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HOUSE BILL NO. 193

IN THE LEGISLATURE OF THE STATE OF ALASKA

EIGHTEENTH LEGISLATURE - FIRST SESSION

BY REPRESENTATIVE B.DAVIS

Introduced: 3/3/93
Referred: Health, Education & Social Services, Labor & Commerce, Judiciary, Finance

A BILL

FOR AN ACT ENTITLED

"An Act establishing the Alaska Health Care Authority; relating to the delivery, quality, access, and financing of health care; requiring the establishment of health care expenditure limits; relating to approval of disability insurance rates; relating to the issuance of certificates of need; 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 secs. 4 - 6 and 8 - 12 of this Act are 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 secs. 4 - 6 and 8 - 12 of this Act to shift the cost of providing health insurance to small employers, to other insured persons, or to the state.

(c) The purpose of secs. 2, 3, and 13 - 17 of this Act is to provide for the

(1) development of statewide health care expenditure limits, and access and quality goals;

(2) development of reimbursement schedules, utilization standards, and performance of other activities necessary to achieve expenditure limits developed under (1) of this section;

(3) establishment of reimbursement schedules, utilization standards, and other measures that may include increased utilization of managed care, increased utilization of alternatives to institutionalization, and procedures for the allocation and limitation of capital investment necessary to achieve the health care budget goals, while maintaining quality, and improving accessibility to health care;

(4) health care needs of certain children and pregnant women who are presently uninsured;

(5) preparation and submission to the legislature, and to the general public, of an annual report concerning the success in achieving the limits and goals established under (1) of this section, together with recommendations the authority considers appropriate to further the objectives of providing access to affordable, quality health care for all Alaskans;

(6) development of a single payer health care financing system;

(7) establishment of uniform billing and claim forms and mandatory reporting requirements to

(A) measure the success in meeting the limits and goals established under (1) of this section;

(B) permit the authority, to the extent practicable, to analyze data acquired under reporting requirements to assist purchasers and consumers in evaluating

the quality and cost of care offered by different providers; and

(C) reduce the administrative cost of the health care system;

(8) recommendation of reimbursement schedules, facility licensing standards, and other measures as appropriate and consistent with expenditure limits developed by the authority to ensure access to quality affordable health care under health insurance programs and programs under which the state provides or enters into contracts for the delivery of health care and to minimize cost-shifting;

(9) recommendation of ways to attract and retain qualified health care professionals in medically underserved areas of the state; recommendations may include forgiveness of student loans, in-state family practice residency programs, and recruitment of residents into health care professions;

(10) development of more flexible facility licensing standards that reflect the different needs of urban and rural areas of the state for health care facilities;

(11) development of a comprehensive long-term care health plan that integrates support services, that promotes human dignity, and that recognizes the individuality of all disabled persons;

(12) performance of studies, issuance of reports, and gathering of data to contribute to the objective of providing access to high quality affordable health care; and

(13) performance of any other activities determined to be necessary to further the goal of making available affordable, accessible, high quality health care in the state.

*** Sec. 2.** AS 18.07.035 is amended to read:

Sec. 18.07.035. APPLICATION AND FEES. Application for a certificate of need shall be made to the department upon a form provided by the department and must contain the information the department requires to reach a decision under AS 18.07.041 - 18.07.111. Each application for a certificate of need must be accompanied by an application fee established by the department by regulation. **A copy of each application for a certificate of need, except an application for a temporary or emergency certificate issued under AS 18.07.071, shall be provided to the Alaska Health Care Authority.**

*** Sec. 3.** AS 18.07.041 is amended to read:

Sec. 18.07.041. STANDARD OF REVIEW FOR APPLICATIONS FOR

CERTIFICATES OF NEED. The office shall grant a sponsor a certificate of need or modify a certificate of need if the availability and quality of existing health care resources or the accessibility to those resources is less than the current or projected requirement for health services required to maintain the good health of citizens of this state. **In determining the availability and quality of existing health care resources, the office shall consider the different needs of urban and rural areas of the state. A certificate of need may not be issued, except for a temporary or emergency certificate under AS 18.07.071, unless the office has received a determination from the Alaska Health Care Authority regarding the effect of the certificate of need on the cost of group health insurance.**

* **Sec. 4.** 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. 5.** 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. 6.** 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. 7.** AS 21.39.020 is amended to read:

Sec. 21.39.020. APPLICABILITY. (a) This chapter applies to all forms of **disability insurance and to** casualty insurance, including fidelity, surety, and guaranty bonds, to all forms of fire, marine, and inland marine insurance, and to a combination of any of them, or risks or operations in this state. Inland marine insurance includes insurance defined by statute, or by interpretation of statute, or if not defined or interpreted, by ruling of the director, or as established by general custom of the business, as inland marine insurance.

(b) This chapter does not apply to

(1) reinsurance, other than joint reinsurance to the extent stated in AS 21.39.110;

(2) [DISABILITY INSURANCE;

(3)] insurance of vessels or craft, their cargoes, marine builders' risks, marine protection and indemnity, or other risks commonly insured under marine, as distinguished from inland marine insurance policies;

(3) [(4)] insurance against loss of or damage to aircraft or against liability, other than workers' compensation and employer's liability, arising out of the ownership, maintenance, or use of aircraft; or, to insurance of hulls of aircraft, including their accessories and equipment.

* **Sec. 8.** 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; and

(5) 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 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) premiums and benefits paid by a reinsuring insurer that are less than an amount determined by the board to justify the cost of collection may not be considered for purposes of determining assessments;

(5) 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;

(6) 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;

(7) 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;

(8) 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;

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

(10) 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;

(11) 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.

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 between small employers in the same geographic region, except as provided in this subsection;

(2) premium rates for small employers in the same geographic region may be adjusted for differences in age, occupation, industry, or family composition, but the adjustments may not result in a premium rate greater than twice the lowest premium rate charged in that geographic region for the same or similar coverage;

(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 10 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 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;

(7) for the purposes of this subsection. a health benefit plan that utilizes a restricted provider network may not be considered similar coverage to a health benefit plan that does not utilize a restricted provider network;

(8) a small employer insurer may not use case characteristics, other than those specified under (a)(2) of this subsection; however, a small employer insurer may offer a premium discount for nonsmoking or participation in wellness programs.

(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 shall adopt regulations that establish geographic regions of the state for determining premium rates and may adopt regulations to ensure that rating practices used by small employer insurers are consistent with the purposes of this chapter 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 health benefit plan must waive any time period applicable to a preexisting condition exclusion or limitation period with respect to particular services for the period of time an individual was previously covered by qualifying previous coverage that provided benefits with respect to the services, provided that the qualifying previous coverage was continuous to a date not more than 30 days before the effective date of the new coverage; 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) a health benefit plan may not, by a rider or amendment applicable to a specific individual, restrict or exclude coverage by type of illness, treatment, medical condition, or accident, except for preexisting conditions as allowed under this section.

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; or

(4) 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 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 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) 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.

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

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

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

(6) "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;

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

(8) "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;

(9) "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;

(10) "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;

(11) "health benefit plan" means a hospital or medical expense policy, 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, but 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;

(12) "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;

(13) "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;

(14) "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;

(15) "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;

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

(17) "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;

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

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

(20) "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;

(21) "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;

(22) "small employer insurer" means an insurer that offers a health benefit plan covering eligible employees of one or more small employers;

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

(24) "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. 9.** AS 21.86.260(a) is amended to read:

(a) Except as provided <u>in AS 21.56 and</u> 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. 10.** 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. 11.** 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. 12.** 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. 13.** AS 24.20.206 is amended to read:

Sec. 24.20.206. DUTIES. The Legislative Budget and Audit Committee shall

(1) report to the legislature its recommendations relating to the confirmation of appointees to the Board of Trustees of the Alaska Permanent Fund Corporation;

(2) annually review the long-range operating plans of all agencies of the state which perform lending or investment functions;

(3) review periodic reports from all agencies of the state which perform lending or investment functions;

(4) present a complete report of investment programs, plans,

performance, and policies of all agencies of the state which perform lending or investment functions to the legislature within 30 days after the convening of each regular session;

(5) present to the legislature within 30 days after the convening of each regular session a review of the report of the governor under AS 37.07.020(d) with recommendations for needed legislation;

(6) in conjunction with the finance committee of each house recommend annually to the legislature the investment policy for the general fund surplus and for the income from the permanent fund;

(7) provide for an annual post audit and annual operational and performance evaluation of the Alaska Permanent Fund Corporation investments and investment programs;

(8) provide for an annual operational and performance evaluation of the Alaska Housing Finance Corporation and the Alaska Industrial Development and Export Authority; the performance evaluation shall include, but is not limited to, a comparison of the effect on various sectors of the economy by public and private lending, the effect on resident and nonresident employment, the effect on real wages, and the effect on state and local operating and capital budgets of the programs of the Alaska Housing Finance Corporation and the Alaska Industrial Development and Export Authority;

(9) provide assistance to the trustees of the trust established in AS 37.14.400 - 37.14.450 in carrying out their duties under AS 37.14.415; **(10) provide for an annual post audit and annual operational and performance evaluation of the Alaska Health Care Authority**.

*** Sec. 14.** AS 37.07.030 is amended to read:

Sec. 37.07.030. RESPONSIBILITIES OF THE LEGISLATURE. The legislature shall

(1) provide for a budget review function;

(2) analyze the comprehensive operating and capital improvements programs and financial plans recommended by the governor;

(3) adopt legislation to authorize implementation of the governor's

comprehensive operating and capital improvements programs and financial plans or appropriate alternatives to those plans;

(4) provide for a post-audit function to cover financial transactions, program accomplishment, and compliance with legislative intent;

(5) adopt or revise the estimate of receipts required to balance the succeeding fiscal year's budget in order that proposed expenditures do not exceed estimated receipts for that fiscal year;

(6) adopt, revise, or initiate revenue measures in order to balance the succeeding fiscal year's budget and the capital improvements section of the budget for the succeeding six years;

(7) appropriate funds for the operation of the Alaska Health Care Authority.

*** Sec. 15.** AS 39.25.110 is amended by adding a new paragraph to read:

(30) the executive director of the Alaska Health Care Authority.

*** Sec. 16.** AS 39.50.200(b) is amended by adding a new paragraph to read:

(55) Alaska Health Care Authority (AS 44.87).

*** Sec. 17.** AS 44 is amended by adding a new chapter to read:

CHAPTER 87. ALASKA HEALTH CARE AUTHORITY.

ARTICLE 1. CREATION, POWERS, AND ADMINISTRATION.

Sec. 44.87.010. AUTHORITY CREATED; PURPOSE. (a) The Alaska Health Care Authority is established. The authority is a public corporation and an instrumentality of the state within the Department of Administration but has a legal existence independent of and separate from the state.

(b) The purpose of the authority is to

(1) develop statewide health care expenditure limits, facility licensing standards, and access and quality goals;

(2) implement statewide health care expenditure limits through reimbursement schedules and utilization standards;

(3) develop a single payer health care financing system;

(4) develop a program to provide access to health care insurance or services for all residents of the state;

(5) administer the children's health care plan described in this chapter;

(6) develop a comprehensive long-term care health plan that integrates support services, that promotes human dignity, and that recognizes the individuality of all disabled persons; and

(7) where possible, coordinate the delivery, quality, access, and financing of health care in the state.

Sec. 44.87.020. BOARD OF DIRECTORS; ORGANIZATION. (a) The authority shall be managed by a board of directors composed of nine members appointed by the governor. In appointing members to the board, the governor shall ensure that

(1) the interests of health care providers and purchasers are fairly represented; and

(2) a majority of the board are experts in health care issues and fairly represent the interests of the general public in having access to quality and affordable health care.

(b) Members of the board serve staggered terms of four years. The board shall elect from its membership a president, vice-president, and secretary. Members of the board serve without compensation but are entitled to receive per diem and travel expenses authorized for boards and commissions under AS 39.20.180. Members of the board are subject to AS 39.50.

Sec. 44.87.030. GENERAL POWERS. The authority may

(1) exercise the powers granted to insurers under the laws of the state; if the authority acts as an insurer, the authority shall comply with the requirements applicable to insurers under AS 21;

(2) sue or be sued;

(3) enter into contracts or agreements;

(4) establish administrative or accounting procedures;

(5) collect, invest, and disburse funds;

(6) charge fees for providing administrative services;

(7) establish appropriate levels of reserves to cover the expenses of the authority;

(8) adopt necessary regulations and procedures for implementation of this chapter.

Sec. 44.87.040. DUTIES OF BOARD; ANNUAL REPORT. The board shall

(1) establish reimbursement schedules and utilization standards necessary to implement this chapter;

(2) develop uniform billing and common claims forms for health care providers and patients;

(3) develop a single payer health care financing system;

(4) in procuring or providing group health insurance allowed under this chapter, procure or provide comprehensive coverage at the lowest possible cost per participant;

(5) provide to the governor and to the legislature an annual report covering the previous fiscal year's activities of the authority;

(6) review each application for a certificate of need under AS 18.07.041 and within 60 days after receiving a copy of the application determine the effect of issuing the certificate on the cost of the group health insurance required under this chapter; a copy of the determination shall be provided to the office of planning and research in the Department of Health and Social Services;

(7) establish a grievance procedure to resolve disputes between the authority and health care providers or participants;

(8) every third fiscal year, include in the annual report a cost and benefit analysis of the activities of the authority;

(9) analyze the health care needs of the state population that is uninsured or underinsured;

(10) provide recommendations to the legislature on ways to attract and retain qualified health care professionals in medically underserved areas of the state;

(11) develop a comprehensive system to deliver long-term care to residents of the state and plan for the long-term care health needs of the state, including analysis of the scope of covered services, the availability, cost and financing of long-term care insurance, and the need to coordinate and integrate long-term care programs and delivery systems;

(12) provide recommendations to the legislature for a systematic approach or plan with alternatives including liabilities and financing alternatives that may be considered to assure access to affordable quality health care for all state residents; the recommendations must be updated each year.

Sec. 44.87.050. STAFF AND PROFESSIONAL SERVICES CONTRACTS. The authority shall employ an executive director who serves at the pleasure of the authority as its chief administrative officer. The executive director may, with the approval of the authority, select and employ additional staff as necessary. The executive director is in the exempt service under AS 39.25.110. Employees of the authority other than the executive director are in the classified service under AS 39.25.100. In addition to its staff of regular employees, the authority may contract for the services of consultants and professional, technical, and financial advisors the authority considers necessary for the purpose of developing information, conducting hearings, studies, investigations, or other proceedings, or otherwise exercising its powers.

ARTICLE 2. STATE HEALTH CARE PROGRAM.

Sec. 44.87.060. STATEWIDE HEALTH CARE DATA SYSTEM. (a) The authority shall develop and periodically update a data system that indicates the total amount expended on health care for residents of the state. To the extent practicable, the data system base year for health care expenditures shall be 1992 and must contain a separate expenditure breakdown for

(1) hospital services;

(2) physician services;

(3) laboratory services;

(4) pharmaceutical products;

(5) durable medical equipment; and

(6) other health services that the authority determines appropriate.

(b) In addition to the data collected under (a) of this section, the authority shall collect data on the following:

(1) the aging of the population and other factors that may affect the demand for health care in the future;

(2) general inflation factors and the costs related to inflation in labor and other inputs used to produce health services;

(3) technological advances that may increase or decrease health care costs;

(4) appropriate improvements in health care productivity;

(5) feasible reductions in unnecessary health care;

(6) the need to assure that all sectors of the population have adequate access to health care services;

(7) the effect and availability of statewide expenditure goals on the quality of health care; and

(8) other factors that the authority determines appropriate.

Sec. 44.87.070. STATEWIDE HEALTH CARE EXPENDITURE LIMITS. (a) The authority shall develop statewide health care budget and expenditure limits, based on the data obtained under AS 44.87.060. To the extent practicable, the base year for the statewide health care budget and expenditure limits shall be 1992.

(b) The authority shall annually adjust the health care expenditure limits developed under this section to reflect changes in the Consumer Price Index for all urban consumers for all items complied by the Bureau of Labor Statistics, United States Department of Labor, for the preceding calendar year. The annual index for 1992 is the reference base index.

(c) In developing expenditure limits applicable in a current year the authority shall adjust the expenditure limits for the following factors if these factors would affect the expenditure limits:

(1) changes in the size or demographic characteristics of the population of the state;

(2) changes in technology and health care delivery that may increase or decrease health care costs;

(3) reduction in unnecessary health care;

(4) access to adequate health care services;

(5) costs of medical malpractice insurance;

(6) administrative cost reduction; and

(7) other factors determined appropriate by the authority.

(d) Health care expenditure limits developed under this section must, to the extent practicable,

(1) include a separate expenditure limit for each health care service described under AS 44.87.060(a) and may include limits for other subcategories of health care services that the authority determines appropriate;

(2) be based on the following criteria as adjusted under (b) and (c) of this section:

(A) for hospitals and health care facilities, the limit must be based on actual costs in the base year;

(B) for health care providers other than hospitals and health care facilities, the limit must be based on the actual expenditures or payments in the base year;

(C) for other health care services not described in (A) or (B) of this paragraph, limits shall be developed as determined by the authority.

Sec. 44.87.080. REQUIRED HEALTH CARE PROVIDER NEGOTIATION. (a) The board shall convene representatives from each class of health care providers to negotiate recommendations for the reimbursement schedules required under AS 44.87.090. A recommendation may not be submitted to the board unless it meets the expenditure limits established under AS 44.87.070. The board shall adopt regulations to establish a good faith negotiating process.

(b) Negotiations required under (a) of this section

(1) shall be conducted annually, shall commence on or before January 1, and shall be completed on or before March 31 unless the board extends the time for completing the negotiation process;

(2) must include an attempt to agree on recommendations to be submitted to the board for reimbursement schedules required under AS 44.87.090;

(3) shall endeavor to recommend reimbursement schedules that, if implemented, will result in the achievement of the expenditure limits established under AS 44.87.070.

(c) Each health care provider class shall be responsible for providing a three-

person negotiating team to represent that class in negotiations required under this section. A negotiating team may not represent a class of health care providers unless the team presents a petition to the authority indicating that at least 50 percent of the health care providers in that class have consented to representation by that negotiating team. A petition required under this subsection shall be submitted annually on or before January 1.

(d) If a class of health care providers fails to select a negotiating team as required by this section, the board shall appoint a three-person negotiating team to represent health care providers in that class.

(e) A reimbursement schedule to which a majority of the negotiators agree shall be adopted by the board as provided under AS 44.87.090(b). If a majority of the negotiators fail to agree on a recommended reimbursement schedule, the board shall adopt regulations establishing reimbursement schedules required under AS 44.87.090.

Sec. 44.87.090. ESTABLISHMENT OF REIMBURSEMENT SCHEDULES. (a) Reimbursement schedules established by the authority shall use a base year of 1992 to the extent practicable, and incorporate the following criteria as adjusted by factors described in AS 44.87.070(b) and (c):

(1) for hospitals, the schedule shall be established to allow payment on a per discharge basis and utilize diagnosis related groups as the classification system; the schedule must reflect uncompensated care or payments received from public programs that are not sufficient to cover costs;

(2) for health care facilities other than hospitals, the schedule shall be based on the actual cost of the service in the base year;

(3) for physician services, the schedule must include a resource based relative value scale;

(4) for other health care services not described in (1) - (3) of this subsection, schedules shall be developed as determined by the authority.

(b) A reimbursement schedule established by the board must include the recommendations resulting from the negotiation process under AS 44.87.080, unless the negotiation process fails to result in recommendations or the authority determines that the recommendations would result in the violation of an expenditure limit

established under AS 44.87.070.

Sec. 44.87.100. MANDATORY HEALTH CARE PROVIDER COMPLIANCE. (a) All health care providers in the state shall comply with the expenditure limits established by the authority under AS 44.87.070 and the reimbursement schedules established by the board.

(b) A health care provider may not submit a charge for health care services that fails to comply with this section. A person receiving a charge that does not comply with (a) of this section may not be required to pay that portion of the charge that exceeds the reimbursement schedules established under AS 44.87.090.

Sec. 44.87.110. REQUIRED COOPERATION IN EXPENDITURE LIMIT AND GOAL DEVELOPMENT. When requested by the authority, a health care provider, insurer, or an agency of the state shall collect and provide information possessed by the health care provider, insurer, or agency, necessary to the development and revision of the health care expenditure, access, and quality goals established by the authority.

Sec. 44.87.120. PROCUREMENT OF INSURANCE. (a) The authority may procure and offer a policy or policies of comprehensive group health insurance to a resident or an employer that the authority determines does not have health insurance or for whom health insurance could be more cost effective if procured by the authority. Group health insurance may include coverage for eligible employees and dependents. The authority shall procure the insurance from an insurer authorized to transact business in the state under AS 21.09, or the authority may elect to act as a self-insurer if approved by the legislature and the authority complies with (d) of this section.

(b) The authority may establish a group health insurance pool or pools of eligible residents or employers that elect to participate in the group health insurance procured or provided by the authority. Coverage provided under this subsection must include eligible dependents of residents and employees.

(c) Except when acting as a self-insurer, the authority shall procure or provide group health insurance in compliance with the provisions of AS 36.30 and shall make available bid specifications for desired group health insurance benefits to all insurance carriers licensed in the state and qualified to provide the desired benefits. The

specifications shall be made available at least once every five years.

(d) Before the authority elects to act as a self-insurer, the authority shall solicit proposals for the required coverage from insurers licensed in this state to offer health insurance. If after the proposal process has been completed, the authority determines that the desired coverage or benefits are not available from insurers licensed in this state or the authority can provide the desired coverage and benefits at a lower cost per eligible person, the authority may submit a plan of the intended self-insurance coverage and benefits to the legislature. The authority may not begin acting as a self-insurer until the legislature has approved the self-insurance plan submitted by the authority.

ARTICLE 3. CHILDREN'S HEALTH CARE PROGRAM.

Sec. 44.87.130. CONTENTS OF PLAN. (a) The children's health care plan consists of the following medical services for children who are eligible under AS 44.87.140:

(1) routine examinations;

(2) diagnostic and screening services;

(3) immunizations and preventive services;

(4) laboratory and x-ray services;

(5) outpatient physician services;

(6) outpatient surgery;

(7) emergency room services;

(8) prescription lenses, eyeglass frames, and vision care;

(9) dental services, except orthodontics;

(10) prescription drugs; and

(11) other services, as approved by the board under (b) of this section.

(b) The board may, by regulations adopted under AS 44.62 (Administrative Procedure Act), determine the scope of the services listed in (a) of this section and add other categories of services for children that will be covered under the plan. A new category of service is not covered under the plan until an insurer agrees to cover it.

(c) The plan also includes prenatal services, delivery services, and at least three months of postnatal services for pregnant women. The board may, by regulations

adopted under AS 44.62 (Administrative Procedure Act), determine the scope of services covered under this subsection, including the duration of postnatal services beyond the minimum set under this subsection.

(d) In addition to the premium copayment required under AS 44.87.170, the board may require a copayment for a service, establish deductibles, set duration and usage limits, develop and implement procedures related to utilization review, and establish other reasonable conditions relating to the provision of services under (a) - (c) of this section to limit the cost of the plan's operation and to ensure the efficiency and efficacy of the services provided under the plan.

Sec. 44.87.140. ELIGIBILITY FOR THE PLAN. (a) A child is eligible for coverage under AS 44.87.130(a) and (b) if

(1) the child is under the age of 19 and has been a resident of the state for the 12 months immediately preceding application for plan coverage or, if the child is less than one year old, at least one of the child's parents has been a resident of the state for the 12 months immediately preceding application for plan coverage;

(2) the child does not have health care coverage under another public or private health insurance plan;

(3) the child's household income is below 300 percent of the income level established under AS 47.25.310 - 47.25.420 for eligibility for aid to families with dependent children;

(4) the child is not eligible for medical coverage under AS 47.07 (Medicaid); and

(5) a portion of the premium for plan coverage is paid on behalf of the child, as determined by the board under AS 44.87.170.

(b) A pregnant woman is eligible for coverage under AS 44.87.130(c) if

(1) the woman has been a resident of the state for the 12 months immediately preceding the woman's application for plan coverage;

(2) the woman does not have coverage for prenatal, delivery, or postnatal services under another public or private health insurance plan;

(3) the woman's income is below 300 percent of the income level established under AS 47.25.310 - 47.25.420 for eligibility for aid to families with

dependent children;

(4) the woman is not eligible for medical coverage under AS 47.07 (Medicaid); and

(5) a portion of the premium for plan coverage is paid on behalf of the woman, as determined by the board under AS 44.87.170.

Sec. 44.87.150. APPLICATION PROCESS. (a) A pregnant woman or the parent or guardian of a child may request an application packet for plan coverage by notifying the board directly or by completing the relevant section of the woman's or child's permanent fund dividend application form as provided under AS 43.23.017.

(b) Upon direct notification by an interested person or upon notification from the Department of Revenue of the name and mailing address of a person who has requested an application packet for the plan under (a) of this section, the board shall send an application packet to the person requesting it.

(c) An application packet sent under (b) of this section must include

(1) a description of the health care coverage available under the plan;

(2) a copy of the sliding fee schedule used by the board to determine the premium copayment responsibility and a description of deductibles and copayment requirements the board has established under AS 44.87.130(d);

(3) an explanation of the eligibility requirements for the plan; and

(4) an application form to be returned to the board if the person wants to apply for coverage personally or on behalf of an eligible child.

(d) Within 30 days after receiving a completed application for plan coverage, the board shall either notify the applicant about whether the plan coverage is approved or request additional information necessary to determine the eligibility. If the board determines that a pregnant woman or a child is eligible for the plan, the notification of eligibility sent under this subsection must include a determination of amount of the premium copayment required under AS 44.87.170.

(e) The board's denial or withdrawal of plan coverage may be appealed to the superior court.

Sec. 44.87.160. ADMINISTRATION OF PLAN. (a) The board shall administer the children's health care plan by

(1) soliciting and accepting funds from private sources for deposit into the fund created under AS 44.87.180; the board may also accept donations of services, supplies, personnel, and other in-kind donations;

(2) evaluating bids and purchasing insurance from one or more insurers to provide plan coverage;

(3) marketing the plan in a manner designed to make its existence known to pregnant women and the parents and guardians of children who may be eligible for the plan;

(4) evaluating applications for plan coverage and determining eligibility for plan coverage;

(5) determining the premium copayment that is required under AS 44.87.170.

(b) The board shall adopt regulations under AS 44.62 (Administrative Procedure Act) to implement this chapter.

Sec. 44.87.170. COPAYMENTS OF PREMIUMS. (a) Coverage under the plan is contingent upon copayment of part of the insurance premium, as determined by the board. The board shall adopt a sliding scale for copayments that takes into account the income and resources of the eligible person's household. The board shall determine whether two copayments are required when eligible children are in a household that includes a woman who is eligible because of pregnancy.

(b) The board, in cooperation with the Department of Revenue, shall adopt regulations under which a pregnant woman or a parent or guardian may request that a permanent fund dividend to which the woman or child is entitled be reduced by the Department of Revenue to provide the premium copayment for the women's or child's plan coverage.

(c) The authority shall deposit copayments received under this section into the general fund. The estimated annual balance in the account maintained by the commissioner of administration under AS 37.05.142 may be used by the legislature to make appropriations to the fund established under AS 44.87.180.

ARTICLE 4. GENERAL PROVISIONS.

Sec. 44.87.180. ALASKA HEALTH CARE FUND. The Alaska health care

fund is created in the general fund. The fund consists of money appropriated by the legislature. The fund shall be managed and invested by the board. The board may expend money from the fund to carry out the provisions of this chapter.

Sec. 44.87.190. INSURANCE PREMIUMS. The authority shall provide that sufficient funds are collected to provide authorized benefits, reserves, and to pay the expenses of the authority. Reserves remaining at the termination of an insurance contract shall be invested by the authority in the same manner as retirement funds are invested under AS 14.25.180.

Sec. 44.87.200. PUBLIC RECORDS; ADMINISTRATIVE PROCEDURES. The provisions of AS 09.25.110 - 09.25.120 apply to records of the authority, except for medical records that identify an individual. AS 44.62 (Administrative Procedure Act) applies to the authority.

Sec. 44.87.900. DEFINITIONS. In this chapter,

(1) "authority" means the Alaska Health Care Authority;

(2) "board" means the board of directors of the Alaska Health Care Authority;

(3) "class" means a group of health care providers who are practicing the same occupation or profession;

(4) "eligible employee" means an employee of a participant who qualifies for group health benefits as determined by the participant;

(5) "employer" means the state, a municipality, a district, a collective bargaining unit, the board of a public corporation of the state created within a principal executive department, a self-employed person, or a person employing one or more persons in a business or industry;

(6) "fund" means the Alaska health care fund;

(7) "group health insurance" means coverage that may include medical care and treatment, dental care, eye care, and other group health coverage as determined by the authority;

(8) "health care provider" means an acupuncturist licensed under AS 08.06; a chiropractor licensed under AS 08.20; a dental hygienist licensed under AS 08.32; a dentist licensed under AS 08.36; a marital or family therapist licensed

under AS 08.63; a nurse licensed under AS 08.68; a dispensing optician licensed under AS 08.71; an optometrist licensed under AS 08.72; a pharmacist licensed under AS 08.80; a physical therapist or occupational therapist licensed under AS 08.84; a physician licensed under AS 08.64; a podiatrist; a psychologist and a psychological associate licensed under AS 08.86; and a hospital as defined in AS 18.20.130, including a governmentally owned or operated hospital; and an employee of a health care provider acting within the course and scope of employment;

(9) "health care services" means services for medical or dental care or hospitalization, furnished for the purpose of alleviating, curing, or healing human illness, injury, or physical disability;

(10) "hospital" has the meaning given in AS 18.20.130;

(11) "insurer" has the meaning given in AS 21.90.900;

(12) "participant" means a person who participates in the group health insurance procured or provided by the authority;

(13) "reimbursement schedules" means a schedule or system that streamlines or results in cost efficient payments to health care providers, and includes a schedule of maximum allowable reimbursement for health care services;

(14) "resident" means a person who is eligible for a permanent fund dividend under AS 43.23.005;

(15) "state" means the executive, legislative, and judicial branches of state government, and includes the University of Alaska and a public corporation of the state created within a principal executive department;

(16) "utilization standards" means a system to monitor, track, and verify patterns of treatment by health care providers and to develop utilization review criteria, that assures that cost efficient and cost effective care is provided within accepted medical standards without reducing the quality of care.

* **Sec. 18.** REPORT. The Alaska Health Care Authority shall report to the Alaska State Legislature

(1) by January 1, 1994, on the progress made by the authority in establishing a single payer health care financing system;

(2) by March 1, 1994, on the progress made by the authority in establishing

a health care provider reimbursement systems and utilization standards; and

(3) by January 1, 1996, on the progress made by the authority in developing a comprehensive system to deliver long-term care to residents of the state.

* Sec. 19. PHASED TRANSITION PERIOD. (a) Notwithstanding the provisions of AS 44.87, the Alaska Health Care Authority shall implement the provisions of AS 44.87 on an orderly and gradual basis as follows:

(1) by July 1, 1994, the authority shall finish collecting data required under AS 44.87.060;

(2) by January 1, 1995, the authority shall implement a single payer health care financing system;

(3) by July 1, 1995, the authority shall complete the statewide health care expenditure budget and reimbursement schedules described in AS 44.87.070 and 44.87.090;

(4) by July 1, 1996, the authority shall implement for hospitals the expenditure limits established under AS 44.87.070 and the reimbursement schedules and utilization standards required under AS 44.87.040(1);

(5) by January 1, 1997, the authority shall implement the

(A) expenditure limits established under AS 44.87.070 and the reimbursement schedules and utilization standards required under AS 44.87.040(1) for health care providers;

(B) the long-term care health plan required under AS 44.87.070(11); and

(C) uniform billing and common claims forms required under AS 44.87.040(2).

(b) In this section, "health care provider" and "hospital" have the meaning given in AS 44.87.900, enacted in sec. 17 of this Act.

* Sec. 20. PREMIUM RATE TRANSITION PERIOD. Regarding a health benefit plan subject to AS 21.56.110, enacted in sec. 8 of this Act, 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. 8 of this Act, through June 30, 1996; on or after July 1, 1996, the premium rate shall meet the requirements set out in AS 21.56.120(a)(1) and (2), enacted in sec. 8 of this Act. However, through June 30, 1996, the premium rate 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

(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 due to change in coverage or change in the case characteristics of the small employer, as determined from the insurer's rate manual; and

(C) 10 percent of the premium rate charged in the prior rating period.

*** Sec. 21.** TRANSITION. (a) Within 180 days after the board is appointed under AS 21.56.020, enacted in sec. 8 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. 8 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. 8 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. 8 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. 22.** AS 21.36.025 and AS 21.56 are repealed.

*** Sec. 23.** (a) This Act takes effect only if an Act requiring that a civil action against a health care provider by a person less than two years of age be brought before the claimant's eighth birthday, allowing prejudgment interest on a medical malpractice judgment to bear interest at the prevailing federal discount rate, requiring mandatory arbitration in medical malpractice actions, and changing the expert advisory panel in a medical malpractice action from three persons to one person, is passed by the Eighteenth Alaska State Legislature during its First Regular Session and is signed into law by the governor.

(b) If the condition described in (a) of this section is fulfilled

(1) secs. 6, 10, 12, and 22 of this Act take effect July 1, 1997;

(2) AS 44.87.080, enacted in sec. 17 of this Act, takes effect January 1, 1996;

(3) AS 44.87.100, enacted in sec. 17 of this Act, takes effect January 1, 1997;

(4) except as provided in (1) - (3) of this subsection, this Act takes effect on the date the Act described in (a) of this section takes effect.