. A regular employee
9 as an individual may not waive the required health care benefits or
10 agree to pay a greater share of the premium for the benefits than is
11 required by this chapter.

12 Sec. 18.12.110. JOINT PROVISION OF COVERAGE. For the purpose of
13 providing prepaid health care protection under this chapter for their
14 regular employees, employers may form associations with the contractors
15 authorized to provide coverage in the state.

16 Sec. 18.12.120. REGULATIONS. The commissioner may adopt regu-
17 lations necessary for the administration and enforcement of this
18 chapter.

19 Sec. 18.12.130. PENALTIES. (a) An employer who fails to comply
20 with AS 18.12.010 - 18.12.090 shall pay a penalty of not less than \$25
21 or of \$1 for each regular employee for every day during which the
22 failure continues, whichever is greater. The penalty shall be assessed
23 under regulations adopted by the commissioner under the Administrative
24 Procedure Act (AS 44.62) and shall be collected by the commissioner and
25 paid into the general fund. The commissioner may, for good cause shown,
26 remit all or a part of the penalty.

27 (b) An employer, regular employee, or prepaid health care plan
28 contractor who wilfully fails to comply with this chapter or a regu-
29 lation adopted under it may be fined not more than \$200 for each

1 violation.

2 Sec. 18.12.140. PREMIUM SUPPLEMENTATION. (a) An employer who
3 employs fewer than eight regular employees who are provided with
4 coverage under this chapter is entitled to premium supplementation if

5 (1) the employer's share of the cost of providing the
6 coverage under AS 18.12.030 and 18.12.050 exceeds 1.5 percent of the
7 total wages payable to regular employees; and

8 (2) the amount of the excess under (1) of this subsection is
9 greater than five percent of the employer's income before taxes directly
10 attributable to the business in which the regular employees are
11 employed.

12 (b) The amount of the supplementation shall be that portion of the
13 employer's share of the premium cost which exceeds the limits specified
14 in (a)(2) of this section.

15 (c) An employer entitled to premium supplementation may file a
16 claim in the manner provided by regulation of the commissioner. The
17 employer has the burden of establishing his entitlement.

18 Sec. 18.12.150. EXISTING PLANS. This chapter may not be construed
19 to interfere with or diminish health benefits already provided under
20 collective bargaining agreements or employer-sponsored plans which are
21 more favorable to the covered employees than the benefits provided by
22 this chapter.

23 Sec. 18.12.160. TERMINATION OF CHAPTER. This chapter terminates
24 on the effective date of federal legislation that provides for voluntary
25 prepaid health care for the people of this state in a manner at least as
26 favorable as the health care provided by this chapter, or upon the
27 effective date of federal legislation that provides for mandatory pre-
28 paid health care for the people of this state.

29 Sec. 18.12.200. DEFINITIONS. In this chapter

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(1) "commissioner" means the commissioner of labor;

(2) "employer"

(A) means an individual or any type of organization, including a partnership, association, trust, estate, joint stock company, insurance company, or corporation, whether domestic or foreign, a debtor in possession or receiver or trustee in bankruptcy, or the legal representative of a deceased person, who has one or more regular employees in his employment;

(B) does not mean

(i) the state, a municipality of the state or an instrumentality of the state or its municipalities;

(ii) the United States government or an instrumentality of the United States;

(iii) another state or municipality or instrumentality of another state or municipality;

(iv) a foreign government or instrumentality wholly owned by a foreign government, if the service performed in its employ is of a character similar to that performed in foreign countries by employees of the United States government or of an instrumentality of the United States, and the United States Secretary of State certifies to the United States Secretary of the Treasury that the foreign government, with respect to whose instrumentality exemption is claimed, grants an equivalent exemption for similar service performed in the foreign country by employees of the United States government and instrumentalities of the United States;

(3) "employment"

(A) means service, including service in interstate commerce, performed for wages under a contract of hire, written or

1 oral, expressed or implied, with an employer, either inside or both
2 inside and outside the state if:

3 (i) the service is localized in the state; or

4 (ii) the service is not localized in any state but
5 some of the service is performed in the state and the individual's
6 base of operation, or, if there is no base operation, the place
7 from which the service is directed or controlled, is in the state;
8 or the individual's base of operation or place from which the
9 service is directed or controlled is not in any state in which some
10 part of the service is performed but the individual's residence is
11 in the state;

12 (B) does not mean service

13 (i) performed by an individual in the employ of an
14 employer who, under the laws of the United States, is re-
15 sponsible for care and cost in connection with the service;

16 (ii) performed by an individual in the employ of his
17 spouse, son, or daughter, and service performed by an
18 individual under the age of 21 in the employ of his father or
19 mother;

20 (iii) performed in the employ of a voluntary em-
21 ployee's beneficiary association providing for the payment of
22 life, sickness, accident, or other benefits to the members of
23 the association or their dependents or their designated bene-
24 ficiaries, if admission to membership in the association is
25 limited to individuals who are officers or employees of the
26 United States government, and no part of the net earnings of
27 the association inures (other than through such payments) to
28 the benefit of a private shareholder or individual;

29 (iv) performed by an individual for an employer as

1 an insurance agent or as an insurance solicitor, if all the
2 service performed by the individual for the employer is per-
3 formed for remuneration solely by way of commission;

4 (v) performed by an individual for an employer as a
5 real estate salesman or as a real estate broker, if all the
6 service performed by the individual for the employer is per-
7 formed for remuneration solely by way of commission;

8 (4) "income directly attributable to the business"

9 (A) means gross profits from the business less deduc-
10 tions for

11 (i) compensation of officers;

12 (ii) salaries and wages, except wages paid by an
13 individual proprietor to himself;

14 (iii) repairs;

15 (iv) taxes on business and business property;

16 (v) business advertising;

17 (vi) amounts contributed to employee benefit plans;

18 (vii) interest on business indebtedness;

19 (viii) rent on business property; and

20 (ix) other expenses necessary for the current con-
21 duct of business;

22 (B) does not mean

23 (i) bad debts;

24 (ii) contributions or gifts, other than those listed
25 under (A)(vi) of this paragraph;

26 (iii) amortization and depreciation; or

27 (iv) losses by fire, storm, casualty, or theft;

28 (5) "premium" means an amount payable to a prepaid health
29 care plan contractor as consideration for his obligations under a pre-

1 paid health care plan;

2 (6) "prepaid health care plan" means an agreement by which a
3 prepaid health care plan contractor undertakes in consideration of a
4 stipulated premium

5 (A) to furnish health care, including hospitalization,
6 surgery, medical or nursing care, drugs or other restorative
7 appliances, subject to, if at all, only a nominal per service
8 charge; or

9 (B) to defray or reimburse, in whole or in part, the
10 expenses of health care;

11 (7) "prepaid health care plan contractor" means

12 (A) a medical group or organization which undertakes
13 under a prepaid health care plan to provide health care;

14 (B) a nonprofit organization which undertakes under a
15 prepaid health care plan to defray or reimburse in whole or in part
16 the expenses of health care; or

17 (C) an insurer who undertakes under a prepaid health
18 care plan to defray or reimburse in whole or in part the expenses
19 of health care;

20 (8) "regular employee" means a person in the employment of an
21 employer for at least 20 hours per week;

22 (9) "wages"

23 (A) means cash remuneration for services from whatever
24 source, including commissions, bonuses, and tips and gratuities
25 paid directly to an individual by a customer of the employer; if
26 the employee does not account to his employer for the tips and
27 gratuities received and is engaged in an occupation in which he
28 customarily and regularly receives more than \$200 a month in tips,
29 the combined amount received by him from his employer and from tips

1 is considered to be at least equal to the wage required by AS 23.-
2 10.065 or a greater sum as determined by regulation of the commis-
3 sioner;

4 (B) does not mean the amount of a payment

5 (i) specified in AS 23.20.530(b);

6 (ii) received for nonoccupational sickness or acci-
7 dent; or

8 (iii) received as workers' compensation.

9 * Sec. 2. AS 21 is amended by adding a new chapter to read:

10 CHAPTER 50. COMPREHENSIVE HEALTH INSURANCE.

11 Sec. 21.50.010. DUTIES OF INSURERS. (a) For each type of quali-
12 fied plan described in AS 21.50.030, an insurer or fraternal issuing
13 individual policies of accident and health insurance in the state other
14 than group conversion policies shall develop and file with the director
15 an individual policy which meets the minimum standards of that type of
16 qualified plan. An insurer or fraternal issuing individual policies of
17 accident and health insurance in the state shall offer each type of
18 qualified plan to each person who applies and is eligible for accident
19 and health insurance from that insurer or fraternal.

20 (b) An insurer or fraternal issuing Medicare supplement plans in
21 the state shall develop and file with the director a Medicare supplement
22 policy which meets the minimum standards of a qualified Medicare supple-
23 ment plan. An insurer or fraternal issuing Medicare supplement plans in
24 the state shall offer a qualified Medicare supplement plan to each
25 person who is eligible for coverage and who applies for a Medicare
26 supplement plan.

27 (c) For each type of qualified plan described in AS 21.50.030, an
28 insurer or fraternal issuing group policies of accident and health
29 insurance in the state shall develop and file with the director a group

1 policy which provides for each member of the group the minimum benefits
2 required by that type of qualified plan. An insurer or fraternal is-
3 suing group policies of accident and health insurance in the state shall
4 offer each type of qualified plan to each eligible applicant for group
5 accident and health insurance.

6 (d) Each insurer and fraternal shall include coverage of major
7 medical costs in every unqualified policy of accident and health in-
8 surance, unless the applicant for a new or renewal policy declines the
9 coverage in writing. The coverage shall provide that when a covered
10 individual incurs out-of-pocket expenses of \$5,000 or more in a calendar
11 year for services covered under AS 21.50.030(a), benefits shall be
12 payable, subject to any copayment authorized by the director, up to a
13 maximum lifetime limit of \$250,000.

14 (e) A policy of accident and health insurance may not be issued or
15 renewed in the state after July 1, 1981, by an insurer or a fraternal
16 which has not complied with this section.

17 (f) An insurer or fraternal may fulfill its obligations under this
18 section by issuing the required coverages in its own name and reinsuring
19 the risk and administration of the coverages with the association in
20 accordance with AS 21.50.070(g)(5) and (6).

21 (g) This section does not require an insurer or fraternal to offer
22 or issue a policy to a person who does not meet the underwriting or
23 membership requirements of the insurer or fraternal.

24 Sec. 21.50.020. CERTIFICATION OF QUALIFIED PLANS. On application
25 by an insurer, fraternal, or employer for certification of a plan of
26 health coverage as a qualified plan or a qualified Medicare supplement
27 plan for the purposes of AS 21.50.010 - 21.50.130, the director shall
28 determine within 90 days whether the plan is qualified. Each plan of
29 health coverage shall be labeled as "qualified" or "nonqualified" on the

1 front of the policy or evidence of insurance. A qualified plan shall
2 indicate whether it is a number one, two, or three coverage plan.

3 Sec. 21.50.030. MINIMUM BENEFITS OF QUALIFIED PLAN. (a) A plan
4 of health coverage shall be certified as a number three qualified plan
5 whether or not the policy is issued in the state if it meets or exceeds
6 the following minimum standards:

7 (1) The minimum benefits for a covered individual shall,
8 subject to the other provisions of this subsection, be equal to at least
9 80 percent of the cost of covered services in excess of an annual de-
10 ductible which may not exceed \$150 per person or \$450 per family. The
11 coverage shall include a limitation of \$3,000 per person on total annual
12 out-of-pocket expenses for services covered under this subsection. The
13 coverage may be subject to a maximum lifetime benefit of not less than
14 \$250,000. Covered expenses shall be the usual and customary charges for
15 the following services and articles when prescribed by a physician:

16 (A) hospital services;

17 (B) professional services for the diagnosis or treatment
18 of injuries, illnesses, or conditions, other than outpatient mental
19 or dental, which are rendered by a physician or at his direction;

20 (C) drugs requiring a physician's prescription;

21 (D) services of a nursing home for not more than 120
22 days in a year if the services begin within 14 days following
23 confinement of at least three days in a hospital for the same
24 condition;

25 (E) service of a home health agency up to a maximum of
26 180 visits per year;

27 (F) use of radium or other radioactive materials;

28 (G) oxygen;

29 (H) anesthetics;

- 1 (I) prostheses;
- 2 (J) rental or purchase, as appropriate, of durable
- 3 medical equipment;
- 4 (K) diagnostic X-rays and laboratory tests;
- 5 (L) oral surgery for partially or completely unerupted
- 6 impacted teeth, a tooth root without the extraction of the entire
- 7 tooth, or the gums and tissues of the mouth when not performed in
- 8 connection with the extraction or repair of teeth;
- 9 (M) services of a physical therapist;
- 10 (N) medically necessary transportation;
- 11 (O) alcoholism treatment.
- 12 (2) Covered expenses for the services and articles specified
- 13 in this subsection do not include the following:
- 14 (A) a charge for care for an injury or disease either
- 15 arising out of an injury in the course of employment and subject to
- 16 a worker's compensation law or for which benefits are payable under
- 17 another policy of accident and health insurance or Medicare;
- 18 (B) a charge for treatment for cosmetic purposes other
- 19 than surgery for the repair of an injury or birth defect;
- 20 (C) a charge for confinement in a private room to the
- 21 extent it is in excess of the institution's charge for its most
- 22 common semi-private room, unless a private room is prescribed as
- 23 medically necessary by a physician;
- 24 (D) a charge for services or articles the provision of
- 25 which is not within the scope of authorized practice of the in-
- 26 stitution or individual rendering the services or articles.
- 27 (3) The minimum benefits for a qualified plan shall include,
- 28 in addition to those benefits specified in (a)(1) of this section,
- 29 benefits for the following services subject to applicable deductibles,

1 coinsurance provisions, and maximum lifetime benefit limitations:

2 (A) well baby care;

3 (B) physicians' services for routine checkups and annual
4 physicals when prescribed by a physician;

5 (C) multiphasic screening and other diagnostic testing.

6 (b) The director shall prescribe by regulation reasonable limits
7 on the reimbursement required for the services specified in (a) of this
8 section.

9 (c) A plan of health coverage shall be certified as a number two
10 qualified plan if

11 (1) it provides at least the minimum benefits listed in (a)
12 of this section; and

13 (2) the annual deductible does not exceed \$500 per person or
14 \$1,500 per family.

15 (d) A plan of health coverage shall be certified as a number one
16 qualified plan if

17 (1) it provides at least the minimum benefits listed in (a)
18 of this section; and

19 (2) the annual deductible does not exceed \$1,000 per person
20 or \$3,000 per family.

21 (e) A health maintenance organization which provides the services
22 required by (a) of this section provides a number three qualified plan.

23 Sec. 21.50.040. QUALIFIED MEDICARE SUPPLEMENT PLAN. A plan which
24 provides benefits to persons over the age of 65 years may be certified
25 as a qualified Medicare supplement plan if the plan is designed to
26 supplement Medicare and provides coverage of 50 percent of the deduc-
27 tible and copayment required under Medicare and 80 percent of the
28 charges for covered services described in AS 21.50.030(a) which charges
29 are not paid by Medicare. The coverage shall include a limitation of

1 \$1,000 per person on total annual out-of-pocket expenses for the covered
2 services. The coverage may be subject to a maximum lifetime benefit of
3 not less than \$100,000.

4 Sec. 21.50.050. STATE PLAN PREMIUM. (a) The association shall
5 establish the schedule of premiums for coverage under the state plan in
6 accordance with generally accepted actuarial principles, subject to the
7 following limitations:

8 (1) The premium for the number one qualified plan may not
9 exceed 125 percent of the average of rates charged by the five insurers
10 with the largest number of individuals in a number one individual
11 qualified plan of insurance in force in the state.

12 (2) The premium for the number two qualified plan may not
13 exceed 125 percent of the average of rates charged by the five insurers
14 with the largest number of individuals in a number two individual
15 qualified plan of insurance in force in the state.

16 (3) The premium for a qualified Medicare supplement plan may
17 not exceed 125 percent of the average of rates charged by the five
18 insurers with the largest number of individuals enrolled in a qualified
19 Medicare supplement plan.

20 (b) The charge for health maintenance organization coverage shall
21 be based on generally accepted actuarial principles.

22 Sec. 21.50.060. DUTIES OF DIRECTOR. The director may

23 (1) formulate general policies to advance the purposes of
24 AS 21.50.010 - 21.50.140 and may adopt regulations under the Administra-
25 tive Procedure Act (AS 44.62) to carry out AS 21.50.010 - 21.50.140.;

26 (2) adopt regulations upgrading minimum benefit standards
27 under AS 21.50.010 - 21.50.040 as may be appropriate due to inflation or
28 changes in prevailing industry standards;

29 (3) supervise the establishment of a comprehensive health

1 association within the limits described in AS 21.50.070;

2 (4) approve the selection of the writing carrier by the
3 association and approve the association's contract with the writing
4 carrier including the state plan coverage and premiums to be charged;

5 (5) appoint advisory committees;

6 (6) conduct periodic audits to assure the general accuracy of
7 the financial data submitted by the writing carrier and the association;

8 (7) contract with the federal government or another unit of
9 government to ensure coordination of the state plan with other govern-
10 mental assistance programs;

11 (8) undertake directly or through contracts studies or demon-
12 stration programs to develop awareness of the benefits of AS 21.50.010 -
13 21.50.140, so that the residents of the state may avail themselves of
14 the health care benefits provided by these sections.

15 Sec. 21.50.070. COMPREHENSIVE HEALTH ASSOCIATION. (a) There is
16 established a comprehensive health association with membership con-
17 sisting of all insurers, self-insurers, fraternal, and health main-
18 tenance organizations licensed or authorized to do business in this
19 state.

20 (b) The board of directors of the association shall be made up of
21 seven individuals selected by participating members, subject to approval
22 by the director. To select the initial board of directors and to
23 initially organize the association, the director shall give notice to
24 all members of the time and place of the organizational meeting. In
25 determining voting rights at the organizational meeting, each member
26 shall be entitled to vote in person or by proxy. The vote shall be a
27 weighted vote based on the member's cost of self-insurance, accident and
28 health insurance premium, subscriber contract charges, or health main-
29 tenance contract payment derived from or on behalf of residents in the

1 previous calendar year, as determined by the director. If the board of
2 directors is not selected within 60 days after notice of the organiza-
3 tional meeting, the director may appoint the initial board. In ap-
4 proving or selecting members of the board, the director shall consider,
5 among other things, whether all types of members are fairly represented.
6 Members of the board may be reimbursed from the money of the association
7 for expenses incurred by them as members, but may not otherwise be
8 compensated by the association for their services. The costs of con-
9 ducting meetings of the association and its board of directors shall be
10 borne by members of the association.

11 (c) Members shall maintain their membership in the association as
12 a condition of doing business in the state. The association shall
13 submit bylaws and operating rules to the director for approval.

14 (d) Meetings of the association, its board, and committees of the
15 association shall comply with AS 44.62.310.

16 (e) Members shall enter into a contract with the association
17 according to terms specified in AS 21.50.080. The contract of re-
18 insurance shall be executed for a period of one year and may be renewed
19 annually. A company which ceases to do business in the state remains
20 liable under the contract for the reinsurance contracted for during that
21 calendar year.

22 (f) In the performance of their duties as members of the associa-
23 tion, the members are exempt from the provisions of AS 45.52.

24 (g) The association may

25 (1) exercise the powers granted to insurers under the laws of
26 the state;

27 (2) sue or be sued;

28 (3) enter into contracts with insurers, similar associations
29 in other states, or other persons for the performance of administrative

1 functions including the functions provided for in (5) and (6) of this
2 subsection;

3 (4) establish administrative and accounting procedures for
4 the operation of the association;

5 (5) provide under (h) of this section for the reinsuring of
6 risks incurred as a result of issuing the coverages required by
7 AS 21.50.010 and 21.50.130 by members of the association;

8 (6) provide under (i) of this section for the administration
9 by the association of policies which are reinsured under (5) of this
10 subsection.

11 (h) Each member which elects to reinsure its required risks under
12 (g)(5) of this section shall determine the categories of coverage it
13 elects to reinsure in the association. The categories of coverage are:
14 (1) individual qualified plans, excluding group conversions; (2) group
15 conversions; (3) group qualified plans with fewer than 50 employees or
16 members; and (4) major medical coverage. A separate election may be
17 made for each category of coverage. If a member elects to reinsure the
18 risks of a category of coverage, it must reinsure the risk of the cover-
19 age of every life covered under every policy issued in that category.
20 Members electing to administer the risks which are reinsured in the
21 association shall comply with the benefit determination guidelines and
22 accounting procedures established by the association. The fee charged
23 by the association for the reinsurance of risks may not be less than 110
24 percent of the total anticipated expenses incurred by the association
25 for the reinsurance.

26 (i) Each member electing to reinsure one or more categories of
27 coverage in the association under (g)(6) of this section may elect to
28 have the association administer the categories of coverage on the mem-
29 ber's behalf under (g)(6) of this section. If a member elects to have

1 the association administer the categories of coverage, it must do so for
2 every life covered under every policy issued in that category. The fee
3 for the administration shall not be less than 110 percent of the total
4 anticipated expenses incurred by the association for the administration.

5 Sec. 21.50.080. OPERATION OF STATE PLAN. (a) Upon certification
6 as an eligible person under AS 21.50.110, an eligible person may enroll
7 in the state plan by payment of the state plan premium to the writing
8 carrier.

9 (b) An employer which has in its employ one or more eligible
10 persons enrolled in the state plan may make all or a portion of the
11 state plan premium payment to the state plan directly to the writing
12 carrier.

13 (c) Not less than 87-1/2 percent of the state plan premium paid to
14 the writing carrier shall be used to pay claims and not more than
15 12-1/2 percent shall be used for the payment of agent referral fees
16 authorized in AS 21.50.120(c) and for payment of the writing carrier's
17 direct and indirect expenses, as specified in AS 21.50.100(g).

18 (d) Income in excess of the costs incurred by the association in
19 providing reinsurance or administrative services shall be held at in-
20 terest and used by the association to offset losses due to claims ex-
21 penses of the state plan or allocated to reduce state plan premiums.

22 (e) Each member of the association shall share the losses due to
23 claims expenses of the state plan according to the terms of the
24 individual reinsurance contracts executed by the association with each
25 member in accordance with AS 21.50.070(e). Claims expenses of the state
26 plan which exceed the premium payments allocated to the payment of
27 benefits shall be the liability of the association members. Association
28 members shall share in the excess costs of the state plan in an amount
29 equal to the ratio of the member's total cost of self-insurance,

1 accident and health insurance premium, subscriber contract charges, or
2 health maintenance organization contract charges received from or on
3 behalf of state residents as divided into the total cost of self-
4 insurance, accident and health insurance premium, subscriber contract
5 charges, and health maintenance organization contract charges, received
6 by all association members from or on behalf of state residents, as
7 determined by the director. The association shall determine each
8 member's liability and may make assessments against members as
9 necessary. Failure by a member to tender to the association the
10 assessment within 30 days of notification by the association is grounds
11 for termination of the member's membership. A member which ceases to do
12 accident and health insurance business in the state remains liable for
13 assessments through the calendar year during which accident and health
14 insurance ceased. Net gains from the operation of the state plan shall
15 be held at interest and used by the association to offset future losses
16 due to claims expenses of the state plan or allocated to reduce state
17 plan premiums.

18 (f) The reinsurance payment assessed against a member may be
19 offset against the income tax payable under AS 43.20 or the premium tax
20 payable under this title by the member for the year in which the payment
21 is assessed. The commissioner of revenue shall report to the legis-
22 lature not later than the 10th day of a regular session the total amount
23 of income tax or premium tax offset claimed by members during the
24 preceding calendar year.

25 Sec. 21.50.090. MINIMUM BENEFITS OF STATE PLAN. The association
26 through its state plan shall offer policies which provide the benefits
27 of a number one qualified plan, a number two qualified plan, and a
28 qualified Medicare supplement plan. It shall offer health maintenance
29 organization contracts in those areas of the state where a health

1 maintenance organization has agreed to make the coverage available and
2 has been selected as a writing carrier.

3 Sec. 21.50.100. ADMINISTRATION OF PLAN. (a) A member of the
4 association may submit to the director the policies of accident and
5 health insurance or the health maintenance organization contracts which
6 are being proposed to serve in the state plan. The time and manner of
7 the submission shall be prescribed by regulation of the director.

8 (b) On the director's approval of the policy forms and contracts
9 submitted under AS 21.50.070, the association shall select policies and
10 contracts or parts of the policies and contracts submitted by a member
11 or members of the association or by the association or others, to
12 develop specifications for bids from any members which wish to be
13 selected as a writing carrier to administer the state plan. The
14 selection of the writing carrier shall be based on criteria including
15 the member's proven ability to handle large group accident and health
16 insurance cases, efficient claim paying capacity, and the estimate of
17 total charges for administering the plan. The association may select
18 separate writing carriers for the two types of qualified plans, the
19 qualified Medicare supplement plan, and the health maintenance
20 organization contract.

21 (c) The writing carrier shall perform all administrative and
22 claims payment functions required by this section. The writing carrier
23 shall provide these services for a period of three years, unless a
24 request to terminate is approved by the director. The director shall
25 approve or deny a request to terminate within 90 days of its receipt.
26 The failure to approve or deny a request to terminate within 90 days of
27 its receipt constitutes an approval. Six months before the expiration
28 of each three-year period, the association shall invite submissions of
29 policy forms from members of the association, including the writing

1 carrier. The association shall select a writing carrier for the follow-
2 ing three-year period under (b) of this section.

3 (d) The writing carrier shall provide to all eligible persons
4 enrolled in the plan an individual certificate which contains a clear
5 and easily understandable statement as to the insurance protection to
6 which he is entitled, with whom claims are to be filed, and to whom
7 benefits are payable. The certificate shall indicate that coverage was
8 obtained through the association.

9 (e) The writing carrier shall submit to the association and the
10 commissioner on a monthly basis a report on the operation of the state
11 plan. Specific information to be contained in this report shall be
12 determined by the association before the effective date of the state
13 plan.

14 (f) All claims shall be paid by the writing carrier under the
15 provisions of AS 21.50.010 - 21.50.140 and shall indicate that the claim
16 was paid by the state plan. Each claim payment shall include infor-
17 mation specifying the procedure to be followed in the event of a dispute
18 over the amount of payment.

19 (g) The writing carrier shall be reimbursed from the state plan
20 premiums received for its direct and indirect expenses. Direct and
21 indirect expenses include but are not limited to a pro rata reimburse-
22 ment for the portion of the writing carrier's administrative, printing,
23 claims administration, management and building overhead expenses which
24 are assignable to the maintenance and administration of the state plan.
25 The association shall approve cost accounting methods to substantiate
26 the writing carrier's cost reports consistent with generally accepted
27 accounting principles. Direct and indirect expenses may not include
28 costs directly related to the original submission of policy forms before
29 selection as the writing carrier.

1 (h) The writing carrier is an agent of the association and the
2 director with civil liability subject to the provisions of AS 09.50.250 -
3 09.50.300 when carrying out its duties under AS 21.50.010 - 21.50.140.

4 (i) Premiums received by the writing carrier for the state plan
5 are exempt from the requirements of AS 21.50.130(c).

6 Sec. 21.50.110. ENROLLMENT BY ELIGIBLE PERSON. (a) The state
7 plan is open for enrollment by eligible persons. An eligible person
8 shall enroll by submission of a certificate of eligibility to the
9 writing carrier which provides:

10 (1) the name, address, age, and length of time at residence
11 of the applicant;

12 (2) the name, address, and age of spouse and children, if
13 any, if they are to be insured;

14 (3) evidence of rejection, a requirement of restrictive
15 riders, a rate up, a preexisting conditions limitation on a qualified
16 plan by at least two association members within six months of the date
17 of the certificate the effect of which is to reduce coverage sub-
18 stantially from that received by a person considered a standard risk or
19 other eligibility requirements adopted by regulation which evidence that
20 a person is unable to obtain coverage substantially similar to that
21 which may be obtained by a person who is considered a standard risk; and

22 (4) a designation of the coverage desired.

23 (b) Within 30 days of receipt of the certificate described in (a)
24 of this section, the writing carrier shall either reject the application
25 for failing to comply with the requirements in (a) of this section or
26 forward the eligible person a notice of acceptance and billing infor-
27 mation. Insurance is effective immediately upon receipt of the first
28 month's state plan premium and shall be retroactive to the date of
29 application if the applicant otherwise complies with the requirements of

1 AS 21.50.010 - 21.50.140. An eligible person may not purchase more than
2 one policy from the state plan. Upon ceasing to be a resident of the
3 state a person is no longer eligible to purchase or renew coverage under
4 the state plan.

5 (c) A person who obtains coverage under this section is not
6 covered for a preexisting condition during the first six months of
7 coverage under the state plan if the person was diagnosed or treated for
8 that condition during the 90 days immediately preceding the filing of an
9 application.

10 Sec. 21.50.120. SOLICITATION OF ELIGIBLE PERSONS. (a) The asso-
11 ciation shall disseminate appropriate information regarding the
12 existence of the state plan and the means of enrollment to the residents
13 of the state under a plan approved by the director.

14 (b) The association shall maintain public awareness of the pro-
15 visions of AS 21.50.010 - 21.50.140 and shall administer this chapter in
16 a manner which encourages public participation in the state plan.

17 (c) The writing carrier shall pay an agent's referral fee of \$25
18 to each insurance agent who refers an applicant to the state plan if the
19 application is accepted. Selling or marketing of qualified state plans
20 may not be limited to the writing carrier or its agents. The referral
21 fees shall be paid by the writing carrier from money received as
22 premiums for the state plan.

23 (d) Every insurer which rejects or applies underwriting restric-
24 tions to an applicant for accident and health insurance shall notify the
25 applicant of the existence of the state plan, the requirements for
26 being accepted in it, and the procedure for applying to it.

27 Sec. 21.50.130. CONVERSION PRIVILEGES. (a) Each program of
28 self-insurance and each policy of group accident and health insurance or
29 contract of coverage by a health maintenance organization written or

1 renewed in the state shall include the right to convert to an individual
2 coverage qualified plan without the addition of underwriting restric-
3 tions regardless of the reason for leaving the group. A person leaving
4 the group may exercise his right to conversion within 30 days of leaving
5 the group.

6 (b) Plans of health coverage shall include a provision which, upon
7 the death of the individual in whose name the contract was issued,
8 permits an individual then covered under the contract to elect, within
9 the period specified in the contract, to continue coverage under the
10 same or a different contract without the addition of underwriting re-
11 strictions until he would have ceased to be entitled to coverage had the
12 individual in whose name the contract was issued lived.

13 Sec. 21.50.200. DEFINITIONS. In this chapter,

14 (1) "accident and health insurance policy" or "policy"

15 (A) means insurance or nonprofit health service plan
16 contracts providing benefits for hospital, surgical, and medical
17 care;

18 (B) does not mean coverage which is

19 (i) limited to disability or income protection
20 coverage,

21 (ii) automobile medical payment coverage,

22 (iii) supplemental to liability insurance,

23 (iv) sold by fraternal and provides payments on a
24 per diem, daily indemnity or nonexpense-incurred basis;

25 (2) "association" means a comprehensive health association
26 established under AS 21.50.070;

27 (3) "dependent" means a spouse or unmarried child under the
28 age of 18 years, a child who is a student under the age of 25 years and
29 financially dependent upon the parent, a dependent child of any age who

1 is disabled, or a household member who is financially dependent on the
2 primary insured;

3 (4) "director" means the director of insurance;

4 (5) "eligible person" means an individual who is a resident
5 of the state and meets the enrollment requirements of AS 21.50.110;

6 (6) "family" means the primary insured and all his covered
7 dependents;

8 (7) "fraternal" means a corporation, society, order, or
9 voluntary association without capital stock which sells health and
10 accident insurance in accordance with AS 21.84;

11 (8) "gross income" means income under AS 43.20;

12 (9) "health benefits" means benefits offered to employees on
13 an indemnity or prepaid basis which pays the costs of or provide
14 medical, surgical, or hospital care;

15 (10) "health maintenance organization" means a nonprofit
16 corporation organized and operated under 42 U.S.C. sec. 300e;

17 (11) "insurer"

18 (A) means a company offering, selling, issuing or
19 renewing policies or contracts of accident and health insurance;

20 (B) does not mean health maintenance organization;

21 (12) "Medicare" means Part A and Part B of the United States
22 Social Security Act, Title XVIII, as amended, 42 U.S.C. sections 1394,
23 et seq;

24 (13) "Medicare supplement plan" means a plan of insurance
25 protection which provides benefits for the costs of medical, surgical,
26 or hospital care and which is marketed as providing benefits which
27 complement or supplement the benefits provided by Medicare;

28 (14) "plan of health coverage" means a plan or combination of
29 plans of coverage, including combinations of self-insurance, individual

1 accident and health insurance policies, group accident and health in-
2 surance policies, coverage under a nonprofit health service plan, or
3 coverage under a health maintenance organization subscriber contract;

4 (15) "qualified expense" means a charge incurred for a health
5 service which is included in the list of covered services described in
6 AS 21.50.040(a) and for which no third party is liable;

7 (16) "qualified Medicare supplement plan" means a health
8 benefit plan which has been certified by the director as providing the
9 minimum benefits required by AS 21.50.050 or the actuarial equivalent of
10 those benefits;

11 (17) "qualified plan" means those health benefit plans which
12 have been certified by the director as providing the minimum benefits
13 required by AS 21.50.040 or the actuarial equivalent of those benefits;

14 (18) "self-insurance" means a plan of health coverage offered
15 by a self-insurer;

16 (19) "self-insurer"

17 (A) means an employer who directly provides a plan of
18 health coverage to his employees and administers the plan of health
19 coverage himself or through an insurer;

20 (B) does not mean an employer engaged in the business of
21 providing health care services to the public who provides health
22 care services directly to his employees at no charge to them;

23 (20) "state plan" means policies of comprehensive health
24 insurance and contracts of health maintenance organization coverage
25 offered by the association through the writing carrier under this
26 chapter;

27 (21) "state plan premium" means a premium determined under
28 AS 21.50.060;

29 (22) "third party" means a person other than the eligible

1 person or his dependents;

2 (23) "writing carrier" means an insurer or insurers and a
3 hospital or medical service corporation or corporations selected by the
4 association and approved by the director to administer the comprehensive
5 health insurance plan.

6 * Sec. 3. AS 47.05 is amended by adding new sections to read:

7 Sec. 47.05.070. MEDICAL ASSISTANCE BY INSURANCE OR SERVICE
8 CONTRACTS. (a) The commissioner shall use available medical assistance
9 funds to purchase and pay premiums on policies of insurance or pay the
10 expenses on health care service contracts or medical or hospital service
11 contracts that provide one or more of the medical and remedial care and
12 services available under state medical assistance programs.

13 (b) The policy of insurance or the contract must by its terms
14 guarantee

15 (1) to provide medical and remedial care and services of the
16 type and according to the standards prescribed by law and regulation;

17 (2) to pay providers of medical and remedial care and
18 services the amount due, based on the number of days of care and the
19 fees, charges, and costs except as to medical or hospital service
20 contracts issued by a hospital association which employs a method of
21 accounting or payment on other than a fee for service basis;

22 (3) to provide medical and remedial care and services under
23 policies of insurance or contracts in compliance with applicable laws
24 and regulations;

25 (4) to provide the statistical data, records, and reports
26 relating to the provision, administration, and costs of providing
27 medical and remedial care and services as required by the commissioner.

28 Sec. 47.05.080. RATES ON INSURANCE OR SERVICE CONTRACTS. (a) The
29 commissioner shall establish uniform areawide rates for the payment on

1 policies of insurance or service contracts from available medical
2 assistance funds.

3 (b) The commissioner may not pay a premium or other periodic
4 charge on a policy of insurance, health care service contract, or
5 hospital service contract unless the insurer or contractor issuing the
6 policy or contract is authorized to do business in the state.

7 Sec. 47.05.090. CONTRACTS WITH DIRECT PROVIDERS OF CARE AND
8 SERVICE. (a) The commissioner may enter into nonexclusive contracts
9 under which funds available for medical assistance may be administered
10 and disbursed by the contractor to direct providers of medical and
11 remedial care and services available under medical assistance for
12 services rendered and supplies furnished by them.

13 (b) A contract under this section shall

14 (1) oblige the contractor to make payments under the contract
15 promptly and not later than 30 days after receipt of the proper evidence
16 of the claim; and

17 (2) provide data, records, and reports required by the com-
18 missioner.

19 Sec. 47.05.100. IMPLEMENTATION. The commissioner shall implement
20 the provisions of AS 47.05.070 - 47.05.100 when the commissioner
21 determines that comparable benefits are available at equal or less cost
22 than direct payments by the department to the providers of medical
23 assistance.

24 Sec. 47.05.110. CASH ADVANCE. The department may make an advance
25 payment, before receipt of billing for service, to providers who serve a
26 large volume of state medical assistance clients under regulations of
27 the department.

28 Sec. 47.05.120. INTEREST ON LATE PAYMENTS. When presented by a
29 provider of medical services with a bill which satisfies the require-

1 ments for payment under a state medical assistance program, the state
2 shall pay

3 (1) interest at the rate of one percent per month when
4 payment is delayed more than 30 days after presentation of the billing;
5 and

6 (2) interest at the rate of two percent per month when
7 payment is delayed more than six months after presentation of the
8 billing.

9 Sec. 47.05.130. DEFINITIONS. In AS 47.05.070 - 47.05.130

10 (1) "commissioner" means the commissioner of health and
11 social services;

12 (2) "department" means the Department of Health and Social
13 Services;

14 (3) "medical assistance" means any program of financial
15 assistance for medical services provided by the department.

16 * Sec. 4. AS 47.07.020(b) is repealed and re-enacted to read:

17 (b) Residents of the state for whom the Social Security Act allows
18 optional Medical coverage qualifying for federal financial participation
19 are eligible for medical assistance.

20 * Sec. 5. AS 47.07.030 is amended to read:

21 Sec. 47.07.030. MEDICAL SERVICES TO BE PROVIDED. Medical services
22 to be offered to eligible persons include inpatient hospital, outpatient
23 hospital, rural health clinic, outpatient surgical care centers,
24 laboratory and X-ray, refractions and eye examinations by ophthal-
25 mologists or optometrists, eyeglasses prescribed by a physician skilled
26 in diseases of the eye or by an optometrist, podiatrist services,
27 chiropractic services, private duty nursing, physical therapist services,
28 occupational therapy services, dental services and dentures, personal
29 care services, prosthetic devices, prescribed drugs, inpatient

1 psychiatric hospital for [PERSONS AGE 65 OR OLDER AND] persons under age
2 21, skilled and intermediate nursing home, physician, home health care
3 services, early periodic screening diagnosis and treatment of persons
4 under 21 years of age, inpatient, skilled nursing, and intermediate
5 care facility services for persons 65 years of age or older in in
6 stitutions for tuberculosis or mental diseases, clinic services,
7 treatment of speech, hearing and language disorders, diagnostic,
8 screening, prevention, and rehabilitation services, and reasonable
9 transportation to and from the point of medical care. No additional
10 services may be provided unless approved by the legislature.

11 * Sec. 6. AS 47.25.120 is amended to read:

12 Sec. 47.25.120. ELIGIBILITY FOR ASSISTANCE. Financial assistance
13 may be given under AS 47.25.120 - 47.25.300 [, SO FAR AS PRACTICABLE
14 UNDER THE CONDITIONS IN THIS STATE,] to

15 (1) a needy person who is eligible under the regulations of
16 the department; and

17 (2) a medically needy person who has incurred medical expense
18 which equal or exceed the difference between the person's monthly income
19 and 150 percent of the current Federal Community Services Administration
20 poverty income guidelines for Alaska (45 C.F.R.,sec. 1060.2).

21 * Sec. 7. AS 47.25.410(3) is amended to read:

22 (3) "dependent child" means a needy child under 18 years of
23 age including an unborn child who is deprived of parental support or
24 care by reason of the death, continued absence from the home, or
25 physical or mental incapacity of a parent, and who is living with his
26 father, mother, grandfather, grandmother, brother, sister, stepfather,
27 stepmother, stepbrother, stepsister, uncle, aunt, first cousin, nephew,
28 or niece in a place of residence maintained by one or more of these
29 relatives as his or their own home, and includes a child

1 (A) who would come within the meaning of dependent child
2 except for his removal after April 30, 1961, from the home of a
3 relative as a result of a judicial determination to the effect that
4 continuation in that home [THEREIN] would be contrary to the
5 welfare of the child,

6 (B) for whose placement the department is responsible,

7 (C) who has been placed in a foster family home as a
8 result of the [SUCH] termination, and

9 (D) who received aid under this plan in and for the
10 month in which court proceedings leading to the [SUCH] deter-
11 mination were initiated;

12 * Sec. 8. AS 47.07.020 is repealed.

13 * Sec. 9. ADJUSTMENT OF EMPLOYER-SPONSORED PLANS. When employees subject
14 to the requirements of AS 18.12 enacted in sec. 1 of this Act are included in
15 the coverage provisions of an employer-sponsored prepaid health care plan
16 covering similar employees employed outside the state and the majority of the
17 employees are not subject to the requirements of AS 18.12, the benefits
18 applicable to the employees covered by AS 18.12 shall be adjusted within one
19 year after the effective date of this Act so as to meet the requirements of
20 AS 18.12.

21 * Sec. 10. This Act takes effect July 1, 1981.

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