SENATE BILL NO. 173

IN THE LEGISLATURE OF THE STATE OF ALASKA

EIGHTEENTH LEGISLATURE - FIRST SESSION

BY SENATORS RIEGER, Pearce, Salo, Kelly, Phillips

Introduced: 3/25/93
Referred: L&C, FIN

A BILL

FOR AN ACT ENTITLED

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

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

4 * **Section 1.** PURPOSE. (a) The purpose of this Act is to
5 (1) promote the availability of health insurance coverage to small employers
6 regardless of their health status or claims experience;
7 (2) prevent abusive rating practices;
8 (3) require disclosure of rating practices to purchasers;
9 (4) establish rules regarding renewability of coverage;
10 (5) establish limitations on the use of preexisting condition exclusions;
11 (6) provide for development of "basic" and "standard" health benefit plans to
12 be offered to all small employers;
13 (7) provide for establishment of a reinsurance program; and
14 (8) improve the overall fairness and efficiency of the small group health

1 insurance market.

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

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

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

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

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

17 * **Sec. 4.** AS 21.36.090(d) is repealed and reenacted to read:

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

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

28 CHAPTER 56. SMALL EMPLOYER HEALTH INSURANCE.

29 ARTICLE 1. SMALL EMPLOYER HEALTH REINSURANCE ASSOCIATION.

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

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

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

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

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

27 Sec. 21.56.030. GENERAL POWERS. The association may

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

30 (2) sue or be sued;

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

1 states, or with other persons for the performance of administrative functions;
2 (4) establish administrative and accounting procedures for the operation
3 of the association;
4 (5) take legal action as necessary to avoid the payment of improper
5 claims against the association;
6 (6) define the array of health coverage products for which reinsurance
7 will be provided and issue reinsurance policies;
8 (7) establish rules, conditions, and procedures pertaining to the
9 reinsurance of members' risks by the association;
10 (8) establish actuarial functions appropriate to the operation of the
11 association;
12 (9) assess members under the provisions of this chapter and make
13 advance interim assessments as may be reasonable and necessary for organizational
14 and interim operating expenses; interim assessments shall be credited as offsets against
15 regular assessments due following the close of the calendar year;
16 (10) appoint appropriate legal, actuarial, and other committees as are
17 necessary to provide technical assistance in the operation of the association, design of
18 a policy or contract, or to assist in other functions of the association;
19 (11) borrow money to accomplish the purposes of the association; notes
20 or other evidence of indebtedness of the association that are not in default are
21 investments for insurers and may be carried as admitted assets.
22 Sec. 21.56.040. PLAN OF OPERATION. (a) The association shall submit
23 to the director a plan of operation and amendments necessary or suitable to assure the
24 fair, reasonable, and equitable administration of the association. The director may,
25 after notice and hearing, approve the plan of operation if the director determines it to
26 be suitable to assure the fair, reasonable, and equitable administration of the program
27 on a proportionate basis under the provisions of this section and it does not shift
28 program costs to other insured persons or the state. The plan of operation and
29 amendments become effective upon approval in writing by the director.
30 (b) All members of the association shall comply with the plan of operation.
31 (c) The plan of operation must establish procedures for

1 (1) handling and accounting of program assets and money of the
2 association and for an annual fiscal report to the director;
3 (2) reinsuring risks under the provisions of this section;
4 (3) collecting assessments from all members to provide for claims
5 reinsured by the association and for administrative expenses incurred or estimated to
6 be incurred by the association;
7 (4) selection of an administering insurer and establish the administering
8 insurer's powers and duties;
9 (5) effectuating a methodology for applying the dollar thresholds
10 contained in this section for insurers that pay or reimburse health care providers by
11 capitation or salary; and
12 (6) provisions necessary or proper for the execution of the powers and
13 duties of the association.
14 Sec. 21.56.050. HEALTH CARE REINSURANCE. (a) A member may
15 reinsure health care coverage of an eligible employee of a small employer or a
16 dependent of an eligible employee of a small employer with the association only under
17 the following provisions:
18 (1) regarding a small employer basic or standard health benefit plan,
19 the association shall reinsure the level of coverage provided;
20 (2) regarding a health care plan other than a small employer health
21 benefit plan, the association shall reinsure the level of coverage provided up to, but not
22 exceeding, the level of coverage provided in a small employer basic or standard health
23 benefit plan;
24 (3) a small employer insurer may reinsure an entire employer group
25 within 60 days of the commencement of the group's coverage under a health benefit
26 plan;
27 (4) a small employer insurer may reinsure an eligible employee or
28 dependent within a period of 60 days following the commencement of the coverage
29 with the small employer; a newly eligible employee or dependent of a reinsured small
30 employer may be reinsured within 60 days of the commencement of coverage;
31 (5) the association may not reimburse a reinsuring insurer regarding the

1 claims of a reinsured employee or dependent until the insurer has paid an initial level
2 of claims for the employee or dependent of $5,000 in a calendar year for benefits
3 covered by the association;
4 (6) a small employer insurer may terminate reinsurance for one or more
5 of the reinsured employees or dependents of a small employer on any plan anniversary.
6 (b) Premium rates charged for coverage reinsured by the association shall be
7 established as required under (e) of this section and adjusted as follows:
8 (1) for whole group small employer reinsurance coverage, 1.5
9 multiplied by the base premium rate established by the association for eligible
10 employees, and dependents of eligible employees, of a small employer all of whose
11 health insurance coverage is reinsured with the association;
12 (2) for eligible employee or dependent health reinsurance coverage, 5.0
13 multiplied by the base premium rate established by the association.
14 (c) If a health benefit plan coverage for a small employer is entirely or
15 partially reinsured with the association, the premium charged to the small employer for
16 a rating period for the coverage issued under this section shall meet the premium rate
17 requirements established under AS 21.56.120.
18 (d) On or before March 1 of each year, the board shall determine and report
19 to the director the association's net loss for the previous calendar year, including
20 administrative expenses and incurred losses for the year, taking into account
21 investment income and other appropriate gains and losses. A net loss for the year
22 shall be recovered by assessments collected from reinsuring insurers. The board shall
23 establish, as part of the plan of operation, a formula by which to make assessments
24 against reinsuring insurers. The assessment formula must be based on each reinsuring
25 insurer's share of the total premiums earned in the preceding calendar year from health
26 benefit plans delivered or issued for delivery to small employers in this state by
27 reinsuring carriers and each reinsuring insurer's share of the premiums earned in the
28 preceding calendar year from newly issued health benefit plans delivered or issued for
29 delivery during the calendar year to small employers in this state by reinsuring
30 insurers. In determining an assessment, if any, that is collected from a member, the
31 following provisions apply:

1 (1) the formula established under this subsection may not result in a
2 reinsuring insurer having an assessment share that is less than 50 percent or more than
3 150 percent of an amount that is based on the proportion of the reinsuring insurer's
4 total premiums earned in the preceding calendar year from health benefit plans
5 delivered or issued for delivery to small employers in this state by reinsuring insurers
6 to total premiums earned in the preceding calendar year from health benefit plans
7 delivered or issued for delivery to small employers in this state by all reinsuring
8 carriers;
9 (2) the board may, with approval of the director, change the assessment
10 formula established under this section from time to time as appropriate; the board may
11 provide for the shares of the assessment base attributable to premiums from all health
12 benefit plans and to premiums from newly issued health benefit plans to vary during
13 a transition period;
14 (3) subject to the approval of the director, the board shall make an
15 adjustment to the assessment formula for reinsuring carriers that are approved health
16 maintenance organizations that are federally qualified under 42 U.S.C. 300, to the
17 extent, if any, that restrictions are imposed on those organizations that are not imposed
18 on other small employer carriers;
19 (4) annually before March 1, the board shall determine and file with
20 the director an estimate of the assessments needed to fund losses incurred by the
21 association in the previous calendar year;
22 (5) if the board determines that the assessments needed to fund the
23 losses incurred by the association in the previous calendar year will exceed five
24 percent of total premiums earned in the previous year from health benefit plans
25 delivered or issued for delivery to small employers in this state by reinsuring insurers,
26 the board shall evaluate the operation of the program and report its findings, including
27 any recommendations for changes to the plan of operation, to the director within 90
28 days following the end of the calendar year in which the losses were incurred; the
29 evaluation must include an estimate of future assessments, the administrative costs of
30 the program, the appropriateness of the premiums charged, and the level of insurer
31 retention under the program and the costs of coverage for small employers; if the

1 board fails to file a report with the director within 90 days following the end of the
2 applicable calendar year, the director may evaluate the operations of the program and
3 implement amendments to the plan of operation the director determines necessary to
4 reduce future losses and assessments;
5 (6) if assessments exceed net losses of the association, the excess shall
6 be held in an interest bearing account and used by the board to offset future losses or
7 to reduce association premiums; in this paragraph, "future losses" include a reserve for
8 incurred but not reported claims;
9 (7) the board shall annually determine a member's proportion of
10 participation in the association based on annual statements and other reports
11 determined necessary by the board and filed by the member with the board; an insurer
12 shall report to the board a claim payment made and administrative expense incurred
13 in this state on a semi-annual basis on a form prescribed by the director;
14 (8) the plan of operation must include a provision for the imposition
15 of an interest penalty for late payment of assessments;
16 (9) a member may request a deferment from the director, in whole or
17 in part, from an assessment issued by the board; the director may defer, in whole or
18 in part, the assessment of a member if, in the opinion of the director payment of the
19 assessment would endanger the ability of the member to fulfill the member's
20 contractual obligations;
21 (10) in the event an assessment against a member is deferred in whole
22 or in part, the amount by which the assessment is deferred may be assessed against the
23 other members in a manner consistent with the basis for assessments set out in this
24 subsection; the member receiving a deferment shall remain liable to the association for
25 the amount deferred; the director may attach conditions to a deferment; a member
26 receiving a deferment may not reinsure an individual or group as provided under this
27 section until the assessment is paid.
28 (e) The board, as part of the plan of operation, shall establish a methodology
29 for determining premium rates to be charged by the program for reinsuring small
30 employers and individuals under this section. The methodology must include a system
31 for classification of small employers that reflects the types of case characteristics

1 commonly used by small employer insurers in the state. The methodology must
2 provide for the development of base reinsurance premium rates that shall be multiplied
3 by the factors set out in (b) of this section to determine the premium rates for the
4 association. The base reinsurance premium rates shall be established by the board,
5 subject to the approval of the director, and shall be set at levels that reasonably
6 approximate gross premiums charged to small employers by small employer insurers
7 for health benefit plans with benefits similar to the standard health benefit plan. The
8 board shall review the methodology established under this subsection to ensure that the
9 methodology reasonably reflects the claims experience of the program. Changes to the
10 methodology may be proposed by the board, and are subject to approval by the
11 director.
12 Sec. 21.56.060. HEALTH BENEFIT PLAN COMMITTEE. (a) The health
13 benefit plan committee is established in the association. The committee is composed
14 of seven members selected by the director as follows:
15 (1) three members who are representatives of participating insurers;
16 (2) one member who represents small employers;
17 (3) one member who represents employees of small employers; and
18 (4) one member who represents health care providers; and
19 (5) one member who represents agents or brokers.
20 (b) The committee shall recommend benefit levels, cost sharing levels,
21 exclusions and limitations for the basic and standard health benefit plan offered under
22 AS 21.56.140. The committee shall also design a basic health benefit plan and a
23 standard health benefit plan that contain benefit and cost sharing levels that are
24 consistent with the basic method of operation and the benefit plans of health
25 maintenance organizations, including restrictions imposed by federal law. The plans
26 recommended by the committee may include the following cost containment features:
27 (1) utilization review of health care services, including review of the
28 medical necessity of hospital and physician services;
29 (2) case management;
30 (3) selective contracting with hospitals, physicians, and other health
31 care providers;

1 (4) reasonable benefit differentials applicable to providers that
2 participate or do not participate in arrangements using restricted network provisions;
3 and
4 (5) other managed care provisions.
5 Sec. 21.56.070. REQUIRED REPORT. The board shall study and report at
6 least once every two years to the director and to the legislature on the effectiveness
7 of this chapter. The report must analyze the effectiveness of the chapter in promoting
8 rate stability, product availability, and coverage affordability. The report may contain
9 recommendations for actions to improve the overall effectiveness, efficiency, and
10 fairness of the small group health insurance marketplace. The report must address
11 whether insurers, agents, brokers, managing general agents, and third-party
12 administrators are fairly and actively marketing or issuing health benefit plans to small
13 employers in fulfillment of the purposes of the chapter. The report may contain
14 recommendations for market conduct or other regulatory standards or action.
15 Sec. 21.56.080. ADMINISTRATIVE PROCEDURE ACT. The association is
16 exempt from AS 44.62 (Administrative Procedure Act).
17 Sec. 21.56.090. TAX EXEMPTION. The association is exempt from the
18 payment of fees and taxes levied by the state or any of its political subdivisions except
19 taxes levied on real or personal property.
20 Sec. 21.56.100. LIMITATION OF LIABILITY. A member of the association
21 is not liable for civil damages resulting from an act or omission of the member on
22 behalf of the association unless the member acts with gross negligence or intentional
23 misconduct.
24 ARTICLE 2. SMALL EMPLOYER HEALTH INSURANCE PLANS.
25 Sec. 21.56.110. APPLICABILITY. (a) An individual or group health benefit
26 plan is subject to the provisions of this chapter if the plan provides health care benefits
27 covering employees of a small employer and if one of the following conditions are
28 met:
29 (1) any portion of the premium or benefits is paid by a small employer;
30 (2) a covered individual or dependent is reimbursed, through wage
31 adjustments or otherwise, by or on behalf of a small employer for all or a portion of

1 the premium; or

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

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

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

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

29 Sec. 21.56.120. PREMIUM RATE RESTRICTIONS DISCLOSURES;
30 REPORTS; CONFIDENTIALITY. (a) A premium rate for a health benefit plan
31 subject to this chapter 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
3 or similar coverage may not vary from the applicable index rate by more than 35
4 percent of the applicable index rate;

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

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

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

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

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

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

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

1 employer insurer's rate manual;

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

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

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

14 (7) a small employer insurer shall

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

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

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

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

29 (b) In connection with the offering for sale of a health benefit plan to a small
30 employer, a small employer insurer shall make a reasonable disclosure, as part of its
31 solicitation and sales materials, of the following:

1 (1) the extent that premium rates for a specified small employer are
2 established or adjusted based upon the actual or expected variation in claims costs or
3 actual or expected variation in health status of the employees of the small employer
4 and their dependents; and
5 (2) the provisions of the health benefit plan
6 (A) concerning the small employer insurer's right to change
7 premium rates and factors, other than claim experience, that affect changes in
8 premium rates;
9 (B) relating to renewability of policies and contracts; and
10 (C) relating to any preexisting condition provision.
11 (c) A small employer insurer shall
12 (1) maintain at its principal place of business a complete and detailed
13 description of its rating practices and renewal underwriting practices, including
14 information and documentation that demonstrate that its rating methods and practices
15 are based upon commonly accepted actuarial assumptions and are in accordance with
16 sound actuarial principles;
17 (2) file with the director annually, on or before March 15, an actuarial
18 certification certifying that the insurer is in compliance with this chapter and that the
19 rating methods of the small employer insurer are actuarially sound; the certification
20 shall be in a form and manner, and must contain information, as specified by the
21 director; a copy of the certification shall be retained by the small employer insurer at
22 its principal place of business;
23 (3) make the information and documentation described in (1) of this
24 subsection available to the director upon request; the information is confidential and
25 not subject to disclosure, except
26 (A) as agreed to by the small employer insurer;
27 (B) as ordered by a court of competent jurisdiction; or
28 (C) the director may use the information or other discovered
29 information in a judicial or administrative proceeding.
30 (d) The director may adopt regulations to implement the provisions of this
31 section and to ensure that rating practices used by small employer insurers are

1 consistent with the purposes of this act, including ensuring that differences in rates
2 charged for health benefit plans by small employer insurers are reasonable and reflect
3 objective differences in plan design, not including differences due to the nature of the
4 groups assumed to select particular health benefit plans.
5 Sec. 21.56.130. RENEWABILITY OF COVERAGE. (a) A health benefit
6 plan subject to this chapter shall be renewable with respect to all eligible employees
7 and dependents at the option of the small employer, except for
8 (1) nonpayment of the required premiums;
9 (2) fraud or misrepresentation of the small employer or, with respect
10 to coverage of individual insureds, the insureds or their representatives;
11 (3) noncompliance with the minimum participation or employer
12 contribution requirements;
13 (4) repeated misuse of a provider network provision; or
14 (5) a small employer insurer who elects not to renew all of its health
15 benefit plans delivered or issued for delivery to small employers in this state; an
16 insurer who elects not to renew as described in this paragraph shall
17 (A) provide advance notice of the decision to the director and
18 to the director or commissioner of insurance in each state in which the insurer
19 is licensed; and
20 (B) provide notice of the decision not to renew coverage to all
21 affected small employers and to the insurance regulatory office in each state
22 in which an affected covered individual is known to reside at least 180 days
23 before the failure to renew the health benefit plan by the insurer; notice to the
24 director under this subparagraph shall be provided at least three working days
25 before the notice to the affected small employers;
26 (6) a health benefit plan for which the director finds that the
27 continuation of the coverage would
28 (A) not be in the best interests of the policyholders or certificate
29 holders; or
30 (B) impair the insurer's ability to meet its contractual
31 obligations.

1 (b) A small employer insurer that elects not to renew a health benefit plan
2 under (a)(5) of this section may not write new business in the small employer market
3 in this state for a period of five years from the date of notice to the director.
4 (c) If a small employer insurer is doing business in only one established
5 geographic service area of the state, the provisions in this section apply only to the
6 insurer's operations in that established service area.
7 Sec. 21.56.140. REQUIRED OFFER OF COVERAGE. (a) Except as
8 provided under AS 21.56.160, a small employer insurer shall, as a condition of
9 transacting business in this state with small employers, offer to small employers at
10 least two health benefit plans. One health benefit plan offered by a small employer
11 insurer shall be a basic health benefit plan and one plan shall be a standard health
12 benefit plan. A small employer insurer shall issue a basic health benefit plan or a
13 standard health benefit plan to an eligible small employer that applies for either plan,
14 agrees to make the required premium payments, and agrees to satisfy the other
15 reasonable provisions of the health benefit plan not inconsistent with this chapter.
16 (b) A small employer insurer shall file with the director, under AS 21.42, the
17 basic health benefit plans and the standard health benefit plans to be used by the
18 insurer.
19 (c) The director at any time may, after providing notice and an opportunity for
20 a hearing to a small employer insurer as provided under AS 21.06.180 - 21.06.210,
21 disapprove the continued use by the small employer insurer of a basic or standard
22 health benefit plan if the plan does not meet the requirements of this chapter.
23 Sec. 21.56.150. REQUIRED HEALTH BENEFIT PROVISIONS. A health
24 benefit plan covering a small employer must include the following provisions:
25 (1) a health benefit plan may not deny, exclude, or limit benefits for
26 a covered individual for losses incurred more than 12 months following the effective
27 date of the individual's coverage due to a preexisting condition; a health benefit plan
28 may not define a preexisting condition more restrictively than
29 (A) a condition that would have caused an ordinarily prudent
30 person to seek medical advice, diagnosis, care, or treatment during the six
31 months immediately preceding the effective date of coverage;

1 (B) a condition for which medical advice, diagnosis, care, or
2 treatment was recommended or received during the six months immediately
3 preceding the effective date of coverage; or
4 (C) a pregnancy existing on the effective date of coverage;
5 (2) a small employer insurer must waive any time period applicable to
6 a preexisting condition exclusion or limitation period with respect to particular services
7 in a health benefit plan for the period of time an individual was previously covered by
8 qualifying previous coverage that provided benefits with respect to the services,
9 provided that the qualifying previous coverage was continuous to a date not more than
10 90 days before the effective date of the new coverage; the period of continuous
11 coverage may not include a waiting period for the effective date of coverage applied
12 by the employer or insurer; this paragraph does not preclude application of a waiting
13 period applicable to all new enrollees under the health benefit plan;
14 (3) a health benefit plan may exclude coverage for late enrollees for the
15 greater of 18 months or for an 18-month preexisting condition exclusion, provided that
16 if both a period of exclusion from coverage and a preexisting condition exclusion are
17 applicable to a late enrollee, the combined period may not exceed 18 months from the
18 date the individual enrolls for coverage under the health benefit plan;
19 (4) requirements used by a small employer insurer in determining
20 whether to provide coverage to a small employer shall be applied uniformly among all
21 small employers with the same number of eligible employees applying for coverage
22 or receiving coverage from the small employer insurer, except that a small employer
23 insurer may vary application of minimum participation requirements and minimum
24 employer contribution requirements by the size of the small employer group;
25 (5) a small employer insurer may not increase a requirement for
26 minimum employee participation or a requirement for minimum employer contribution
27 applicable to a small employer at any time after the small employer has been accepted
28 for coverage, except as allowed under (4) of this section;
29 (6) if a small employer insurer offers coverage to a small employer, the
30 small employer insurer shall offer coverage to all of the eligible employees of a small
31 employer and their dependents; a small employer insurer may not offer coverage to

1 only certain individuals in a small employer group or to only part of the group, except
2 in the case of late enrollees as provided in (3) of this section;
3 (7) except as provided in (1) and (3) of this section, a small employer
4 insurer may not, by a rider or amendment applicable to a specific individual, restrict
5 or exclude coverage or benefits by type of illness, treatment, medical condition, or
6 service otherwise covered by the plan.
7 Sec. 21.56.160. EXEMPTION FROM REQUIRED OFFER OF COVERAGE.
8 (a) A small employer insurer is not required to offer coverage or accept applications
9 under AS 21.56.140(a)
10 (1) if the small employer is not physically located in the insurer's
11 established geographic service area;
12 (2) if the employee does not work or reside within the insurer's
13 established geographic service area;
14 (3) within an established geographic service area where the small
15 employer insurer reasonably anticipates, and demonstrates to the satisfaction of the
16 director, that it will not have the capacity to deliver service adequately to the members
17 of the groups because of its obligations to existing group policyholders and enrollees;
18 (4) if the small employer insurer is only maintaining in-force business
19 and has ceased enrolling new employer groups on or before January 1, 1993; this
20 paragraph does not exempt a small employer insurer from the other provisions of this
21 chapter; or
22 (5) if the certificate of authority or bylaws of the insurer do not permit
23 the insurer to issue coverage on a marketwide basis; an insurer described in this
24 paragraph shall comply with AS 21.56.140 regarding small employers that meet the
25 requirements of the insurer's certificate of authority or bylaws; this paragraph does not
26 apply to insurers who limit coverage based on health status or health risk.
27 (b) A small employer insurer that cannot offer coverage under (a)(3) of this
28 section may not offer health insurance coverage in the applicable area to new cases of
29 employer groups with more than 25 eligible employees or to small employer groups
30 until the later of 180 days following each refusal or the date on which the insurer
31 notifies the director that it has regained capacity to deliver services to small employer

1 groups.

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

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

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

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

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

11 (d) A small employer insurer

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

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

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

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

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

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

31 Sec. 21.56.190. MANDATORY REISSUE OF COVERAGE. The director

1 may adopt regulations to require small employer insurers, as a condition of transacting
2 business with small employers in this state after July 1, 1993, to reissue a health
3 benefit plan to a small employer who has had its health benefit plan terminated or not
4 renewed by the insurer after January 1, 1993. The director may prescribe the terms
5 for the reissue of coverage that the director determines are reasonable and necessary
6 to provide continuity of coverage to small employers.
7 Sec. 21.56.250. DEFINITIONS. In this chapter,
8 (1) "actuarial certification" means a written statement by a member of
9 the American Academy of Actuaries or another individual acceptable to the director
10 indicating that based on the person's examination, including a review of the
11 appropriate records, actuarial assumptions, and methods used by the insurer in
12 establishing premium rates for applicable health insurance plans that a small employer
13 insurer is in compliance with the provisions of AS 21.56.120;
14 (2) "affiliate" or "affiliated" means a person who directly or indirectly,
15 through one or more intermediaries, controls or is controlled by or is under common
16 control with, a specified person;
17 (3) "association" means the Small Employer Health Reinsurance
18 Association created in AS 21.56.010;
19 (4) "base premium rate" means the lowest premium rate charged or that
20 could have been charged under the rating system by the small employer insurer to
21 small employers with similar case characteristics for health benefit plans with the same
22 or similar coverage;
23 (5) "basic health benefit plan" means a lower cost plan offered under
24 AS 21.56.140;
25 (6) "board" means the board of directors of the association;
26 (7) "case characteristics" means demographic or other objective
27 characteristics of a small employer that are considered by the small employer insurer
28 in the determination of premium rates for the small employer, provided that claim
29 experience, health status, and duration of coverage may not be case characteristics for
30 the purposes of this chapter;
31 (8) "committee" means the health benefit plan committee established

1 in AS 21.56.060;

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

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

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

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

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

30 (14) "insurer" has the meaning given in AS 21.90.900 and includes a
31 welfare arrangement, a fraternal benefit society, a health maintenance organization, a

1 hospital service corporation, and a medical service corporation;
2 (15) "late enrollee" means an eligible employee or dependent who
3 requests enrollment in a small employer's health benefit plan following the initial
4 enrollment period for which the employee or dependent was eligible to enroll under
5 the terms of the health benefit plan except that an eligible employee or dependent may
6 not be considered a late enrollee if
7 (A) the individual
8 (i) was covered under qualifying previous coverage at
9 the time of the initial enrollment;
10 (ii) has lost coverage under qualifying previous coverage
11 as a result of the termination of employment or eligibility, the
12 involuntary termination of the qualifying previous coverage, death of a
13 spouse, or divorce or dissolution of marriage; and
14 (iii) requests enrollment within 30 days after the
15 termination of the qualifying previous coverage; or
16 (B) the individual is employed by an employer who offers
17 multiple health benefit plans and the individual elects a different health benefit
18 plan during an open enrollment period; or
19 (C) a court has ordered coverage to be provided for a spouse
20 or minor child under a covered employee's plan and request for enrollment is
21 made within 30 days after issuance of the court order;
22 (16) "member" means all insurers issuing health benefit plans, welfare
23 arrangements and, to the extent permitted under 29 U.S.C. 1001 - 1461 (Employee
24 Retirement Income Security Act), other benefit arrangements providing health benefit
25 plans in this state;
26 (17) "new business premium rate" means the lowest premium rate
27 charged or offered, or that could have been charged or offered, by the small employer
28 insurer to small employers with similar case characteristics for newly issued health
29 benefit plans with the same or similar coverage;
30 (18) "plan of operation" means the plan of operation of the association
31 adopted by the board under AS 21.56.040;

1 (19) "qualifying previous coverage" and "qualifying existing coverage"
2 mean benefits or coverage provided under
3 (A) Medicare or Medicaid;
4 (B) an employer-based health insurance or health benefit
5 arrangement that provides benefits similar to or exceeding benefits provided
6 under the basic health benefit plan; or
7 (C) an individual health insurance policy, including coverage
8 issued under AS 21.84, AS 21.86, or AS 21.87 that provides benefits similar
9 to or exceeding the benefits provided under the basic health benefit plan,
10 provided that the policy has been in effect for a period of at least one year;
11 (20) "rating period" means the calendar period for which premium rates
12 established by a small employer insurer are assumed to be in effect;
13 (21) "reinsuring insurer" means a small employer insurer participating
14 in the reinsurance association under AS 21.56.010;
15 (22) "restricted network provision" means a provision of a health
16 benefit plan that conditions the payment of benefits, in whole or in part, on the use of
17 health care providers that have entered into a contractual arrangement with the insurer
18 under AS 21.86 to provide health care services to covered individuals;
19 (23) "small employer" means a person, firm, corporation, partnership,
20 or association actively engaged in business whose total employed work force consisted
21 of, on at least 50 percent of its working days during the preceding 12 months, at least
22 two but not more than 25 eligible employees, the majority of whom are employed
23 within the state; in determining the number of eligible employees, companies that are
24 affiliated companies or that are eligible to file a combined tax return for purposes of
25 federal taxation, are considered one employer; except as otherwise specifically
26 provided, provisions of this chapter that apply to a small employer that has a health
27 benefit plan continue to apply until the plan anniversary following the date the
28 employer no longer meets the requirements of this definition;
29 (24) "small employer insurer" means an insurer that offers a health
30 benefit plan covering eligible employees of one or more small employers;
31 (25) "standard health benefit plan" means a health benefit plan offered

1 under AS 21.56.140 that includes benefits not offered under a basic benefit plan;
2 (26) "Taft-Hartley trust" means a jointly managed trust, as allowed by
3 29 U.S.C. 141 - 187, containing a plan of benefits for employees that is negotiated in
4 a collective bargaining agreement governing wages, hours, and working conditions of
5 employees as allowed by 29 U.S.C. 157;
6 (27) "welfare arrangement" means a multiple employer welfare
7 arrangement as defined in 29 U.S.C. 1002, but does not include a multiple employer
8 welfare arrangement that is fully insured as provided in 29 U.S.C. 1060.
9 * **Sec. 6.** AS 21.86.260(a) is amended to read:
10 (a) Except as provided **in AS 21.56 and** in this chapter, this title does not
11 apply to a health maintenance organization that obtains a certificate of authority under
12 this chapter. This subsection does not apply to an insurer licensed under AS 21.09 or
13 a hospital or medical service corporation licensed under AS 21.87 except with respect
14 to its health maintenance organization activities authorized by and regulated under this
15 chapter.
16 * **Sec. 7.** AS 21.86.260(a) is repealed and reenacted to read:
17 (a) Except as provided in this chapter, this title does not apply to a health
18 maintenance organization that obtains a certificate of authority under this chapter. This
19 subsection does not apply to an insurer licensed under AS 21.09 or a hospital or
20 medical service corporation licensed under AS 21.87 except with respect to its health
21 maintenance organization activities authorized by and regulated under this chapter.
22 * **Sec. 8.** AS 21.87.340 is amended to read:
23 Sec. 21.87.340. OTHER PROVISIONS APPLICABLE. In addition to the
24 provisions contained or referred to previously in this chapter, the following chapters
25 and provisions of this title also apply with respect to service corporations to the extent
26 applicable and not in conflict with the express provisions of this chapter and the
27 reasonable implications of the express provisions, and for the purposes of the
28 application the corporations shall be considered to be mutual "insurers":
29 (1) AS 21.03
30 (2) AS 21.06
31 (3) AS 21.09, except AS 21.09.090

1 (4) AS 21.18.010
2 (5) AS 21.18.030
3 (6) AS 21.18.040
4 (7) AS 21.18.120
5 (8) AS 21.21.321
6 (9) AS 21.36
7 (10) AS 21.42.345 - 21.42.365, 21.42.375, 21.42.380, and 21.42.385
8 (11) AS 21.51.120
9 (12) AS 21.53
10 (13) AS 21.54.020
11 (14) AS 21.56
12 (15) AS 21.69.400
13 (16) [(15)] AS 21.69.520
14 (17) [(16)] AS 21.69.600, 21.69.620, and 21.69.630
15 (18) [(17)] AS 21.78
16 (19) [(18)] AS 21.89.040
17 (20) [(19)] AS 21.89.060
18 (21) [(20)] AS 21.90.
19 * **Sec. 9.** AS 21.87.340 is repealed and reenacted to read:
20 Sec. 21.87.340. OTHER PROVISIONS APPLICABLE. In addition to the
21 provisions contained or referred to previously in this chapter, the following chapters
22 and provisions of this title also apply with respect to service corporations to the extent
23 applicable and not in conflict with the express provisions of this chapter and the
24 reasonable implications of the express provisions, and for the purposes of the
25 application the corporations shall be considered to be mutual "insurers":
26 (1) AS 21.03
27 (2) AS 21.06
28 (3) AS 21.09, except AS 21.09.090
29 (4) AS 21.18.010
30 (5) AS 21.18.030
31 (6) AS 21.18.040

1 (7) AS 21.18.120
2 (8) AS 21.21.321
3 (9) AS 21.36
4 (10) AS 21.42.345 - 21.42.365, 21.42.375, 21.42.380, and 21.42.385
5 (11) AS 21.51.120
6 (12) AS 21.53
7 (13) AS 21.54.020
8 (14) AS 21.69.400
9 (15) AS 21.69.520
10 (16) AS 21.69.600, 21.69.620, and 21.69.630
11 (17) AS 21.78
12 (18) AS 21.89.040
13 (19) AS 21.89.060
14 (20) AS 21.90.
15 * Sec. 10. PREMIUM RATE RESTRICTION. Regarding a health benefit plan subject to
16 AS 21.56.110, enacted in sec. 5 of this Act, that is delivered or issued for delivery before
17 July 1, 1993, a premium rate for a rating period may exceed the ranges set out in
18 AS 21.56.120(a)(1) and (2), enacted in sec. 5 of this Act, through June 30, 1996; on or after
19 July 1, 1996, the premium rate may not exceed the ranges set out in AS 21.56.120(a)(1) and
20 (2). However, through June 30, 1996, the percentage increase in the premium rate charged
21 to a small employer for a new rating period may not exceed the sum of
22 (1) the percentage change in the new business premium rate measured from
23 the first day of the prior rating period to the first day of the new rating period; in the case of
24 a health benefit plan into which the small employer insurer is no longer enrolling new small
25 employers, the small employer insurer shall use the percentage change in the base premium
26 rate, provided that the change does not exceed, on a percentage basis, the change in the new
27 business premium rate for the most similar health benefit plan into which the small employer
28 insurer is actively enrolling new small employers; and
29 (2) any adjustment due to change in coverage or change in the case
30 characteristics of the small employer, as determined from the insurer's rate manual.
31 * Sec. 11. TRANSITION. (a) Within 180 days after the board is appointed under

1 AS 21.56.020, enacted in sec. 5 of this Act, the board of directors of the Small Employer
2 Health Reinsurance Association shall submit a small employer health benefit plan to the
3 director of the division of insurance for approval. If the association fails to submit a suitable
4 plan of operation, the director may, after notice and hearing, adopt reasonable regulations
5 necessary or advisable to effectuate the provisions of this chapter. These regulations continue
6 in force until modified by the director or superseded by a plan submitted by the association
7 and approved by the director.
8 (b) Notwithstanding AS 21.56.140(a), enacted in sec. 5 of this Act, a small employer
9 insurer is not required to offer a small employer a basic or standard health benefit plan until
10 180 days after the director of the division of insurance has approved a basic and a standard
11 small employer health benefit plan under AS 21.56.140, except that, if the Small Employer
12 Health Reinsurance Association has not adopted a plan of operation, a small employer insurer
13 is not required to offer a basic or standard health benefit plan until the date a plan of operation
14 is adopted as provided under AS 21.56.040.
15 (c) By September 1, 1993, a small employer insurer shall file with the director the
16 insurer's net insurance premium earned from health benefit plans delivered or issued for
17 delivery to small employers in this state in the previous calendar year.
18 (d) The Health Benefit Plan Committee, enacted in sec. 5 of this Act, shall submit the
19 required health benefit plans within 180 days after the members of the committee are
20 appointed.
21 (e) Notwithstanding AS 21.56.070, enacted in sec. 5 of this Act, the board of directors
22 of the Small Employer Health Reinsurance Association shall provide the report required under
23 AS 21.56.070 to the director of the division of insurance annually until December 31, 1997.
24 * Sec. 12. AS 21.36.025 and AS 21.56 are repealed.
25 * Sec. 13. Sections 4, 7, 9, and 12 of this Act take effect July 1, 1997.
26 * Sec. 14. Except as provided in sec. 13 of this Act, this Act takes effect July 1, 1993.