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CS FOR SPONSOR SUBSTITUTE FOR HOUSE BILL NO. 12(L&C)

IN THE LEGISLATURE OF THE STATE OF ALASKA

EIGHTEENTH LEGISLATURE - FIRST SESSION

BY THE HOUSE LABOR AND COMMERCE COMMITTEE

Offered: 4/8/93
Referred: Judiciary, Finance

Sponsor(s): REPRESENTATIVES B.DAVIS, Ulmer, Nordlund, Brice

A BILL

FOR AN ACT ENTITLED

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

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

*** Section 1.** PURPOSE. (a) The purpose of this Act is to

(1) promote the availability of health insurance coverage to small employers regardless of their health status or claims experience;

(2) prevent abusive rating practices;

(3) require disclosure of rating practices to purchasers;

(4) establish rules regarding renewability of coverage;

(5) establish limitations on the use of preexisting condition exclusions;

(6) provide for development of "basic" and "standard" health benefit plans to be offered to all small employers;

(7) provide for establishment of a reinsurance program; and

(8) improve the overall fairness and efficiency of the small group health

insurance market.

(b) It is not the purpose of this Act to shift the cost of providing health insurance to small employers, to other insured persons, or to the state.

* **Sec. 2.** AS 21.36 is amended by adding a new section to read:

Sec. 21.36.025. UNFAIR MARKETING PRACTICES PROHIBITED. A person may not violate the applicable provisions of AS 21.56.180.

* **Sec. 3.** AS 21.36.090(d) is amended to read:

(d) Except to the extent necessary to comply with AS 21.42.365 **and** AS 21.56, a person may not practice or permit unfair discrimination against a person who provides a service covered under a group disability policy that extends coverage on an expense incurred basis, or under a group service or indemnity type contract issued by a nonprofit corporation, if the service is within the scope of the provider's occupational license. In this subsection, "provider" means a state licensed physician, dentist, osteopath, optometrist, chiropractor, nurse midwife, advanced nurse practitioner, naturopath, physical therapist, occupational therapist, psychologist, psychological associate, or licensed clinical social worker.

* **Sec. 4.** AS 21.36.090(d) is repealed and reenacted to read:

(d) Except to the extent necessary to comply with AS 21.42.365, a person may not practice or permit unfair discrimination against a person who provides a service covered under a group disability policy that extends coverage on an expense incurred basis, or under a group service or indemnity type contract issued by a nonprofit corporation, if the service is within the scope of the provider's occupational license. In this subsection, "provider" means a state licensed physician, dentist, osteopath, optometrist, chiropractor, nurse midwife, advanced nurse practitioner, naturopath, physical therapist, occupational therapist, psychologist, psychological associate, or licensed clinical social worker.

* **Sec. 5.** AS 21 is amended by adding a new chapter to read:

CHAPTER 56. SMALL EMPLOYER HEALTH INSURANCE.

ARTICLE 1. SMALL EMPLOYER HEALTH REINSURANCE ASSOCIATION.

Sec. 21.56.010. CREATION; MEMBERSHIP. A nonprofit incorporated legal entity to be known as the Small Employer Health Reinsurance Association is

established. Membership consists of all insurers licensed to transact health insurance in the state that offer a health benefit plan. All members shall maintain membership in the association as a condition of doing health insurance business, or being able to offer subscriber contracts, in the state.

Sec. 21.56.020. BOARD OF DIRECTORS; ORGANIZATION. (a) The board of directors of the association consists of nine individuals selected by participating members, subject to approval by the director. The director shall endeavor to appoint at least six board members who are also small employer insurers. If the director is unable to appoint six board members who are also small employer insurers, the director may fill the remaining seats with any insurer. In selecting members of the board, the director shall consider, among other things, whether all types of participating members are fairly represented.

(b) To the extent possible, one board member shall represent a health maintenance organization, one board member shall represent a hospital or medical service corporation, one board members' principal health insurance business shall be in the small employer market, and one board member's principal health insurance business shall be in the large employer market. Members of the board may be reimbursed from the association for expenses incurred by them as members, but may not otherwise be compensated by the association for their services. The costs of conducting meetings of the association and its board of directors shall be borne by the association.

(c) A member of the board serves for a term of three years and may be reappointed to an unlimited number of terms. The term of a board member shall continue until a successor is appointed. A vacancy on the board shall be filled by participating members, subject to approval by the director. A board member may be removed by the director for cause.

Sec. 21.56.030. GENERAL POWERS. The association may

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

(2) sue or be sued;

(3) enter into contracts with insurers, similar associations in other

states, or with other persons for the performance of administrative functions;

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

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

(6) define the array of health coverage products for which reinsurance will be provided and issue reinsurance policies;

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

(8) establish actuarial functions appropriate to the operation of the association;

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

(10) appoint appropriate legal, actuarial, and other committees as are necessary to provide technical assistance in the operation of the association, design of a policy or contract, or to assist in other functions of the association;

(11) borrow money to accomplish the purposes of the association; notes or other evidence of indebtedness of the association that are not in default are investments for insurers and may be carried as admitted assets.

Sec. 21.56.040. PLAN OF OPERATION. (a) The association shall submit to the director a plan of operation and amendments necessary or suitable to assure the fair, reasonable, and equitable administration of the association. The director may, after notice and hearing, approve the plan of operation if the director determines it to be suitable to assure the fair, reasonable and equitable administration of the program on a proportionate basis under the provisions of this section and it does not shift program costs to other insured persons or the state. The plan of operation and amendments become effective upon approval in writing by the director.

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

(c) The plan of operation must establish procedures for

(1) handling and accounting of program assets and money of the association and for an annual fiscal report to the director;

(2) reinsuring risks under the provisions of this section;

(3) collecting assessments from all members to provide for claims reinsured by the association and for administrative expenses incurred or estimated to be incurred by the association;

(4) selection of an administering insurer and establish the administering insurer's powers and duties;

(5) effectuating a methodology for applying the dollar thresholds contained in this section for insurers that pay or reimburse health care providers by capitation or salary; and

(6) provisions necessary or proper for the execution of the powers and duties of the association.

Sec. 21.56.050. HEALTH CARE REINSURANCE. (a) A member may reinsure coverage of an eligible employee of a small employer or a dependent of an eligible employee of a small employer with the association only under the following provisions:

(1) regarding a small employer basic or standard health benefit plan, the association shall reinsure the level of coverage provided;

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

(3) a small employer insurer may reinsure an entire employer group within 60 days of the commencement of the group's coverage under a health benefit plan;

(4) a small employer insurer may reinsure an eligible employee or dependent within a period of 60 days following the commencement of the coverage with the small employer; a newly eligible employee or dependent of a reinsured small employer may be reinsured within 60 days of the commencement of coverage;

(5) the association may not reimburse a reinsuring insurer regarding the

claims of a reinsured employee or dependent until the insurer has paid an initial level of claims for the employee or dependent of $5,000 in a calendar year for benefits covered by the association;

(6) a small employer insurer may terminate reinsurance for one or more of the reinsured employees or dependents of a small employer on any plan anniversary.

(b) Premium rates charged for coverage reinsured by the association shall be established as required under (e) of this section and adjusted as follows:

(1) for whole group small employer reinsurance coverage, 1.5 multiplied by the base premium rate established by the association for eligible employees, and dependents of eligible employees, of a small employer all of whose coverage is reinsured with the association;

(2) for eligible employee or dependent reinsurance coverage, 5.0 multiplied by the base premium rate established by the association.

(c) If a health benefit plan coverage for a small employer is entirely or partially reinsured with the association, the premium charged to the small employer for a rating period for the coverage issued under this section shall meet the premium rate requirements established under AS 21.56.120.

(d) On or before March 1 of each year, the board shall determine and report to the director the association's net loss for the previous calendar year, including administrative expenses and incurred losses for the year, taking into account investment income and other appropriate gains and losses. A net loss for the year shall be recovered by assessments collected from reinsuring insurers. The board shall establish, as part of the plan of operation, a formula by which to make assessments against reinsuring insurers. The assessment formula must be based on each reinsuring insurer's share of the total premiums earned in the preceding calendar year from health benefit plans delivered or issued for delivery to small employers in this state by reinsuring carriers and each reinsuring insurer's share of the premiums earned in the preceding calendar year from newly issued health benefit plans delivered or issued for delivery during the calendar year to small employers in this state by reinsuring insurers. In determining an assessment, if any, that is collected from a member, the following provisions apply:

(1) the formula established under this subsection may not result in a reinsuring insurer having an assessment share that is less than 50 percent or more than 150 percent of an amount that is based on the proportion of the reinsuring insurer's total premiums earned in the preceding calendar year from health benefit plans delivered or issued for delivery to small employers in this state by reinsuring insurers to total premiums earned in the preceding calendar year from health benefit plans delivered or issued for delivery to small employers in this state by all reinsuring carriers;

(2) the board may, with approval of the director, change the assessment formula established under this section from time to time as appropriate; the board may provide for the shares of the assessment base attributable to premiums from all health benefit plans and to premiums from newly issued health benefit plans to vary during a transition period;

(3) subject to the approval of the director, the board shall make an adjustment to the assessment formula for reinsuring carriers that are approved health maintenance organizations that are federally qualified under 42 U.S.C. 300, to the extent, if any, that restrictions are imposed on those organizations that are not imposed on other small employer carriers;

(4) annually before March 1, the board shall determine and file with the director an estimate of the assessments needed to fund losses incurred by the association in the previous calendar year;

(5) if the board determines that the assessments needed to fund the losses incurred by the association in the previous calendar year will exceed five percent of total premiums earned in the previous year from health benefit plans delivered or issued for delivery to small employers in this state by reinsuring insurers, the board shall evaluate the operation of the program and report its findings, including any recommendations for changes to the plan of operation, to the director within 90 days following the end of the calendar year in which the losses were incurred; the evaluation must include an estimate of future assessments, the administrative costs of the program, the appropriateness of the premiums charged, and the level of insurer retention under the program and the costs of coverage for small employers; if the

board fails to file a report with the director within 90 days following the end of the applicable calendar year, the director may evaluate the operations of the program and implement amendments to the plan of operation the director determines necessary to reduce future losses and assessments;

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

(7) the board shall annually determine a member's proportion of participation in the association based on annual statements and other reports determined necessary by the board and filed by the member with the board; an insurer shall report to the board a claim payment made and administrative expense incurred in this state on a semi-annual basis on a form prescribed by the director;

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

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

(10) in the event an assessment against a member is deferred in whole or in part, the amount by which the assessment is deferred may be assessed against the other members in a manner consistent with the basis for assessments set out in this subsection; the member receiving a deferment shall remain liable to the association for the amount deferred; the director may attach conditions to a deferment; a member receiving a deferment may not reinsure an individual or group as provided under this section until the assessment is paid.

(e) The board, as part of the plan of operation, shall establish a methodology for determining premium rates to be charged by the program for reinsuring small employers and individuals under this section. The methodology must include a system for classification of small employers that reflects the types of case characteristics

commonly used by small employer insurers in the state. The methodology must provide for the development of base reinsurance premium rates that shall be multiplied by the factors set out in (b) of this section to determine the premium rates for the association. The base reinsurance premium rates shall be established by the board, subject to the approval of the director, and shall be set at levels that reasonably approximate gross premiums charged to small employers by small employer insurers for health benefit plans with benefits similar to the standard health benefit plan. The board shall review the methodology established under this subsection to ensure that the methodology reasonably reflects the claims experience of the program. Changes to the methodology may be proposed by the board, and are subject to approval by the director.

Sec. 21.56.060. HEALTH BENEFIT PLAN COMMITTEE. (a) The health benefit plan committee is established in the association. The committee is composed of seven members selected by the director as follows:

(1) three members who are representatives of participating insurers;

(2) one member who represents small employers;

(3) one member who represents employees of small employers; and

(4) one member who represents health care providers; and

(5) one member who represents agents or brokers.

(b) The committee shall recommend benefit levels, cost sharing levels, exclusions and limitations for the basic and standard health benefit plan offered under AS 21.56.140. The committee shall also design a basic health benefit plan and a standard health benefit plan that contain benefit and cost sharing levels that are consistent with the basic method of operation and the benefit plans of health maintenance organizations, including restrictions imposed by federal law. The plans recommended by the committee may include the following cost containment features:

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

(2) case management;

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

(4) reasonable benefit differentials applicable to providers that participate or do not participate in arrangements using restricted network provisions; and

(5) other managed care provisions.

Sec. 21.56.070. REQUIRED REPORT. The board shall study and report at least once every two years to the director and to the legislature on the effectiveness of this chapter. The report must analyze the effectiveness of the chapter in promoting rate stability, product availability, and coverage affordability. The report may contain recommendations for actions to improve the overall effectiveness, efficiency, and fairness of the small group health insurance marketplace. The report must address whether insurers, agents, brokers, managing general agents, and third-party administrators are fairly and actively marketing or issuing health benefit plans to small employers in fulfillment of the purposes of the chapter. The report may contain recommendations for market conduct or other regulatory standards or action.

Sec. 21.56.080. ADMINISTRATIVE PROCEDURE ACT. The association is exempt from AS 44.62 (Administrative Procedure Act).

Sec. 21.56.090. TAX EXEMPTION. The association is exempt from the payment of fees and taxes levied by the state or any of its political subdivisions except taxes levied on real or personal property.

Sec. 21.56.100. LIMITATION OF LIABILITY. A member of the association is not liable for civil damages resulting from an act or omission of the member on behalf of the association unless the member acts with gross negligence or intentional misconduct.

ARTICLE 2. SMALL EMPLOYER HEALTH INSURANCE PLANS.

Sec. 21.56.110. APPLICABILITY. (a) An individual or group health benefit plan is subject to the provisions of this chapter if the plan provides health care benefits covering employees of a small employer and if one of the following conditions are met:

(1) any portion of the premium or benefits is paid by a small employer;

(2) a covered individual or dependent is reimbursed, through wage adjustments or otherwise, by or on behalf of a small employer for all or a portion of

the premium; or

(3) the health benefit plan is treated by the employer or any of the eligible employees or dependents as part of a plan or program for the purposes of 26 U.S.C. 106 or 26 U.S.C. 162 (Internal Revenue Code).

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

(c) Except as provided in this subsection, for purposes of this chapter insurers that are affiliated companies or that are eligible to file a consolidated tax return shall be treated as one insurer and a restriction or limitation imposed under this chapter shall apply as if all health benefit plans delivered or issued for delivery to a small employer in this state by an affiliated insurer were issued by one insurer. An affiliated insurer that is a health maintenance organization having a certificate of authority under AS 21.86 may be considered to be a separate insurer for the purposes of this chapter.

(d) This chapter does not apply to a policy or certificate of insurance that covers a specified disease or to a hospital indemnity or limited benefit health insurance policy if the insurer offering the policy or certificate files with the director on or before March 1 of each year a statement that (1) certifies that the policy or certificate described in this subsection is being offered and marketed as supplemental health insurance and not as a substitute for hospital or medical expense insurance, or major medical expense insurance and (2) includes a summary description of each policy or certificate, including the average annual premium rate or range of rates, charged for the policy or certificate in this state. An insurer who offers a policy or certificate described in this subsection in this state for the first time shall provide the information described in this subsection not less than 30 days before the policy or certificate is issued or delivered in this state.

Sec. 21.56.120. PREMIUM RATE .RESTRICTIONS DISCLOSURES; REPORTS; CONFIDENTIALITY. (a) A premium rate for a health benefit plan subject to this chapter is subject to the following provisions:

(1) the premium rate charged or offered during a rating period to small employers with similar case characteristics as determined by the insurer for the same or similar coverage may not vary from the applicable index rate by more than 35 percent of the applicable index rate;

(2) regarding a health benefit plan issued before July 1, 1993, if premium rates charged or offered for the same or similar coverage under a health benefit plan covering a small employer with similar case characteristics as determined by the insurer exceeds the applicable index rate by more than 35 percent, an increase in premium rates for a new rating period may not exceed the sum of

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

(B) adjustments due to changes in case characteristics or plan design of the small employer, as determined by the insurer;

(3) the percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of the following:

(A) the percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period; in the case of a health benefit plan into which the small employer insurer is no longer enrolling new small employers, the small employer insurer shall use the percentage change in the base premium rate, provided that the change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan into which the small employer insurer is actively enrolling new small employers;

(B) any adjustment, not to exceed 15 percent annually and adjusted pro rata for rating periods of less than one year, due to the claim experience, health status, or duration of coverage of the employees or dependents of the small employer as determined from the small employer insurer's rate manual; and

(C) any adjustment due to change in coverage or change in the case characteristics of the small employer, as determined from the small

employer insurer's rate manual;

(4) adjustments in rates for claim experience, health status, and duration of coverage may not be charged to individual employees or dependents; any adjustment must be applied uniformly to the rates charged for all employees and dependents of the small employer;

(5) a premium rate for a health benefit plan shall comply with the requirements of this section notwithstanding an assessment paid or payable by small employer insurers under AS 21.56.050(d);

(6) a small employer insurer may utilize industry as a case characteristic in establishing premium rates, provided that the rate factor associated with an industry classification may not vary by more than 15 percent from the arithmetic average of the highest and lowest rate factors associated with all industry classifications;

(7) a small employer insurer shall

(A) apply rating factors, including case characteristics, consistently with respect to all small employers; rating factors must produce premiums for identical groups that differ only by amounts attributable to plan design and do not reflect differences due to the nature of the groups assumed to select particular health benefit plans; and

(B) treat all health benefit plans issued or renewed in the same calendar month as having the same rating period;

(8) for the purposes of this subsection, a health benefit plan that contains a restricted network provision may not be considered similar coverage to a health benefit plan that does not contain a restricted network provision, if the restriction of benefits to network providers results in substantial differences in claim costs;

(9) a small employer insurer may not use case characteristics, other than age, gender, industry, geographic area, family composition, and group size without prior approval of the director.

(b) In connection with the offering for sale of a health benefit plan to a small employer, a small employer insurer shall make a reasonable disclosure, as part of its

solicitation and sales materials, of the following:

(1) the extent that premium rates for a specified small employer are established or adjusted based upon the actual or expected variation in claims costs or actual or expected variation in health status of the employees of the small employer and their dependents; and

(2) the provisions of the health benefit plan

(A) concerning the small employer insurer's right to change premium rates and factors, other than claim experience, that affect changes in premium rates;

(B) relating to renewability of policies and contracts; and

(C) relating to any preexisting condition provision.

(c) A small employer insurer shall

(1) maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles;

(2) file with the director annually, on or before March 15, an actuarial certification certifying that the insurer is in compliance with this chapter and that the rating methods of the small employer insurer are actuarially sound; the certification shall be in a form and manner, and must contain information, as specified by the director; a copy of the certification shall be retained by the small employer insurer at its principal place of business;

(3) make the information and documentation described in (1) of this subsection available to the director upon request; the information is confidential and not subject to disclosure, except

(A) as agreed to by the small employer insurer;

(B) as ordered by a court of competent jurisdiction; or

(C) the director may use the information or other discovered information in a judicial or administrative proceeding.

(d) The director may adopt regulations to implement the provisions of this

section and to ensure that rating practices used by small employer insurers are consistent with the purposes of this act, including ensuring that differences in rates charged for health benefit plans by small employer insurers are reasonable and reflect objective differences in plan design, not including differences due to the nature of the groups assumed to select particular health benefit plans.

Sec. 21.56.130. RENEWABILITY OF COVERAGE. (a) A health benefit plan subject to this chapter shall be renewable with respect to all eligible employees and dependents at the option of the small employer, except for

(1) nonpayment of the required premiums;

(2) fraud or misrepresentation of the small employer or, with respect to coverage of individual insureds, the insureds or their representatives;

(3) noncompliance with the minimum participation or employer contribution requirements;

(4) repeated misuse of a provider network provision; or

(5) a small employer insurer who elects to nonrenew all of its health benefit plans delivered or issued for delivery to small employers in this state; an insurer who elects to nonrenew as described in this paragraph shall

(A) provide advance notice of the decision to the director and to the director or commissioner of insurance in each state in which the insurer is licensed; and

(B) provide notice of the decision not to renew coverage to all affected small employers and to the insurance regulatory office in each state in which an affected covered individual is known to reside at least 180 days before the nonrenewal of the health benefit plan by the insurer; notice to the director under this subparagraph shall be provided at least three working days before the notice to the affected small employers;

(6) a health benefit plan for which the director finds that the continuation of the coverage would

(A) not be in the best interests of the policyholders or certificate holders; or

(B) impair the insurer's ability to meet its contractual

obligations.

(b) A small employer insurer that elects not to renew a health benefit plan under (a)(5) of this section may not write new business in the small employer market in this state for a period of five years from the date of notice to the director.

(c) If a small employer insurer is doing business in only one established geographic service area of the state, the provisions in this section apply only to the insurer's operations in that established service area.

Sec. 21.56.140. REQUIRED OFFER OF COVERAGE. (a) Except as provided under AS 21.56.160, a small employer insurer shall, as a condition of transacting business in this state with small employers, offer to small employers at least two health benefit plans. One health benefit plan offered by a small employer insurer shall be a basic health benefit plan and one plan shall be a standard health benefit plan. A small employer insurer shall issue a basic health benefit plan or a standard health benefit plan to an eligible small employer that applies for either plan, agrees to make the required premium payments, and agrees to satisfy the other reasonable provisions of the health benefit plan not inconsistent with this chapter.

(b) A small employer insurer shall file with the director, under AS 21.42, the basic health benefit plans and the standard health benefit plans to be used by the insurer.

(c) The director at any time may, after providing notice and an opportunity for a hearing to a small employer insurer as provided under AS 21.06.180 - 21.06.210, disapprove the continued use by the small employer insurer of a basic or standard health benefit plan if the plan does not meet the requirements of this chapter.

Sec. 21.56.150. REQUIRED HEALTH BENEFIT PROVISIONS. A health benefit plan covering a small employer must include the following provisions:

(1) a health benefit plan may not deny, exclude, or limit benefits for a covered individual for losses incurred more than 12 months following the effective date of the individual's coverage due to a preexisting condition; a health benefit plan may not define a preexisting condition more restrictively than

(A) a condition that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment during the six

months immediately preceding the effective date of coverage;

(B) a condition for which medical advice, diagnosis, care, or treatment was recommended or received during the six months immediately preceding the effective date of coverage; or

(C) a pregnancy existing on the effective date of coverage;

(2) a small employer insurer must waive any time period applicable to a preexisting condition exclusion or limitation period with respect to particular services in a health benefit plan for the period of time an individual was previously covered by qualifying previous coverage that provided benefits with respect to the services, if the qualifying previous coverage was continuous to a date not more than 90 days before the effective date of the new coverage; the period of continuous coverage may not include a waiting period for the effective date of coverage applied by the employer or insurer; this paragraph does not preclude application of a waiting period applicable to all new enrollees under the health benefit plan;

(3) a health benefit plan may exclude coverage for late enrollees for the greater of 18 months or for an 18-month preexisting condition exclusion, provided that if both a period of exclusion from coverage and a preexisting condition exclusion are applicable to a late enrollee, the combined period may not exceed 18 months from the date the individual enrolls for coverage under the health benefit plan;

(4) requirements used by a small employer insurer in determining whether to provide coverage to a small employer shall be applied uniformly among all small employers with the same number of eligible employees applying for coverage or receiving coverage from the small employer insurer, except that a small employer insurer may vary application of minimum participation requirements and minimum employer contribution requirements by the size of the small employer group;

(5) a small employer insurer may not increase a requirement for minimum employee participation or a requirement for minimum employer contribution applicable to a small employer at any time after the small employer has been accepted for coverage, except as allowed under (4) of this section;

(6) if a small employer insurer offers coverage to a small employer, the small employer insurer shall offer coverage to all of the eligible employees of a small

employer and their dependents; a small employer insurer may not offer coverage to only certain individuals in a small employer group or to only part of the group, except in the case of late enrollees as provided in (3) of this section;

(7) except as provided in (1) and (3) of this section, a small employer insurer may not, by a rider or amendment applicable to a specific individual, restrict or exclude coverage or benefits by specific type of illness, treatment, medical condition or service, otherwise covered by the plan.

Sec. 21.56.160. EXEMPTION FROM REQUIRED OFFER OF COVERAGE. (a) A small employer insurer is not required to offer coverage or accept applications under AS 21.56.140(a)

(1) if the small employer is not physically located in the insurer's established geographic service area;

(2) if the employee does not work or reside within the insurer's established geographic service area;

(3) within an established geographic service area where the small employer insurer reasonably anticipates, and demonstrates to the satisfaction of the director, that it will not have the capacity to deliver service adequately to the members of the groups because of its obligations to existing group policyholders and enrollees;

(4) if the small employer insurer is only maintaining in-force business and has ceased enrolling new employer groups on or before January 1, 1993; this paragraph does not exempt a small employer insurer from the other provisions of this chapter; or

(5) if the certificate of authority or bylaws of the insurer do not permit the insurer to issue coverage on a marketwide basis; an insurer described in this subparagraph shall comply with AS 21.56.140 regarding small employers that meet the requirements of the insurer's certificate of authority or bylaws; this subparagraph does not apply to insurers who limit coverage based on health status or health risk.

(b) A small employer insurer that cannot offer coverage under (a)(3) of this section may not offer health insurance coverage in the applicable area to new cases of employer groups with more than 25 eligible employees or to small employer groups until the later of 180 days following each refusal or the date on which the insurer

notifies the director that it has regained capacity to deliver services to small employer groups.

(c) A small employer insurer may not be required to provide health insurance coverage to small employers for any period of time for which the director determines that requiring the acceptance of small employers would place the small employer insurer in a financially impaired condition.

Sec. 21.56.170. CONDITIONS FOR CEASING TO DO BUSINESS. A small employer insurer or a welfare arrangement may cease doing business in the small employer market if the insurer or welfare arrangement provides notice of the decision to cease doing business in the small employer market to the division, the board, the policyholder or contract holder, and the employer, and coverage under a health benefit plan subject to this chapter is continued for one year after the date of the notice required under this section. A small employer insurer or a welfare arrangement that ceases doing business in the small employer marketplace may not reenter the small employer marketplace for a period of five years from the date of the notice required under this section.

Sec. 21.56.180. FAIR MARKETING STANDARDS. (a) A small employer insurer shall actively market health benefit plan coverage, including the basic and standard health benefit plans, to eligible small employers in the state. If a small employer insurer denies coverage to a small employer on the basis of the health status or claims experience of the small employer or its employees or dependents, the small employer insurer shall offer the small employer the opportunity to purchase a basic health benefit plan and a standard health benefit plan.

(b) Except as provided in this subsection, a small employer insurer may not, directly or indirectly, encourage or direct small employers to refrain from filing an application for coverage with the small employer insurer because of the health status, claims experience, industry, occupation, or geographic location of the small employer, or encourage or direct small employers to seek coverage from another insurer because of the health status, claims experience, industry, occupation, or geographic location of the small employer. This subsection does not apply to information provided by a small employer insurer to a small employer regarding the established geographic

service area or a restricted network provision of a small employer insurer.

(c) Except as provided in this subsection, a small employer insurer may not, directly or indirectly, enter into a contract, agreement, or arrangement with an agent, broker, managing general agent, or third-party administrator that provides for or results in the compensation paid to an agent or broker for the sale of a health benefit plan to be varied because of the health status, claims experience, industry, occupation, or geographic location of the small employer. This subsection does not apply to a compensation arrangement that provides compensation to an agent, broker, managing general agent, or third-party administrator on the basis of a percentage of premium, provided that the percentage does not vary because of the health status, claims experience, industry, occupation, or geographic area of the small employer.

(d) A small employer insurer

(1) shall provide reasonable compensation, as provided under the plan of operation of the program, to an agent, broker, managing general agent, or third-party administrator, if any, for the sale of a basic or standard health benefit plan;

(2) or agent, broker, managing general agent, or third-party administrator may not induce or otherwise encourage a small employer to separate or otherwise exclude an employee from health coverage or benefits provided in connection with the employee's employment;

(3) may only deny an application for coverage from a small employer in writing and if the reasons for the denial are stated.

(e) The director may by regulation establish additional standards to provide for the fair marketing and broad availability of health benefit plans to small employers in this state.

(f) A violation of this section by a person is an unfair trade practice for purposes of AS 21.36.

(g) If a small employer insurer enters into a contract, agreement, or other arrangement with a third-party administrator to provide administrative, marketing, or other services related to the offering of health benefit plans to small employers in this state, the third-party administrator is subject to this section as if it were a small employer insurer.

Sec. 21.56.190. MANDATORY REISSUE OF COVERAGE. The director of the division of insurance may adopt regulations to require small employer insurers, as a condition of transacting business with small employers in this state after July 1, 1993, to reissue a health benefit plan to a small employer who has had its health benefit plan terminated or not renewed by the insurer after January 1, 1993. The director may prescribe the terms for the reissue of coverage that the director determines are reasonable and necessary to provide continuity of coverage to small employers.

Sec. 21.56.250. DEFINITIONS. In this chapter,

(1) "actuarial certification" means a written statement by a member of the American Academy of Actuaries or another individual acceptable to the director indicating that based on the person's examination, including a review of the appropriate records, actuarial assumptions, and methods used by the insurer in establishing premium rates for applicable health insurance plans that a small employer insurer is in compliance with the provisions of AS 21.56.120;

(2) "affiliate" or "affiliated" means a person who directly or indirectly, through one or more intermediaries, controls or is controlled by or is under common control with, a specified person;

(3) "association" means the Small Employer Health Reinsurance Association created in AS 21.56.010;

(4) "base premium rate" means the lowest premium rate charged or that could have been charged under the rating system by the small employer insurer to small employers with similar case characteristics for health benefit plans with the same or similar coverage;

(5) "basic health benefit plan" means a lower cost plan offered under AS 21.56.140;

(6) "board" means the board of directors of the association;

(7) "case characteristics" means demographic or other objective characteristics of a small employer that are considered by the small employer insurer in the determination of premium rates for the small employer, provided that claim experience, health status, and duration of coverage may not be case characteristics for

the purposes of this chapter;

(8) "committee" means the health benefit plan committee established in AS 21.56.060;

(9) "dependent" means the spouse or an unmarried child of an eligible employee who is not yet 19 years of age; an unmarried child who is a full-time student, who is not yet 23 years of age, and who is financially dependent upon the parent; and an unmarried child of any age who is medically certified as disabled and dependent upon the parent, subject to applicable terms of the health benefit plan covering the employee;

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

(11) "established geographic service area" means a geographic area within which the insurer is authorized to provide coverage under the insurer's certificate of authority as approved by the director;

(12) "health benefit plan" means a hospital or medical policy or certificate, major medical expense insurance, health, hospital, or medical service corporation contract, a plan provided by an insurer or welfare arrangement, and a health maintenance organization contract offered by an employer; "health benefit plan" does not include a policy covering only accident, credit, dental, disability income, long-term care, hospital indemnity, fixed indemnity, Medicare supplement, specified disease, vision care, coverage issued as a supplement to liability insurance, worker's compensation insurance, automobile medical payment insurance if the insurer complies with the provisions of AS 21.56.110(d), or a Taft-Hartley trust;

(13) "index rate" means for small employers with similar case characteristics and plan designs as determined by the insurer for a rating period, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate;

(14) "insurer" has the meaning given in AS 21.90.900 and includes a welfare arrangement, a fraternal benefit society, a health maintenance organization, a hospital service corporation, and a medical service corporation;

(15) "late enrollee" means an eligible employee or dependent who requests enrollment in a small employer's health benefit plan following the initial enrollment period for which the employee or dependent was eligible to enroll under the terms of the health benefit plan except that an eligible employee or dependent may not be considered a late enrollee if

(A) the individual

(i) was covered under qualifying previous coverage at the time of the initial enrollment;

(ii) has lost coverage under qualifying previous coverage as a result of the termination of employment or eligibility, the involuntary termination of the qualifying previous coverage, death of a spouse, or divorce or dissolution of marriage; and

(iii) requests enrollment within 30 days after the termination of the qualifying previous coverage; or

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

(C) a court has ordered coverage to be provided for a spouse or minor child under a covered employee's plan and request for enrollment is made within 30 days after issuance of the court order;

(16) "member" means all insurers issuing health benefit plans, welfare arrangements and, to the extent permitted under 29 U.S.C. 1001 - 1459 (Employee Retirement Income Security Act), other benefit arrangements providing health benefit plans in this state;

(17) "new business premium rate" means the lowest premium rate charged or offered, or that could have been charged or offered, by the small employer insurer to small employers with similar case characteristics for newly issued health benefit plans with the same or similar coverage;

(18) "plan of operation" means the plan of operation of the association adopted by the board under AS 21.56.040;

(19) "qualifying previous coverage" and "qualifying existing coverage" mean benefits or coverage provided under

(A) Medicare or Medicaid;

(B) an employer-based health insurance or health benefit arrangement that provides benefits similar to or exceeding benefits provided under the basic health benefit plan; or

(C) an individual health insurance policy, including coverage issued under AS 21.84, AS 21.86, or AS 21.87 that provides benefits similar to or exceeding the benefits provided under the basic health benefit plan, provided that the policy has been in effect for a period of at least one year;

(20) "rating period" means the calendar period for which premium rates established by a small employer insurer are assumed to be in effect;

(21) "reinsuring insurer" means a small employer insurer participating in the reinsurance association under AS 21.56.010;

(22) "restricted network provision" means a provision of a health benefit plan that conditions the payment of benefits, in whole or in part, on the use of health care providers that have entered into a contractual arrangement with the insurer under AS 21.86 to provide health care services to covered individuals;

(23) "small employer" means a person, firm, corporation, partnership, or association actively engaged in business whose total employed work force consisted of, on at least 50 percent of its working days during the preceding 12 months, at least two but not more than 25 eligible employees, the majority of whom are employed within the state; in determining the number of eligible employees, companies that are affiliated companies or that are eligible to file a combined tax return for purposes of federal taxation, are considered one employer; except as otherwise specifically provided, provisions of this chapter that apply to a small employer that has a health benefit plan continue to apply until the plan anniversary following the date the employer no longer meets the requirements of this definition;

(24) "small employer insurer" means an insurer that offers a health

benefit plan covering eligible employees of one or more small employers;

(25) "standard health benefit plan" means a health benefit plan developed under AS 21.56.140;

(26) "Taft-Hartley trust" means a jointly managed trust, as allowed by 29 U.S.C. 141 - 187, containing a plan of benefits for employees that is negotiated in a collective bargaining agreement governing wages, hours and working conditions of employees as allowed by 29 U.S.C. 157;

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

*** Sec. 6.** AS 21.86.260(a) is amended to read:

(a) Except as provided **in AS 21.56 and** in this chapter, this title does not apply to a health maintenance organization that obtains a certificate of authority under this chapter. This subsection does not apply to an insurer licensed under AS 21.09 or a hospital or medical service corporation licensed under AS 21.87 except with respect to its health maintenance organization activities authorized by and regulated under this chapter.

*** Sec. 7.** AS 21.86.260(a) is repealed and reenacted to read:

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

*** Sec. 8.** AS 21.87.340 is amended to read:

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

(1) AS 21.03

(2) AS 21.06

(3) AS 21.09, except AS 21.09.090

(4) AS 21.18.010

(5) AS 21.18.030

(6) AS 21.18.040

(7) AS 21.18.120

(8) AS 21.21.321

(9) AS 21.36

(10) AS 21.42.345 - 21.42.365, 21.42.375, 21.42.380, and 21.42.385

(11) AS 21.51.120

(12) AS 21.53

(13) AS 21.54.020

(14) **AS 21.56**

(15) AS 21.69.400

(16) [(15)] AS 21.69.520

(17) [(16)] AS 21.69.600, 21.69.620, and 21.69.630

(18) [(17)] AS 21.78

(19) [(18)] AS 21.89.040

(20) [(19)] AS 21.89.060

(21) [(20)] AS 21.90.

* **Sec. 9.** AS 21.87.340 is repealed and reenacted to read:

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

(1) AS 21.03

(2) AS 21.06

(3) AS 21.09, except AS 21.09.090

(4) AS 21.18.010

(5) AS 21.18.030

(6) AS 21.18.040

(7) AS 21.18.120

(8) AS 21.21.321

(9) AS 21.36

(10) AS 21.42.345 - 21.42.365, 21.42.375, 21.42.380, and 21.42.385

(11) AS 21.51.120

(12) AS 21.53

(13) AS 21.54.020

(14) AS 21.69.400

(15) AS 21.69.520

(16) AS 21.69.600, 21.69.620, and 21.69.630

(17) AS 21.78

(18) AS 21.89.040

(19) AS 21.89.060

(20) AS 21.90.

* **Sec. 10.** PREMIUM RATE RESTRICTION. Regarding a health benefit plan subject to AS 21.56.110(a), enacted in sec. 5 of this Act, that is delivered or issued for delivery before July 1, 1993, a premium rate for a rating period may exceed the ranges set out in AS 21.56.120(a)(1) and (2), enacted in sec. 5 of this Act, through June 30, 1996; on or after July 1, 1996, the premium rate may not exceed the ranges set out in AS 21.56.120(a)(1) and (2). However, through June 30, 1996, the percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of

(1) the percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period; in the case of a health benefit plan into which the small employer insurer is no longer enrolling new small employers, the small employer insurer shall use the percentage change in the base premium rate, provided that the change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan into which the small employer insurer is actively enrolling new small employers; and

(2) any adjustment due to change in coverage or change in the case

characteristics of the small employer, as determined from the insurer's rate manual.

*** Sec. 11. TRANSITION.** (a) Within 180 days after the board is appointed under AS 21.56.020, enacted in sec. 5 of this Act, the board of directors of the Small Employer Health Reinsurance Association shall submit a small employer health benefit plan to the director of the division of insurance for approval. If the association fails to submit a suitable plan of operation, the director may, after notice and hearing, adopt reasonable regulations necessary or advisable to effectuate the provisions of this chapter. These regulations continue in force until modified by the director or superseded by a plan submitted by the association and approved by the director.

(b) Notwithstanding AS 21.56.140(a), enacted in sec. 5 of this Act, a small employer insurer is not required to offer a small employer a basic or standard health benefit plan until 180 days after the director of the division of insurance has approved a basic and a standard small employer health benefit plan under AS 21.56.140, except that, if the Small Employer Health Reinsurance Association has not adopted a plan of operation, a small employer insurer is not required to offer a basic or standard health benefit plan until the date a plan of operation is adopted as provided under AS 21.56.040.

(c) By September 1, 1993, a small employer insurer shall file with the director the insurer's net insurance premium earned from health benefit plans delivered or issued for delivery to small employers in this state in the previous calendar year.

(d) The Health Benefit Plan Committee, enacted in sec. 5 of this Act, shall submit the required health benefit plans within 180 days after the members of the committee are appointed.

(e) Notwithstanding AS 21.56.070, enacted in sec. 5 of this Act, the board of directors of the Small Employer Health Reinsurance Association shall provide the report required under AS 21.56.070 to the director of the division of insurance annually until December 31, 1998.

*** Sec. 12.** AS 21.36.025 and AS 21.56 are repealed.

*** Sec. 13.** Sections 4, 7, 9, and 12 of this Act take effect July 1, 1997.

*** Sec. 14.** Except as provided in sec. 13 of this Act, this Act takes effect July 1, 1993.