

**SPONSOR SUBSTITUTE FOR SENATE BILL NO. 114**

**IN THE LEGISLATURE OF THE STATE OF ALASKA**

**EIGHTEENTH LEGISLATURE - FIRST SESSION**

**BY SENATORS DUNCAN, Ellis, Donley**

**Introduced: 3/2/93**

**Referred: HES, L&C, JUD, FIN**

**A BILL**

**FOR AN ACT ENTITLED**

1 "An Act establishing the Alaska Health Care Authority; relating to the delivery,  
2 quality, access, and financing of health care; requiring the establishment of health  
3 care expenditure limits; relating to approval of disability insurance rates; relating  
4 to the issuance of certificates of need; relating to health insurance for small  
5 employers; and providing for an effective date."

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

7 \* Section 1. PURPOSE. (a) The purpose of secs. 4 - 6 and 8 - 12 of this Act are to

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

10 (2) prevent abusive rating practices;

11 (3) require disclosure of rating practices to purchasers;

12 (4) establish rules regarding renewability of coverage;

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

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

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

4 (8) improve the overall fairness and efficiency of the small group health  
5 insurance market.

6 (b) It is not the purpose of secs. 4 - 6 and 8 - 12 of this Act to shift the cost of  
7 providing health insurance to small employers, to other insured persons, or to the state.

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

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

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

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

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

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

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

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

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

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

- 1 the quality and cost of care offered by different providers; and
- 2 (C) reduce the administrative cost of the health care system;
- 3 (8) recommendation of reimbursement schedules, facility licensing standards,
- 4 and other measures as appropriate and consistent with expenditure limits developed by the
- 5 authority to ensure access to quality affordable health care under health insurance programs
- 6 and programs under which the state provides or enters into contracts for the delivery of health
- 7 care and to minimize cost-shifting;
- 8 (9) recommendation of ways to attract and retain qualified health care
- 9 professionals in medically underserved areas of the state; recommendations may include
- 10 forgiveness of student loans, in-state family practice residency programs, and recruitment of
- 11 residents into health care professions;
- 12 (10) development of more flexible facility licensing standards that reflect the
- 13 different needs of urban and rural areas of the state for health care facilities;
- 14 (11) development of a comprehensive long-term care health plan that integrates
- 15 support services, that promotes human dignity, and that recognizes the individuality of all
- 16 disabled persons;
- 17 (12) performance of studies, issuance of reports, and gathering of data to
- 18 contribute to the objective of providing access to high quality affordable health care; and
- 19 (13) performance of any other activities determined to be necessary to further
- 20 the goal of making available affordable, accessible, high quality health care in the state.

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

22 Sec. 18.07.035. APPLICATION AND FEES. Application for a certificate of

23 need shall be made to the department upon a form provided by the department and

24 must contain the information the department requires to reach a decision under

25 AS 18.07.041 - 18.07.111. Each application for a certificate of need must be

26 accompanied by an application fee established by the department by regulation. **A**

27 **copy of each application for a certificate of need, except an application for a**

28 **temporary or emergency certificate issued under AS 18.07.071, shall be provided**

29 **to the Alaska Health Care Authority.**

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

31 Sec. 18.07.041. STANDARD OF REVIEW FOR APPLICATIONS FOR

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

11 \* Sec. 4. AS 21.36 is amended by adding a new section to read:

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

14 \* Sec. 5. AS 21.36.090(d) is amended to read:

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

24 \* Sec. 6. AS 21.36.090(d) is repealed and reenacted to read:

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

1 physical therapist, occupational therapist, psychologist, psychological associate, or  
2 licensed clinical social worker.

3 \* Sec. 7. AS 21.39.020 is amended to read:

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

11 (b) This chapter does not apply to

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

14 (2) [DISABILITY INSURANCE;

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

18 (3) [(4)] insurance against loss of or damage to aircraft or against  
19 liability, other than workers' compensation and employer's liability, arising out of the  
20 ownership, maintenance, or use of aircraft; or, to insurance of hulls of aircraft,  
21 including their accessories and equipment.

22 \* Sec. 8. AS 21 is amended by adding a new chapter to read:

23 CHAPTER 56. SMALL EMPLOYER HEALTH INSURANCE.

24 ARTICLE 1. SMALL EMPLOYER HEALTH REINSURANCE ASSOCIATION.

25 Sec. 21.56.010. **CREATION; MEMBERSHIP.** A nonprofit incorporated legal  
26 entity to be known as the Small Employer Health Reinsurance Association is  
27 established. Membership consists of all insurers licensed to transact health insurance  
28 in the state that offer a health benefit plan. All members shall maintain membership  
29 in the association as a condition of doing health insurance business, or being able to  
30 offer subscriber contracts, in the state.

31 Sec. 21.56.020. **BOARD OF DIRECTORS; ORGANIZATION.** (a) The board

1 of directors of the association consists of nine individuals selected by participating  
2 members, subject to approval by the director. The director shall endeavor to appoint  
3 at least six board members who are also small employer insurers. If the director is  
4 unable to appoint six board members who are also small employer insurers, the  
5 director may fill the remaining seats with any insurer. In selecting members of the  
6 board, the director shall consider, among other things, whether all types of  
7 participating members are fairly represented.

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

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

22 Sec. 21.56.030. GENERAL POWERS. The association may

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

25 (2) sue or be sued;

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

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

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

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

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

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

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

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

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

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

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

26 (c) The plan of operation must establish procedures for

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

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

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

- 1 be incurred by the association;
- 2 (4) selection of an administering insurer and establish the administering
- 3 insurer's powers and duties; and
- 4 (5) provisions necessary or proper for the execution of the powers and
- 5 duties of the association.

6 Sec. 21.56.050. HEALTH CARE REINSURANCE. (a) A member may

7 reinsure coverage of an eligible employee of a small employer or a dependent of an

8 eligible employee of a small employer with the association only under the following

9 provisions:

10 (1) regarding a small employer basic or standard health benefit plan,

11 the association shall reinsure the level of coverage provided;

12 (2) regarding a plan other than a small employer health benefit plan,

13 the association shall reinsure the level of coverage provided up to, but not exceeding,

14 the level of coverage provided in a small employer basic or standard health benefit

15 plan;

16 (3) a small employer insurer may reinsure an entire employer group

17 within 60 days of the commencement of the group's coverage under a health benefit

18 plan;

19 (4) a small employer insurer may reinsure an eligible employee or

20 dependent within a period of 60 days following the commencement of the coverage

21 with the small employer; a newly eligible employee or dependent of a reinsured small

22 employer may be reinsured within 60 days of the commencement of coverage;

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

24 claims of a reinsured employee or dependent until the insurer has paid an initial level

25 of claims for the employee or dependent of \$5,000 in a calendar year for benefits

26 covered by the association;

27 (6) a small employer insurer may terminate reinsurance for one or more

28 of the reinsured employees or dependents of a small employer on any plan anniversary.

29 (b) Premium rates charged for coverage reinsured by the association shall be

30 established as required under (e) of this section and adjusted as follows:

31 (1) for whole group small employer reinsurance coverage, 1.5

1 multiplied by the base premium rate established by the association for eligible  
2 employees, and dependents of eligible employees, of a small employer all of whose  
3 coverage is reinsured with the association;

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

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

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

24 (1) the formula established under this subsection may not result in a  
25 reinsuring insurer having an assessment share that is less than 50 percent or more than  
26 150 percent of an amount that is based on the proportion of the reinsuring insurer's  
27 total premiums earned in the preceding calendar year from health benefit plans  
28 delivered or issued for delivery to small employers in this state by reinsuring insurers  
29 to total premiums earned in the preceding calendar year from health benefit plans  
30 delivered or issued for delivery to small employers in this state by all reinsuring  
31 carriers;

- 1                   (2) the board may, with approval of the director, change the assessment
- 2 formula established under this section from time to time as appropriate; the board may
- 3 provide for the shares of the assessment base attributable to premiums from all health
- 4 benefit plans and to premiums from newly issued health benefit plans to vary during
- 5 a transition period;
- 6                   (3) subject to the approval of the director, the board shall make an
- 7 adjustment to the assessment formula for reinsuring carriers that are approved health
- 8 maintenance organizations that are federally qualified under 42 U.S.C. 300, to the
- 9 extent, if any, that restrictions are imposed on those organizations that are not imposed
- 10 on other small employer carriers;
- 11                   (4) premiums and benefits paid by a reinsuring insurer that are less than
- 12 an amount determined by the board to justify the cost of collection may not be
- 13 considered for purposes of determining assessments;
- 14                   (5) annually before March 1, the board shall determine and file with
- 15 the director an estimate of the assessments needed to fund losses incurred by the
- 16 association in the previous calendar year;
- 17                   (6) if the board determines that the assessments needed to fund the
- 18 losses incurred by the association in the previous calendar year will exceed five
- 19 percent of total premiums earned in the previous year from health benefit plans
- 20 delivered or issued for delivery to small employers in this state by reinsuring insurers,
- 21 the board shall evaluate the operation of the program and report its findings, including
- 22 any recommendations for changes to the plan of operation, to the director within 90
- 23 days following the end of the calendar year in which the losses were incurred; the
- 24 evaluation must include an estimate of future assessments, the administrative costs of
- 25 the program, the appropriateness of the premiums charged, and the level of insurer
- 26 retention under the program and the costs of coverage for small employers; if the
- 27 board fails to file a report with the director within 90 days following the end of the
- 28 applicable calendar year, the director may evaluate the operations of the program and
- 29 implement amendments to the plan of operation the director determines necessary to
- 30 reduce future losses and assessments;
- 31                   (7) if assessments exceed net losses of the association, the excess shall

1 be held in an interest bearing account and used by the board to offset future losses or  
2 to reduce association premiums; in this paragraph, "future losses" include a reserve for  
3 incurred but not reported claims;

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

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

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

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

23 (e) The board, as part of the plan of operation, shall establish a methodology  
24 for determining premium rates to be charged by the program for reinsuring small  
25 employers and individuals under this section. The methodology must include a system  
26 for classification of small employers that reflects the types of case characteristics  
27 commonly used by small employer insurers in the state. The methodology must  
28 provide for the development of base reinsurance premium rates that shall be multiplied  
29 by the factors set out in (b) of this section to determine the premium rates for the  
30 association. The base reinsurance premium rates shall be established by the board,  
31 subject to the approval of the director, and shall be set at levels that reasonably

1 approximate gross premiums charged to small employers by small employer insurers  
2 for health benefit plans with benefits similar to the standard health benefit plan. The  
3 board shall review the methodology established under this subsection to ensure that the  
4 methodology reasonably reflects the claims experience of the program. Changes to the  
5 methodology may be proposed by the board, and are subject to approval by the  
6 director.

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

- 10 (1) three members who are representatives of participating insurers;
- 11 (2) one member who represents small employers;
- 12 (3) one member who represents employees of small employers; and
- 13 (4) one member who represents health care providers; and
- 14 (5) one member who represents agents or brokers.

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

- 22 (1) utilization review of health care services, including review of the  
23 medical necessity of hospital and physician services;
- 24 (2) case management;
- 25 (3) selective contracting with hospitals, physicians, and other health  
26 care providers;
- 27 (4) reasonable benefit differentials applicable to providers that  
28 participate or do not participate in arrangements using restricted network provisions;  
29 and
- 30 (5) other managed care provisions.

31 **Sec. 21.56.070. REQUIRED REPORT.** The board shall study and report at

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

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

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

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

19 ARTICLE 2. SMALL EMPLOYER HEALTH INSURANCE PLANS.

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

24 (1) any portion of the premium or benefits is paid by a small employer;  
25 (2) a covered individual or dependent is reimbursed, through wage  
26 adjustments or otherwise, by or on behalf of a small employer for all or a portion of  
27 the premium; or

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

31 (b) Except as provided in this chapter, other provisions of law requiring the

1 coverage or the offer of coverage of a health care service or benefit and other  
2 provisions of law requiring the reimbursement, utilization, or consideration of a  
3 specific category of a licensed or certified health care practitioner do not apply to a  
4 health benefit plan offered or delivered to a small employer.

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

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

15 (1) the premium rate charged or offered during a rating period to small  
16 employers with similar case characteristics as determined by the insurer for the same  
17 or similar coverage may not vary between small employers in the same geographic  
18 region, except as provided in this subsection;

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

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

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

1 which the small employer insurer is actively enrolling new small employers;  
2 (B) any adjustment, not to exceed 10 percent annually and  
3 adjusted pro rata for rating periods of less than one year, due to the claim  
4 experience, health status, or duration of coverage of the employees or  
5 dependents of the small employer as determined from the small employer  
6 insurer's rate manual; and

7 (C) any adjustment due to change in coverage or change in the  
8 case characteristics of the small employer, as determined from the small  
9 employer insurer's rate manual;

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

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

17 (6) a small employer insurer shall

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

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

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

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

31 (b) In connection with the offering for sale of a health benefit plan to a small

1 employer, a small employer insurer shall make a reasonable disclosure, as part of its  
2 solicitation and sales materials, of the following:

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

7 (2) the provisions of the health benefit plan

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

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

12 (C) relating to any preexisting condition provision.

13 (c) A small employer insurer shall

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

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

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

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

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

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

1 (d) The director shall adopt regulations that establish geographic regions of the  
2 state for determining premium rates and may adopt regulations to ensure that rating  
3 practices used by small employer insurers are consistent with the purposes of this  
4 chapter including ensuring that differences in rates charged for health benefit plans by  
5 small employer insurers are reasonable and reflect objective differences in plan design,  
6 not including differences due to the nature of the groups assumed to select particular  
7 health benefit plans.

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

11 (1) nonpayment of the required premiums;

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

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

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

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

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

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

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

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

1 holders; or  
2 (B) impair the insurer's ability to meet its contractual  
3 obligations.

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

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

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

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

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

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

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

1 (A) a condition that would have caused an ordinarily prudent  
2 person to seek medical advice, diagnosis, care, or treatment during the six  
3 months immediately preceding the effective date of coverage;

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

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

8 (2) a health benefit plan must waive any time period applicable to a  
9 preexisting condition exclusion or limitation period with respect to particular services  
10 for the period of time an individual was previously covered by qualifying previous  
11 coverage that provided benefits with respect to the services, provided that the  
12 qualifying previous coverage was continuous to a date not more than 30 days before  
13 the effective date of the new coverage; this paragraph does not preclude application  
14 of a waiting period applicable to all new enrollees under the health benefit plan;

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

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

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

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

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

4 (7) a health benefit plan may not, by a rider or amendment applicable  
5 to a specific individual, restrict or exclude coverage by type of illness, treatment,  
6 medical condition, or accident, except for preexisting conditions as allowed under this  
7 section.

8 **Sec. 21.56.160. EXEMPTION FROM REQUIRED OFFER OF COVERAGE.**

9 (a) A small employer insurer is not required to offer coverage or accept applications  
10 under AS 21.56.140(a)

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

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

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

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

25 (b) A small employer insurer that cannot offer coverage under (a)(3) of this  
26 section may not offer coverage in the applicable area to new cases of employer groups  
27 with more than 25 eligible employees or to small employer groups until the later of  
28 180 days following each refusal or the date on which the insurer notifies the director  
29 that it has regained capacity to deliver services to small employer groups.

30 (c) A small employer insurer may not be required to provide coverage to small  
31 employers for any period of time for which the director determines that requiring the

1 acceptance of small employers would place the small employer insurer in a financially  
2 impaired condition.

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

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

20 (b) Except as provided in this subsection, a small employer insurer may not,  
21 directly or indirectly, encourage or direct small employers to refrain from filing an  
22 application for coverage with the small employer insurer because of the health status,  
23 claims experience, industry, occupation, or geographic location of the small employer,  
24 or encourage or direct small employers to seek coverage from another insurer because  
25 of the health status, claims experience, industry, occupation, or geographic location of  
26 the small employer. This subsection does not apply to information provided by a  
27 small employer insurer to a small employer regarding the established geographic  
28 service area or a restricted network provision of a small employer insurer.

29 (c) Except as provided in this subsection, a small employer insurer may not,  
30 directly or indirectly, enter into a contract, agreement, or arrangement with an agent,  
31 broker, managing general agent, or third-party administrator that provides for or results

1 in the compensation paid to an agent or broker for the sale of a health benefit plan to  
2 be varied because of the health status, claims experience, industry, occupation, or  
3 geographic location of the small employer. This subsection does not apply to a  
4 compensation arrangement that provides compensation to an agent, broker, managing  
5 general agent, or third-party administrator on the basis of a percentage of premium,  
6 provided that the percentage does not vary because of the health status, claims  
7 experience, industry, occupation, or geographic area of the small employer.

8 (d) A small employer insurer

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

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

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

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

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

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

28 Sec. 21.56.250. DEFINITIONS. In this chapter,

29 (1) "actuarial certification" means a written statement by a member of  
30 the American Academy of Actuaries or another individual acceptable to the director  
31 indicating that based on the person's examination, including a review of the

1 appropriate records, actuarial assumptions, and methods used by the insurer in  
2 establishing premium rates for applicable health insurance plans that a small employer  
3 insurer is in compliance with the provisions of AS 21.56.120;

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

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

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

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

12 (6) "case characteristics" means demographic or other objective  
13 characteristics of a small employer that are considered by the small employer insurer  
14 in the determination of premium rates for the small employer, provided that claim  
15 experience, health status, and duration of coverage may not be case characteristics for  
16 the purposes of this chapter;

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

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

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

31 (10) "established geographic service area" means a geographic area

1 within which the insurer is authorized to provide coverage under the insurer's  
2 certificate of authority as approved by the director;

3 (11) "health benefit plan" means a hospital or medical expense policy,  
4 health, hospital, or medical service corporation contract, a plan provided by an insurer  
5 or welfare arrangement, and a health maintenance organization contract offered by an  
6 employer, but does not include a policy covering only accident, credit, dental,  
7 disability income, long-term care, hospital indemnity, fixed indemnity, Medicare  
8 supplement, specified disease, vision care, coverage issued as a supplement to liability  
9 insurance, worker's compensation insurance, automobile medical payment insurance;

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

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

18 (A) the individual

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

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

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

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

30 (C) a court has ordered coverage to be provided for a spouse  
31 or minor child under a covered employee's plan and request for enrollment is

1 made within 30 days after issuance of the court order;

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

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

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

12 (17) "qualifying previous coverage" and "qualifying existing coverage"  
13 mean benefits or coverage provided under

14 (A) Medicare or Medicaid;

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

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

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

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

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

30 (21) "small employer" means a person, firm, corporation, partnership,  
31 or association actively engaged in business whose total employed work force consisted

1 of, on at least 50 percent of its working days during the preceding 12 months, at least  
2 two but not more than 25 eligible employees, the majority of whom are employed  
3 within the state; in determining the number of eligible employees, companies that are  
4 affiliated companies or that are eligible to file a combined tax return for purposes of  
5 federal taxation, are considered one employer; except as otherwise specifically  
6 provided, provisions of this chapter that apply to a small employer that has a health  
7 benefit plan continue to apply until the plan anniversary following the date the  
8 employer no longer meets the requirements of this definition;

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

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

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

16 \* Sec. 9. AS 21.86.260(a) is amended to read:

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

23 \* Sec. 10. AS 21.86.260(a) is repealed and reenacted to read:

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

29 \* Sec. 11. AS 21.87.340 is amended to read:

30 Sec. 21.87.340. **OTHER PROVISIONS APPLICABLE.** In addition to the  
31 provisions contained or referred to previously in this chapter, the following chapters

1 and provisions of this title also apply with respect to service corporations to the extent  
2 applicable and not in conflict with the express provisions of this chapter and the  
3 reasonable implications of the express provisions, and for the purposes of the  
4 application the corporations shall be considered to be mutual "insurers":

5 (1) AS 21.03

6 (2) AS 21.06

7 (3) AS 21.09, except AS 21.09.090

8 (4) AS 21.18.010

9 (5) AS 21.18.030

10 (6) AS 21.18.040

11 (7) AS 21.18.120

12 (8) AS 21.21.321

13 (9) AS 21.36

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

15 (11) AS 21.51.120

16 (12) AS 21.53

17 (13) AS 21.54.020

18 (14) AS 21.56

19 (15) AS 21.69.400

20 (16) [(15)] AS 21.69.520

21 (17) [(16)] AS 21.69.600, 21.69.620, and 21.69.630

22 (18) [(17)] AS 21.78

23 (19) [(18)] AS 21.89.040

24 (20) [(19)] AS 21.89.060

25 (21) [(20)] AS 21.90.

26 \* Sec. 12. AS 21.87.340 is repealed and reenacted to read:

27 Sec. 21.87.340. OTHER PROVISIONS APPLICABLE. In addition to the  
28 provisions contained or referred to previously in this chapter, the following chapters  
29 and provisions of this title also apply with respect to service corporations to the extent  
30 applicable and not in conflict with the express provisions of this chapter and the  
31 reasonable implications of the express provisions, and for the purposes of the

- 1 application the corporations shall be considered to be mutual "insurers":
- 2 (1) AS 21.03
  - 3 (2) AS 21.06
  - 4 (3) AS 21.09, except AS 21.09.090
  - 5 (4) AS 21.18.010
  - 6 (5) AS 21.18.030
  - 7 (6) AS 21.18.040
  - 8 (7) AS 21.18.120
  - 9 (8) AS 21.21.321
  - 10 (9) AS 21.36
  - 11 (10) AS 21.42.345 - 21.42.365, 21.42.375, 21.42.380, and 21.42.385
  - 12 (11) AS 21.51.120
  - 13 (12) AS 21.53
  - 14 (13) AS 21.54.020
  - 15 (14) 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.

22 \* Sec. 13. AS 24.20.206 is amended to read:

- 23 Sec. 24.20.206. DUTIES. The Legislative Budget and Audit Committee shall
- 24 (1) report to the legislature its recommendations relating to the
  - 25 confirmation of appointees to the Board of Trustees of the Alaska Permanent Fund
  - 26 Corporation;
  - 27 (2) annually review the long-range operating plans of all agencies of
  - 28 the state which perform lending or investment functions;
  - 29 (3) review periodic reports from all agencies of the state which perform
  - 30 lending or investment functions;
  - 31 (4) present a complete report of investment programs, plans,

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

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

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

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

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

21 (9) provide assistance to the trustees of the trust established in  
22 AS 37.14.400 - 37.14.450 in carrying out their duties under AS 37.14.415;

23 (10) provide for an annual post audit and annual operational and  
24 performance evaluation of the Alaska Health Care Authority.

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

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

28 (1) provide for a budget review function;

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

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

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

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

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

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

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

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

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

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

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

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

18 CHAPTER 87. ALASKA HEALTH CARE AUTHORITY.

19 ARTICLE 1. CREATION, POWERS, AND ADMINISTRATION.

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

24 (b) The purpose of the authority is to

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

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

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

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

- 1 (5) administer the children's health care plan described in this chapter;
- 2 (6) develop a comprehensive long-term care health plan that integrates
- 3 support services, that promotes human dignity, and that recognizes the individuality
- 4 of all disabled persons; and
- 5 (7) where possible, coordinate the delivery, quality, access, and
- 6 financing of health care in the state.

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

- 11 (1) the interests of health care providers and purchasers are fairly
- 12 represented; and
- 13 (2) a majority of the board are experts in health care issues and fairly
- 14 represent the interests of the general public in having access to quality and affordable
- 15 health care.

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

21 Sec. 44.87.030. GENERAL POWERS. The authority may

- 22 (1) exercise the powers granted to insurers under the laws of the state;
- 23 if the authority acts as an insurer, the authority shall comply with the requirements
- 24 applicable to insurers under AS 21;
- 25 (2) sue or be sued;
- 26 (3) enter into contracts or agreements;
- 27 (4) establish administrative or accounting procedures;
- 28 (5) collect, invest, and disburse funds;
- 29 (6) charge fees for providing administrative services;
- 30 (7) establish appropriate levels of reserves to cover the expenses of the
- 31 authority;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5 **Sec. 44.87.050. STAFF AND PROFESSIONAL SERVICES CONTRACTS.**

6 The authority shall employ an executive director who serves at the pleasure of the  
7 authority as its chief administrative officer. The executive director may, with the  
8 approval of the authority, select and employ additional staff as necessary. The  
9 executive director is in the exempt service under AS 39.25.110. Employees of the  
10 authority other than the executive director are in the classified service under  
11 AS 39.25.100. In addition to its staff of regular employees, the authority may contract  
12 for the services of consultants and professional, technical, and financial advisors the  
13 authority considers necessary for the purpose of developing information, conducting  
14 hearings, studies, investigations, or other proceedings, or otherwise exercising its  
15 powers.

16 **ARTICLE 2. STATE HEALTH CARE PROGRAM.**

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

- 22 (1) hospital services;  
23 (2) physician services;  
24 (3) laboratory services;  
25 (4) pharmaceutical products;  
26 (5) durable medical equipment; and  
27 (6) other health services that the authority determines appropriate.

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

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

- 1 (2) general inflation factors and the costs related to inflation in labor
- 2 and other inputs used to produce health services;
- 3 (3) technological advances that may increase or decrease health care
- 4 costs;
- 5 (4) appropriate improvements in health care productivity;
- 6 (5) feasible reductions in unnecessary health care;
- 7 (6) the need to assure that all sectors of the population have adequate
- 8 access to health care services;
- 9 (7) the effect and availability of statewide expenditure goals on the
- 10 quality of health care; and
- 11 (8) other factors that the authority determines appropriate.

12 Sec. 44.87.070. STATEWIDE HEALTH CARE EXPENDITURE LIMITS. (a)

13 The authority shall develop statewide health care budget and expenditure limits, based

14 on the data obtained under AS 44.87.060. To the extent practicable, the base year for

15 the statewide health care budget and expenditure limits shall be 1992.

16 (b) The authority shall annually adjust the health care expenditure limits

17 developed under this section to reflect changes in the Consumer Price Index for all

18 urban consumers for all items compiled by the Bureau of Labor Statistics, United

19 States Department of Labor, for the preceding calendar year. The annual index for

20 1992 is the reference base index.

21 (c) In developing expenditure limits applicable in a current year the authority

22 shall adjust the expenditure limits for the following factors if these factors would affect

23 the expenditure limits:

- 24 (1) changes in the size or demographic characteristics of the population
- 25 of the state;
- 26 (2) changes in technology and health care delivery that may increase
- 27 or decrease health care costs;
- 28 (3) reduction in unnecessary health care;
- 29 (4) access to adequate health care services;
- 30 (5) costs of medical malpractice insurance;
- 31 (6) administrative cost reduction; and

1 (7) other factors determined appropriate by the authority.  
2 (d) Health care expenditure limits developed under this section must, to the  
3 extent practicable,  
4 (1) include a separate expenditure limit for each health care service  
5 described under AS 44.87.060(a) and may include limits for other subcategories of  
6 health care services that the authority determines appropriate;  
7 (2) be based on the following criteria as adjusted under (b) and (c) of  
8 this section:

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

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

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

16 Sec. 44.87.080. REQUIRED HEALTH CARE PROVIDER NEGOTIATION.

17 (a) The board shall convene representatives from each class of health care providers  
18 to negotiate recommendations for the reimbursement schedules required under  
19 AS 44.87.090. A recommendation may not be submitted to the board unless it meets  
20 the expenditure limits established under AS 44.87.070. The board shall adopt  
21 regulations to establish a good faith negotiating process.

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

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

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

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

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

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

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

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

14 Sec. 44.87.090. ESTABLISHMENT OF REIMBURSEMENT SCHEDULES.

15 (a) Reimbursement schedules established by the authority shall use a base year of  
16 1992 to the extent practicable, and incorporate the following criteria as adjusted by  
17 factors described in AS 44.87.070(b) and (c):

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

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

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

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

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

1 established under AS 44.87.070.

2 **Sec. 44.87.100. MANDATORY HEALTH CARE PROVIDER COMPLIANCE.**

3 (a) All health care providers in the state shall comply with the expenditure limits  
4 established by the authority under AS 44.87.070 and the reimbursement schedules  
5 established by the board.

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

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

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

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

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

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

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

11 ARTICLE 3. CHILDREN'S HEALTH CARE PROGRAM.

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

- 15 (1) routine examinations;
- 16 (2) diagnostic and screening services;
- 17 (3) immunizations and preventive services;
- 18 (4) laboratory and x-ray services;
- 19 (5) outpatient physician services;
- 20 (6) outpatient surgery;
- 21 (7) emergency room services;
- 22 (8) prescription lenses, eyeglass frames, and vision care;
- 23 (9) dental services, except orthodontics;
- 24 (10) prescription drugs; and
- 25 (11) other services, as approved by the board under (b) of this section.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 dependent children;  
2 (4) the woman is not eligible for medical coverage under AS 47.07  
3 (Medicaid); and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

30 **ARTICLE 4. GENERAL PROVISIONS.**

31 **Sec. 44.87.180: ALASKA HEALTH CARE FUND.** The Alaska health care

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

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

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

13 Sec. 44.87.900. **DEFINITIONS.** In this chapter,

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 a health care provider reimbursement systems and utilization standards; and  
2 (3) by January 1, 1996, on the progress made by the authority in developing  
3 a comprehensive system to deliver long-term care to residents of the state.

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

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

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

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

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

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

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

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

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

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

26 \* **Sec. 20. PREMIUM RATE TRANSITION PERIOD.** Regarding a health benefit plan  
27 subject to AS 21.56.110, enacted in sec. 8 of this Act, a premium rate for a rating period may  
28 exceed the ranges set out in AS 21.56.120(a)(1) and (2), enacted in sec. 8 of this Act, through  
29 June 30, 1996; on or after July 1, 1996, the premium rate shall meet the requirements set out  
30 in AS 21.56.120(a)(1) and (2), enacted in sec. 8 of this Act. **However, through June 30, 1996,**  
31 the premium rate is subject to the following provisions:

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

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

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

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

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

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

24 (B) any adjustment due to change in coverage or change in the case  
25 characteristics of the small employer, as determined from the insurer's rate manual;  
26 and

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

28 \* Sec. 21. TRANSITION. (a) Within 180 days after the board is appointed under  
29 AS 21.56.020, enacted in sec. 8 of this Act, the board of directors of the Small Employer  
30 Health Reinsurance Association shall submit a small employer health benefit plan to the  
31 director of the division of insurance for approval. If the association fails to submit a suitable

1 plan of operation, the director may, after notice and hearing, adopt reasonable regulations  
2 necessary or advisable to effectuate the provisions of this chapter. These regulations continue  
3 in force until modified by the director or superseded by a plan submitted by the association  
4 and approved by the director.

5 (b) Notwithstanding AS 21.56.140(a), enacted in sec. 8 of this Act, a small employer  
6 insurer is not required to offer a small employer a basic or standard health benefit plan until  
7 180 days after the director of the division of insurance has approved a basic and a standard  
8 small employer health benefit plan under AS 21.56.140, except that, if the Small Employer  
9 Health Reinsurance Association has not adopted a plan of operation, a small employer insurer  
10 is not required to offer a basic or standard health benefit plan until the date a plan of operation  
11 is adopted as provided under AS 21.56.040.

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

15 (d) The Health Benefit Plan Committee, enacted in sec. 8 of this Act, shall submit the  
16 required health benefit plans within 180 days after the members of the committee are  
17 appointed.

18 (e) Notwithstanding AS 21.56.070, enacted in sec. 8 of this Act, the board of directors  
19 of the Small Employer Health Reinsurance Association shall provide the report required under  
20 AS 21.56.070 to the director of the division of insurance annually until December 31, 1998.

21 \* Sec. 22. AS 21.36.025 and AS 21.56 are repealed.

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

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

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

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

- 1 (3) AS 44.87.100, enacted in sec. 17 of this Act, takes effect January 1, 1997;
- 2 (4) except as provided in (1) - (3) of this subsection, this Act takes effect on
- 3 the date the Act described in (a) of this section takes effect.