

SENATE BILL NO. 242

IN THE LEGISLATURE OF THE STATE OF ALASKA

SEVENTEENTH LEGISLATURE - FIRST SESSION

BY SENATOR COLLINS

Introduced: 4/5/91

Referred: L&C, HES, Finance

A BILL**FOR AN ACT ENTITLED**

1 "An Act relating to health insurance for small employers; and providing for an effective
2 date."

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

4 * Section 1. FINDINGS. The legislature finds that

5 (1) an unacceptable number of residents of this state are without appropriate health care
6 because of the rapid increase in the cost of health care, the lack of access to health care, and the lack
7 of availability of health insurance coverage;

8 (2) maintenance of proper coverage of employees and dependents of employees of small
9 employers under a health benefit plan is important to ensuring the availability of appropriate health care
10 for the residents of this state and provides more stability and predictability of both rate increases and
11 coverage continuation.

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

13 CHAPTER 55. SMALL EMPLOYER HEALTH INSURANCE.

14 ARTICLE 1. SMALL EMPLOYER HEALTH REINSURANCE ASSOCIATION.

1 **Sec. 21.55.010. CREATION; MEMBERSHIP.** There is established a nonprofit
2 incorporated legal entity to be known as the Small Employer Health Reinsurance Association.
3 Membership consists of all licensed hospital or medical service corporations in the state that offer
4 subscriber contracts for health benefits, all welfare arrangements, and all insurers licensed to
5 transact health insurance in the state that offer a health benefit plan. All members shall maintain
6 membership in the association as a condition of doing health insurance business, or being able
7 to offer subscriber contracts, in the state.

8 **Sec. 21.55.020. BOARD OF DIRECTORS; ORGANIZATION.** (a) The board of
9 directors of the association consists of nine individuals selected by participating members, subject
10 to approval by the director. The director or the director's designee shall serve as a nonvoting
11 ex officio member of the board. In approving members of the board, the director shall consider,
12 among other things, whether all types of participating members are fairly represented.

13 (b) To the extent possible, one board member shall represent a health maintenance
14 organization, one board member shall represent a hospital or medical service corporation, at least
15 six board members' principal health insurance business shall be in the small employer market,
16 and one board member's principal health insurance business shall be in the large employer
17 market. Members of the board other than the director or the director's designee may be reim-
18 bursed from the association for expenses incurred by them as members, but may not otherwise
19 be compensated by the association for their services. The costs of conducting meetings of the
20 association and its board of directors shall be borne by the association.

21 **Sec. 21.55.030. GENERAL POWERS.** The association may

22 (1) exercise the powers granted to insurers under the laws of the state, except that
23 the association may not issue insurance;

24 (2) sue or be sued;

25 (3) enter into contracts with insurers, similar associations in other states, or with
26 other persons for the performance of administrative functions;

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

29 (5) take legal action as necessary to avoid the payment of improper claims against
30 the association;

31 (6) design the array of health coverage products for which reinsurance will be

1 provided and issue reinsurance policies;

2 (7) establish rules, conditions, and procedures pertaining to the reinsurance of
3 members' risks by the association;

4 (8) establish appropriate rates, rate schedules, rate adjustments, rate classifications,
5 and other actuarial functions appropriate to the operation of the association;

6 (9) assess members under the provisions of this chapter and make advance interim
7 assessments as may be reasonable and necessary for organizational and interim operating
8 expenses; interim assessments shall be credited as offsets against regular assessments due
9 following the close of the fiscal year;

10 (10) appoint from among members appropriate legal, actuarial, and other
11 committees as are necessary to provide technical assistance in the operation of the association.

12 Sec. 21.55.040. PLAN OF OPERATION. (a) The association shall submit to the
13 director a plan of operation and amendments necessary or suitable to assure the fair, reasonable,
14 and equitable administration of the association. The plan of operation and amendments become
15 effective upon approval in writing by the director. If the director has not approved or
16 disapproved a plan of operation submitted by the association within 90 days after receiving the
17 plan of operation, the plan of operation is considered approved by the director. If the association
18 fails to submit a suitable plan of operation by a date that is 180 days after the effective date of
19 this Act, or if at subsequent time the association fails to submit suitable amendments to the plan,
20 the director may, after notice and hearing, adopt reasonable regulations necessary or advisable
21 to effectuate the provisions of this chapter. These regulations shall continue in force until mod-
22 ified by the director or superseded by a plan submitted by the association and approved by the
23 director.

24 (b) All members of the association shall comply with the plan of operation.

25 (c) The plan of operation must

26 (1) establish procedures for the performance of the powers and duties of the
27 association under this chapter;

28 (2) establish procedures for handling assets of the association and for an annual
29 fiscal report to the director;

30 (3) establish the amount and method of reimbursing members of the board under
31 AS 21.55.020;

- 1 (4) establish regular places and times for meetings of the board;
- 2 (5) establish procedures for records to be kept of all financial transactions of the
3 association, its agents, and the board;
- 4 (6) provide that a member insurer aggrieved by a final action or decision of the
5 association may appeal to the director within 30 days after the action or decision;
- 6 (7) establish procedures for the submission to the director of selections for the
7 board;
- 8 (8) provide for reinsuring risks under the provisions of this section;
- 9 (9) provide for collecting assessments from all members to provide for claims
10 reinsured by the association and for administrative expenses incurred or estimated to be incurred
11 during the period for which the assessment is made;
- 12 (10) provide protection for guaranteed issue insurers from the financial risk
13 associated with small employers that present poor credit risks;
- 14 (11) establish standards for the coverage of small employers that have high
15 employee turnover;
- 16 (12) establish an appeals process for guaranteed issue insurers to seek relief when
17 a guaranteed issue insurer has experienced an unfair share of administrative and credit risks;
- 18 (13) determine the adjusted average market premium prices for small employer
19 health plans sold in this state;
- 20 (14) establish participation standards at issue and renewal for reinsured cases;
- 21 (15) establish and maintain a list of guaranteed issue insurers;
- 22 (16) establish standards for those conditions under which a guaranteed issue
23 insurer would not be required to write business received from a particular agent or broker; and
- 24 (17) provide for selection of an administering insurer and establish the
25 administering insurer's powers and duties;
- 26 (18) contain additional provisions necessary or proper for the execution of the
27 powers and duties of the association.

28 Sec. 21.55.050. HEALTH CARE REINSURANCE. (a) A member may only reinsure
29 coverage of an eligible employee of a small employer or a dependent of an eligible employee of
30 a small employer with the association under the following provisions:

- 31 (1) regarding a small employer health benefit plan, the association shall reinsure

1 the level of coverage provided;

2 (2) regarding a plan other than a small employer health benefit plan, the
3 association shall reinsure the level of coverage provided up to, but not exceeding, the level of
4 coverage provided in a small employer health benefit plan;

5 (3) regarding the coverage provided to small employers, the insurer or welfare
6 arrangement, or, to the extent permitted under 29 U.S.C. 1001 - 1459, other benefit arrangement
7 shall be required to use high-cost case management, hospital precertification techniques, and other
8 cost containment techniques as established by the association;

9 (4) regarding eligible employees, and their dependents, who are hired subsequent
10 to the commencement of the employer's coverage by an insurer, welfare arrangement, or other
11 benefit arrangement and who are not late enrollees, coverage may be reinsured by a
12 nonguaranteed issue insurer within 60 days of the commencement of coverage under the plan;

13 (5) regarding eligible employees, and their dependents, who are hired subsequent
14 to the commencement of the employer's coverage by a guaranteed issue insurer and who are not
15 late enrollees, coverage may be reinsured by the guaranteed issue insurer

16 (A) within 60 days of the commencement of coverage under the plan; or

17 (B) commencing on a date established by the board but not later than 18
18 months after the association becomes operational on the first plan anniversary after the
19 small employer coverage has been in effect with the small employer for at least three
20 years and every third year anniversary thereafter;

21 (6) regarding eligible employees, and their dependents, who are employed by a
22 small employer as of the date the employer's coverage by the guaranteed issue insurer
23 commences, coverage may be reinsured

24 (A) within 60 days of the commencement of the employer's coverage with
25 the insurer or welfare arrangement, or other benefit arrangement except in the case of late
26 enrollees; or

27 (B) commencing on a date established by the board but not later than 18
28 months after the association becomes operational on the first plan anniversary after the
29 small employer coverage has been in effect with the small employer for at least three
30 years and every third year anniversary thereafter;

31 (7) regarding eligible employees and their dependents, a guaranteed issue insurer

1 may reinsure the entire employer group

2 (A) within 60 days of the commencement of the group's coverage under
3 the plan;

4 (B) in the case where a new entrant to an employer group is reinsured
5 under the provisions of (4) of this subsection, on the first plan anniversary after the new
6 entrant became a member of the employer's plan; or

7 (C) commencing on a date established by the board but not later than 18
8 months after the association becomes operational on the first plan anniversary after the
9 small employer coverage has been in effect with the small employer for at least three
10 years and every third year anniversary thereafter;

11 (8) regarding employees or dependents reinsured under (4), (5), or (6) of this
12 subsection, reinsurance may not be provided until \$5,000 in benefit payments have been made
13 for services provided during that calendar year for that reinsured employee or dependent; in this
14 paragraph "benefit payments" include those payments that would have been reimbursed through
15 reinsurance in the absence of the annual \$5,000 deductible; the amount of the deductible shall
16 be periodically reviewed by the board and may be adjusted for appropriate factors as determined
17 by the board.

18 (b) If an employer group is covered under a plan other than a small employer health plan
19 and the insurer chooses to reinsure the group subsequent to the initial coverage period, or if a
20 new individual joins the group and the insurer wants to reinsure that individual, the insurer may
21 not require the employer to change to a small employer health plan and the insurer shall allow
22 the employer to maintain the same benefit plan and reinsure only the portion of the plan
23 consistent with a small employer health plan.

24 (c) Except as provided in (d) of this section, premium rates charged for coverage
25 reinsured by the association shall be established as follows:

26 (1) for whole group reinsurance coverage, 1.5 multiplied by the adjusted average
27 market premium price established by the association for that classification or group with similar
28 characteristics and coverage, for eligible employees, and dependents of eligible employees, of a
29 small employer all of whose coverage is reinsured with the association, minus a ceding expense
30 factor determined by the association;

31 (2) for individual reinsurance coverage, 5.0 multiplied by the adjusted average

1 market premium price established by the association for an individual in that classification or
2 group with similar characteristics and coverage, with respect to an eligible employee, or the
3 employee's dependents, minus a ceding expense factor determined by the association.

4 (d) Premium rates charged for reinsurance by the association to a health maintenance
5 organization that is approved by the Secretary of Health and Human Services as a federally
6 qualified health maintenance organization under 42 U.S.C. 300 and, as a health maintenance
7 organization, is subject to requirements that limit the amount of risk that may be ceded to the
8 association, may be modified to reflect the portion of risk that may be ceded to the association.

9 (e) If a health benefit plan coverage for a small employer is entirely or partially reinsured
10 with the association, the premium charged to the small employer for a rating period for the
11 coverage issued under this section may not be more than 1.5 times the adjusted average market
12 premium price established by the association for that classification or group with similar
13 characteristics and coverage.

14 (f) In determining the assessment, if any, that is collected from a member, the following
15 provisions apply:

16 (1) following the close of a fiscal year, the administering insurer shall determine
17 the net premiums, the association expenses for administration and the incurred losses, if any, for
18 the year, taking into account investment income and other appropriate gains and losses; for
19 purposes of this subsection, health benefit plan premiums earned by an insurer, welfare
20 arrangement, or other benefit arrangement shall be established by adding paid claim losses and
21 administrative expenses of the insurer, welfare arrangement, or other benefit arrangement; health
22 benefit plan premiums and benefits paid by a member that are less than an amount determined
23 by the board to justify the cost of collection may not be considered for purposes of determining
24 an assessment; in this paragraph, "net premiums" means health benefit plan premiums less
25 administrative expense allowances;

26 (2) a net loss for the year shall be covered first by assessment against members
27 to the extent provided as follows:

28 (A) assessments shall first be apportioned by the board among all
29 members in proportion to the member's respective share of the total premiums net of
30 reinsurance premiums paid for coverage under this chapter earned in this state from health
31 benefit plans covering small employers and to the extent permitted under 29 U.S.C.

1 1001 - 1459, apportioned among other benefit arrangements covering small employers
2 during the calendar year coinciding with or ending during the fiscal year of the
3 association, or apportioned on another equitable basis reflecting coverage of small
4 employers as may be provided in the plan of operation; an assessment shall be made
5 under this subparagraph against a health maintenance organization that is approved by the
6 secretary of health and human services as a federally qualified health maintenance
7 organization under 42 U.S.C. 300e, subject to an assessment adjustment formula adopted
8 by the board and approved by the director for qualified health maintenance organizations
9 that recognizes the restrictions imposed on qualified health maintenance organizations
10 under federal law; the adjustment formula shall be adopted by the board and approved by
11 the director before the first anniversary of the operation of the association;

12 (B) an assessment under (2)(A) of this subsection shall be capped at four
13 percent of premiums charged for health benefit plans covering a small employer;

14 (3) if assessments exceed actual losses and administrative expenses of the
15 association, the excess shall be held in an interest bearing account and used by the board to offset
16 future losses or to reduce association premiums; in this paragraph, "future losses" include a
17 reserve for incurred but not reported claims;

18 (4) the board shall annually determine a member's proportion of participation in
19 the association based on annual statements and other reports determined necessary by the board
20 and filed by the member with the board; an insurer, welfare arrangement, or other benefit
21 arrangement shall report to the board a claim payment made and administrative expense incurred
22 in this state on an annual basis on a form prescribed by the director;

23 (5) the plan of operation must include a provision for the imposition of an interest
24 penalty for late payment of assessments;

25 (6) a member may request a deferment from the director, in whole or in part,
26 from an assessment issued by the board; the director may defer, in whole or in part, the
27 assessment of a member if, in the opinion of the director payment of the assessment would
28 endanger the ability of the member to fulfill the member's contractual obligations;

29 (7) in the event an assessment against a member is deferred in whole or in part,
30 the amount by which the assessment is deferred may be assessed against the other members in
31 a manner consistent with the basis for assessments set out in this subsection; the member

1 receiving a deferment shall remain liable to the association for the amount deferred; the director
2 may attach conditions to a deferment.

3 Sec. 21.55.060. ADMINISTRATIVE PROCEDURE ACT. The association is exempt
4 from the Administrative Procedure Act (AS 44.62).

5 Sec. 21.55.070. TAX EXEMPTION. The association is exempt from the payment of fees
6 and taxes levied by the state or any of its political subdivisions except taxes levied on real or
7 personal property.

8 Sec. 21.55.080. LIMITATION OF LIABILITY. A member of the association is not
9 liable for civil damages resulting from an act or omission of the member on behalf of the
10 association unless the member acts with gross negligence or intentional misconduct.

11 ARTICLE 2. SMALL EMPLOYER HEALTH INSURANCE PLANS.

12 Sec. 21.55.100. APPLICABILITY. (a) An individual or group health benefit plan is
13 subject to the provisions of this chapter if the plan provides health care benefits covering one or
14 more employees of a small employer and if one of the following conditions are met:

15 (1) all or a portion of the premium or benefits is paid by a small employer or a
16 covered individual is reimbursed, through wage adjustments or otherwise, by a small employer
17 for all or a portion of the premium; or

18 (2) the health benefit plan is treated by the employer or a covered individual as
19 part of a plan or program for the purposes of 26 U.S.C. 106 or 26 U.S.C. 162 (Internal Revenue
20 Code).

21 (b) Except as provided in this chapter, other provisions of law requiring the coverage or
22 the offer of coverage of a health care service or benefit and other provisions of law requiring the
23 reimbursement, utilization, or consideration of a specific category of a licensed or certified health
24 care practitioner do not apply to a health benefit plan offered or delivered to a small employer.

25 (c) Except as provided in this chapter, a health benefit plan offered to a small employer
26 is not subject to a law that would

27 (1) inhibit an insurer, welfare arrangement, or other benefit arrangement from
28 contracting with providers or groups of providers regarding health care services or benefits;

29 (2) impose a restriction on the ability to negotiate with providers regarding the
30 level or method of reimbursing care or services provided under the health benefit plan;

31 (3) require an insurer, welfare arrangement, or other benefit arrangement to either

1 include a specific provider or class of provider when contracting for health care services or
2 benefits, or to exclude a class of provider that is generally authorized by law to provide health
3 care.

4 Sec. 21.55.110. UNDERWRITING AND RATING REQUIREMENTS. Health benefit
5 plans covering small employers and, to the extent permitted under 29 U.S.C. 1001 - 1459, other
6 benefit arrangements covering small employers, are subject to the following provisions:

7 (1) preexisting conditions provisions may not exclude or limit coverage for a
8 period beyond 12 months following the individual's effective date of coverage and may only
9 relate to conditions that had, during the six months immediately preceding the effective date of
10 coverage, occurred in a manner that would cause an ordinarily prudent person to seek medical
11 advice, diagnosis, care, or treatment or for which medical advice, diagnosis, care, or treatment
12 was recommended or received, or that related to a pregnancy existing on the effective date of
13 coverage;

14 (2) in determining whether a preexisting condition limitation provision applies to
15 an eligible employee or dependent, all health benefit plans shall credit the time the person was
16 covered under a previous employer based health benefit plan provided by an insurer or welfare
17 arrangement if the previous coverage was continuous to a date not more than 30 days before the
18 effective date of the new coverage, exclusive of the applicable service waiting period under the
19 health benefit plan;

20 (3) the health benefit plan and, to the extent permitted under 29 U.S.C. 1001 -
21 1459, other benefit arrangements covering small employers must be renewable with respect to
22 all eligible employees or dependents at the option of the policyholder, contract holder, or small
23 employer except for

24 (A) nonpayment of the required premiums by the policyholder, contract
25 holder, or employer;

26 (B) noncompliance with health benefit plan provisions;

27 (C) a health benefit plan of an employer under which the total number of
28 insured individuals covered under all of the health benefit plans of one employer is less
29 than the total number of individuals or percentage of individuals required by participation
30 requirements under a specific health benefit plan of that employer; or

31 (D) a health benefit plan issued by an insurer or welfare arrangement that

1 ceases doing business in the small employer market under AS 21.55.140;

2 (4) notwithstanding (3) of this section, a health benefit plan or coverage provided
3 to an individual covered by a health benefit plan subject to the provisions of this chapter may
4 be rescinded, cancelled, or not renewed for fraud, material misrepresentation, or concealment by
5 an applicant, employee, dependent, or small employer or an agent of an applicant, employee,
6 dependent, or small employer;

7 (5) an insurer or a welfare arrangement, and, to the extent permitted by 29 U.S.C.
8 1001 - 1459, a benefit arrangement may not exclude an eligible employee or dependent who
9 would otherwise be covered under a health benefit plan on the basis of an actual or expected
10 health condition of the person, except that an insurer, welfare arrangement, or other benefit
11 arrangement may exclude a late enrollee for the greater of 18 months or the remainder of the
12 three-year reinsurance period, as provided under AS 21.55.060;

13 (6) an insurer or a welfare arrangement doing business in the small employer
14 market retains the authority to underwrite and rate small employer groups using accepted
15 underwriting and actuarial practices; small employer groups that are declined because they fail
16 to satisfy insurer or welfare arrangement underwriting requirements shall be notified by the
17 insurer or welfare arrangement that the insurer or welfare arrangement will not issue a health
18 benefit plan to the small employer, that the small employer is eligible for a small employer health
19 plan provided by a guaranteed issue insurer, and shall be provided with a list, prepared by the
20 board, containing the address, telephone number, and service area of all guaranteed issue insurers;

21 (7) a health benefit plan issued by a insurer, welfare arrangement, or, to the extent
22 permitted by 29 U.S.C. 1001 - 1459, another benefit arrangement, may not limit or exclude, by
23 use of a rider or amendment applicable to a specific individual, coverage by type of illness,
24 treatment, medical condition, or accident, except for preexisting conditions or diseases as
25 permitted under (1) of this section;

26 (8) a health benefit plan and, to the extent permitted by 29 U.S.C. 1001 - 1459,
27 another benefit arrangement shall make coverage available to eligible employees of a small
28 employer without a service waiting period, except that a small employer may impose a service
29 waiting period for eligible employees of the small employer if the small employer chooses from
30 the service waiting periods offered by the insurer or welfare arrangement; a service waiting
31 period offered by an insurer or welfare arrangement may not exceed 90 days;

1 (9) the benefit structure of a health benefit plan subject to the provisions of this
2 chapter may be changed by the insurer or welfare arrangement to make it consistent with the
3 benefit structure contained in a health benefit plan being marketed to new groups;

4 (10) regarding a health benefit plan of an insurer or welfare arrangement, the
5 premium rates charged or offered for a rating period for the same or similar coverage under a
6 health benefit plan covering a small employer with similar case characteristics as determined by
7 the insurer or welfare arrangement may not vary from the applicable midpoint rate by more than
8 35 percent of the applicable midpoint rate, as to

9 (A) a health benefit plan issued on or after July 1, 1991; and

10 (B) within three years after July 1, 1991, for a health benefit plan issued
11 before July 1, 1991;

12 (11) regarding a health benefit plan issued before July 1, 1991, if an insurer or
13 welfare arrangement charged or offered a premium rate for the same or similar coverage under
14 a health benefit plan covering a small employer with similar case characteristics as determined
15 by the insurer or welfare arrangement, and the premium rate exceeds the applicable midpoint rate
16 by more than 35 points of the applicable midpoint rate, an increase in premium rates for a new
17 rating period may not exceed the sum of

18 (A) a percentage change in the base premium rate measured from the first
19 day of the prior rating period to the first day of the new rating period, plus

20 (B) an adjustment due to a change in case characteristics or plan design
21 of the small employer, as determined by the insurer or welfare arrangement;

22 (12) a premium rate may not vary by more than 15 percent based on industry
23 classification;

24 (13) subject to the provisions of (10), (11), and (12) of this section, an increase
25 in a premium rate for a new rating period may not exceed the sum of

26 (A) a percentage change in the base premium rate measured from the first
27 day of the prior rating period to the first day of the new rating period plus 15 percent,
28 adjusted on a pro rata basis for a rating period greater or lesser than one year, of the base
29 premium rate for the new rating period; and

30 (B) an adjustment due to a change in case characteristics or plan design
31 of the small employer, as determined by the insurer or welfare arrangement;

1 (14) when offering for sale a health benefit plan to a small employer, an insurer
2 or welfare arrangement shall make a reasonable disclosure as part of its solicitation and sales
3 materials of

4 (A) the extent to which premium rates for a specific small employer are
5 established or adjusted in part based on the actual or expected variation in claims costs
6 or actual or expected variation in health condition of the employees and dependents of
7 the small employer;

8 (B) the provisions concerning the insurer's or welfare arrangement's right
9 to change a premium rate; and

10 (C) provisions relating to renewability of a policy or contract;

11 (15) compliance with the underwriting and rating requirements contained in this
12 chapter shall be demonstrated through actuarial certification; insurers or welfare arrangements
13 offering a health benefit plan to a small employer shall file annually with the director an actuarial
14 certification stating that the underwriting and rating methods of the insurer or welfare
15 arrangement

16 (A) comply with accepted actuarial practices;

17 (B) are uniformly applied to health benefit plans covering small
18 employers; and

19 (C) comply with the provisions of this chapter.

20 Sec. 21.55.120. GUARANTEED ISSUE INSURERS. (a) Guaranteed issue insurers shall
21 offer at least one small employer health plan to a small employer requesting a small employer
22 health plan and shall provide at least the coverage of a small employer health plan to a small
23 employer requesting the coverage.

24 (b) Guaranteed issue insurers may

25 (1) reinsure an individual with a group or may reinsure an entire group subject
26 to the provisions of AS 21.55.060;

27 (2) as provided for in the association's plan of operation,

28 (A) require advance premium deposits for poor credit risks; and

29 (B) make special arrangements to cover an employee in a small employer
30 group with exceptionally high employee turnover rates;

31 (3) appeal to the board for a finding that the guaranteed issue carrier is

1 experiencing an unfair share of administrative or credit risk; if the board determines that a
2 guaranteed issue carrier has experienced an unfair burden, the board may grant the guaranteed
3 issue carrier a decreased reinsurance price to offset administrative expenses or temporarily
4 suspend the guaranteed issue insurer's requirement to guarantee issue.

5 **Sec. 21.55.130. SMALL EMPLOYER HEALTH BENEFIT PLANS.** (a) The board shall
6 design small employer health benefit plans that are eligible for reinsurance by the association.
7 The board shall establish the form and level of coverage to be made available by insurer or
8 welfare arrangements, and to the extent permitted under 29 U.S.C. 1001 - 1459, other benefit
9 arrangements in the small employer health benefit plans. In designing the small employer health
10 benefit plans, the board shall also establish benefit levels, deductibles, coinsurance factors,
11 exclusions, and limitations for the small employer health benefit plans. The form and level of
12 coverage established by the board must specify those components of a health benefit plan offered
13 by an insurer of a small employer that may be reinsured.

14 (b) A small employer health benefit plan may include cost containment features
15 including, but not limited to

16 (1) utilization review of health care services, including review of the medical
17 necessity of hospital and physician services;

18 (2) case management benefit alternatives;

19 (3) selective contracting with hospitals, physicians, and other health care
20 providers;

21 (4) reasonable benefit differentials applicable to participating and nonparticipating
22 providers; and

23 (5) other provisions for the cost effective management of a small employer health
24 benefit plan.

25 (c) The small employer health benefit plan established for use by health maintenance
26 organizations must be consistent with the basic method of operation of health maintenance
27 organizations.

28 (d) A small employer health benefit plan shall be submitted to the director for approval.

29 (e) After the director's approval of the small employer health benefit plans submitted by
30 the board, an insurer or welfare arrangement, or, to the extent permitted by 29 U.S.C. 1001 -
31 1459, other benefit arrangements may certify to the director, in the form and manner prescribed

1 by the director, that the small employer health benefit plans filed by the insurer or welfare
2 arrangement, or other benefit arrangement are in substantial compliance with the provisions in
3 the corresponding approved board plan. Upon receipt by the department of certification described
4 in this subsection, the insurer or welfare arrangement, or other benefit arrangement may use the
5 certified plan until the director, after notice and hearing, disapproves the use of the plan.

6 Sec. 21.55.140. **CONDITIONS FOR CEASING TO DO BUSINESS.** An insurer or a
7 welfare arrangement may cease doing business in the small employer market if the insurer or
8 welfare arrangement provides notice of the decision to cease doing business in the small
9 employer market to the division, the board, the policyholder or contract holder, and the employer,
10 and coverage under a health benefit plan subject to this chapter is continued for one year after
11 the date of the notice required under this section. An insurer or a welfare arrangement that
12 ceases doing business in the small employer marketplace may not reenter the small employer
13 marketplace for a period of five years from the date of the notice required under this section.

14 Sec. 21.55.250. **DEFINITIONS.** In this chapter,

15 (1) "adjusted average market premium price" means, as determined by the board,
16 the arithmetic mean of all guaranteed issue insurer's premium rates for a given small employer
17 health benefit plan sold to groups with similar case characteristics by all insurers or welfare
18 arrangements selling small employer health benefit plans in the state;

19 (2) "association" means the Small Employer Health Reinsurance Association
20 created in AS 21.55.010;

21 (3) "base premium rate" means

22 (A) as to a health benefit plan covering one or more employees of a small
23 employer, the lowest new business premium rate prescribed by the insurer or welfare
24 arrangement for the same or similar coverage under a plan or arrangement covering a
25 small employer with similar case characteristics; and

26 (B) as to an insurer or welfare arrangement not issuing a new health
27 benefit plan to a small employer, the lowest rate charged a small employer for the same
28 or similar coverage under a plan covering a small employer with similar case
29 characteristics;

30 (4) "board" means the board of directors of the association;

31 (5) "case characteristics" means with respect to a small employer, the geographic

1 area in which the employees reside, the age and sex of the individual employees and dependents,
2 the appropriate industry classification as determined by the insurer or welfare arrangement, or
3 other benefit arrangement, the number of employees and dependents and other objective criteria
4 as may be established by the insurer or welfare arrangement, or other benefit arrangement;

5 (6) "dependent" means the spouse or child of an eligible employee, subject to
6 applicable terms of the health benefit plan covering the employee;

7 (7) "eligible employee" means an employee who works on a full-time basis, with
8 a normal work week of 30 or more hours, and includes a sole proprietor, a partner of a
9 partnership or an independent contractor, provided the sole proprietor, partner, or contractor is
10 included as an employee under a health benefit plan of a small employer, but does not include
11 an employee who works on a part-time, temporary, or substitute basis;

12 (8) "financially impaired" means a member that is not insolvent but is

13 (A) determined by the director to be potentially unable to fulfill the
14 member's contractual obligations; or

15 (B) placed under an order of rehabilitation or conservation by a court of
16 competent jurisdiction;

17 (9) "guaranteed issue insurer" means an insurer that

18 (A) is one of the top 10 insurers based on total premium volume in the
19 small employer market as determined by the board; and

20 (B) an insurer that informs the board that the insurer wishes to become
21 a guaranteed issue insurer, except that an insurer wishing to become a guaranteed issue
22 insurer shall notify the board of the insurer's intention to become a guaranteed issue
23 insurer one year in advance of the insurer becoming a guaranteed issue insurer;

24 (10) "health benefit plan" means a hospital or medical expense policy, health,
25 hospital, or medical service corporation contract, a plan provided by an insurer or welfare
26 arrangement, and a health maintenance organization contract offered by an employer, but does
27 not include a policy covering only accident, credit, dental, disability income, long-term care,
28 hospital indemnity, Medicare supplement, specified disease, vision care, coverage issued as a
29 supplement to liability insurance, worker's compensation insurance, automobile medical payment
30 insurance, or insurance under which benefits are payable with or without regard to fault and that
31 is statutorily required to be contained in a liability insurance policy or equivalent self-insurance;

1 (11) "initial enrollment period" means the period of time specified in the health
2 benefit plan during which an individual is first eligible to enroll in a small employer health
3 benefit plan; the period of time may not be less than 30 days nor more than 60 days commencing
4 on the day following the end of a service waiting period required by the small employer of all
5 employees before the employees are eligible to participate in a small employer health benefit
6 plan;

7 (12) "insurer" has the meaning given in AS 21.90.900 and includes a health
8 maintenance organization, a hospital service corporation, and a medical service corporation;

9 (13) "late enrollee" means an eligible employee or dependent who requests
10 enrollment in a small employer's health benefit plan following the initial enrollment period
11 provided under the terms of the first plan for which the employee or dependent was eligible
12 through the small employer, except that an eligible employee or dependent may not be considered
13 a late enrollee if

14 (A) the individual

15 (i) was covered under another employer provided health benefit
16 plan at the time the individual was eligible to enroll;

17 (ii) states, at the time of the initial eligibility, that coverage under
18 another employer health benefit plan was the reason for declining enrollment;

19 (iii) has lost coverage under another employer health benefit plan
20 as a result of the termination of employment, the termination of the other plan's
21 coverage, death of a spouse, or divorce or dissolution of marriage; and

22 (iv) requests enrollment within 31 days after the termination of
23 coverage under another employer health benefit plan; or

24 (B) the individual is employed by an employer who offers multiple health
25 benefit plans and the individual elects a different health benefit plan during an open
26 enrollment period; or

27 (C) a court has ordered coverage to be provided for a spouse or minor
28 child under a covered employee's plan and request for enrollment is made within 31 days
29 after issuance of the court order;

30 (14) "member" means all insurers issuing health benefit plans, welfare
31 arrangements and, to the extent permitted under 29 U.S.C. 1001 - 1459 (Employee Retirement

1 Income Security Act), other benefit arrangements providing health benefit plans in this state;

2 (15) "midpoint rate" means for a small employer with similar case characteristics
3 and plan designs, as determined by the applicable insurer or welfare arrangement for a rating
4 period, the arithmetic average of the applicable base premium rate and the corresponding highest
5 premium rate;

6 (16) "other benefit arrangement" means a health benefit plan offered by a small
7 employer who is in whole, or in part, self-insured;

8 (17) "plan of operation" means the articles, bylaws, and operating rules of the
9 association adopted by the board;

10 (18) "preexisting conditions provision" means a policy provision that excludes or
11 limits coverage for charges or expenses incurred during a specified period following the insured's
12 effective date of coverage as to a condition that, during a specified period immediately preceding
13 the effective date of coverage, had manifested itself in a manner that would cause an ordinarily
14 prudent person to seek medical advice, diagnosis, care, or treatment, or for which medical advice,
15 diagnosis, care, or treatment was recommended or received and includes a pregnancy existing on
16 the effective date of coverage;

17 (19) "service waiting period" means a period of time after full-time employment
18 begins before an employee is first eligible to enroll in an applicable health benefit plan offered
19 by the small employer;

20 (20) "small employer" means a person, firm, corporation, partnership, or
21 association actively engaged in business whose total employed work force consisted of, on at
22 least 50 percent of its working days during the preceding year, more than two but not more than
23 25 eligible employees, the majority of whom are employed within the state; in determining the
24 number of eligible employees, companies that are affiliated companies or that are eligible to file
25 a combined tax return for purposes of federal taxation, are considered one employer; except as
26 otherwise specifically provided, provisions of this chapter that apply to a small employer that has
27 a health benefit plan continue to apply until the plan anniversary following the date the employer
28 no longer meets the requirements of this definition;

29 (21) "welfare arrangement" means a multiple employer welfare arrangement as
30 defined in 29 U.S.C. 1003, but does not include a multiple employer welfare arrangement that
31 is fully insured as provided in 26 U.S.C. 1060.

1 * Sec. 3. AS 21.86.260(a) is amended to read:

2 (a) Except as provided in AS 21.55 and in this chapter, this title does not apply to a
3 health maintenance organization that obtains a certificate of authority under this chapter. This
4 subsection does not apply to an insurer licensed under AS 21.09 or a hospital or medical service
5 corporation licensed under AS 21.87 except with respect to its health maintenance organization
6 activities authorized by and regulated under this chapter.

7 * Sec. 4. AS 21.87.340 is amended to read:

8 Sec. 21.87.340. OTHER PROVISIONS APPLICABLE. In addition to the provisions
9 contained or referred to previously in this chapter, the following chapters and provisions of this
10 title also apply with respect to service corporations to the extent applicable and not in conflict
11 with the express provisions of this chapter and the reasonable implications of the express
12 provisions, and for the purposes of the application the corporations shall be considered to be
13 mutual "insurers":

- 14 (1) AS 21.03
15 (2) AS 21.06
16 (3) AS 21.09, except AS 21.09.090
17 (4) AS 21.18.010
18 (5) AS 21.18.030
19 (6) AS 21.18.040
20 (7) AS 21.18.120
21 (8) AS 21.21.321
22 (9) AS 21.36
23 (10) AS 21.42.345 - 21.42.365
24 (11) AS 21.51.120
25 (12) AS 21.53
26 (13) AS 21.54.020
27 (14) AS 21.55
28 (15) AS 21.69.400
29 (16) [(15)] AS 21.69.520
30 (17) [(16)] AS 21.69.600, 21.69.620, and 21.69.630
31 (18) [(17)] AS 21.78

1 (19) [(18)] AS 21.89.040
2 (20) [(19)] AS 21.89.060
3 (21) [(20)] AS 21.90.

4 * Sec. 5. TRANSITION. Within 180 days after the board is organized under AS 21.55.020, enacted
5 in sec. 2 of this Act, the board of directors of the Small Employer Health Reinsurance Association shall
6 submit a small employer health benefit plan to the director of the division of insurance for approval.
7 Notwithstanding AS 21.55.120(a), enacted in sec. 2 of this Act, a guaranteed issue insurer is not required
8 to offer a small employer a health benefit plan until 60 days after the director of the division of
9 insurance has approved a small employer health benefit plan.

10 * Sec. 6. This Act takes effect July 1, 1991.