

H B

5 3 7

COMMENTS BY GORDON E. EVANS
ON BEHALF OF HEALTH INSURANCE ASSOCIATION OF AMERICA
at
"ALASKA FORUM ON NATIONAL HEALTH CARE REFORM"
February 10, 1992

My name is Gordon Evans and I represent the Health Insurance Association of America ("HIAA"), which is a national, voluntary trade association of 300 private health insurance companies which provide health insurance for over 95 million Americans. Blue Cross and Blue Shield are not HIAA members.

The escalating spiral of health care costs continues to plague our society. The cost of health care has risen at a rate that is matched by no other item represented in our economy. All aspects of medical care, including the private health insurance market as well as the Medicaid and Medicare programs, have been affected by this phenomena.

The small employer market provides one of the most vivid examples of how health care cost inflation continues to afflict our financing system. Faced with unrelenting demands to hold health care costs down, insurers and employers have intensified the search for ways to moderate premium increases. Leaving high risk individuals out of group coverage has been one such response. We constantly hear the charge by small employers that the presence of a high-risk individual in their group has made it impossible to obtain coverage at any price.

HIAA Position

This dynamic is complicated further by the tumultuous labor market of the small employer. Small employers -- those with 3 to 25 employees -- are far more likely than larger organizations to go in and out of business. Also, employees of small firms are more likely to change jobs. Employee turnover among small, insured firms is about 23 percent annually, and is twice that level for small employers without coverage. These factors contribute to the reluctance of such employers to offer coverage as well as the difficulties of serving the market.

As the complexities of the small employer market have grown and the likelihood of individuals being separated from the financing system has increased, there is a growing perception that even if they have coverage, they stand a reasonable chance of losing it if they change employers or if they have a poor claims experience.

The NAIC and
HIAA has developed a comprehensive proposal to facilitate universal access to health care financing -- one that focuses on expanding health care coverage through the workplace and through public health care services. The essence of HIAA's proposal is to make certain changes in the market so that it provides substantially more predictability and protection to the purchaser of coverage.

The key word to HIAA's proposal is "accessability".

HIAA's proposal -- which has been introduced in the Alaska Legislature by Sen. Virginia Collins as Senate Bill 242 -- would enable all employers with 25 or fewer employees to obtain relatively affordable private health coverage. I'll talk a little more about the "affordability" aspect in a few moments. First, SB 242 features five important precepts:

-- **Guaranteed Availability.** All small employer groups would be able to obtain private health insurance regardless of the health risk they present.

-- **Whole Coverage.** Coverage would be made available to entire employer groups. Neither employers nor insurers could exclude individuals from a group's coverage because they present a high medical risk.

-- **Renewability of Coverage.** At renewal time, employer groups and/or individuals within these groups would be assured that their coverage would not be cancelled because their health had deteriorated.

-- **Continuity of Coverage (or Portability).** Once an individual is covered in the small employer market and has met a plan's initial preexisting condition restrictions, he or she would not be faced with meeting those restrictions again in the event that they change jobs or their employer changes carriers.

--Premium Pricing Limits. There would be specific limits on how much an insurance carrier's rates could vary for employer groups of similar composition -- similar demography, geography, and benefit plan design. Further, there would be limits on rate variations by industry. The proposal would involve limits on how much a carrier could raise rates for a specific group above and beyond general increases in trend factors. Insurance carriers would retain the right to medically underwrite for purposes of assessing risk and setting rates but not to exclude individuals from coverage in a group plan.

Specifically, and this may be getting a bit technical, a carrier's premiums for similar groups could not vary by more than 35 percent from the carrier's mid-point rate (with the mid-point rate defined as being halfway between the lowest and highest rate). There would also be a 15 percent limitation on how much a carrier could vary rates by industry. Finally, carriers would have to limit a group's year-to-year premium increase to no more than 15 percent above the carrier's trend -- which is the year-to-year increase in the lowest new business rate.

How do we make it work? To make these small employer reforms possible, SB 242 would authorize creation of a Small Employer Health Reinsurance Association. Reinsurance means to insure again.

Under reinsurance, the primary insurance company (the one which writes the policy) purchases insurance from a reinsurer to cover all or part of the loss which the group policyholder is protected against. The reinsurer is, in a sense, a silent partner of the original insurer. Reinsurance enables an insurer to accept a greater variety of risks. The reinsurer stands behind the insurer and simply reimburses for claims associated with reinsured individuals. This allows the insurer to spread high risks broadly through the private market rather than concentrated in one small employer group.

However, HIAA wants to emphasize that, to work, these new rules as embodied in SB 242 will have to apply to all players in the small employer market. All competing entities in the small employer market, insurers as well as non-insured benefit plans, will have to be bound by the same rules in order to prevent any company or segment of the market from being placed at a disadvantage.

The implementation of the small employer market reforms mentioned, in conjunction with the establishment of a reinsurance mechanism as outlined, may cause a slight increase in premiums initially for the healthiest employer groups as premiums for the least healthy groups decline and risks for all groups are more

broadly spread. Actuaries tell us that this increase may be about 2 to 6 percent. In the end, however, HIAA believes that an equitable balance can and should be attained between premiums paid by the least healthy and most healthy employer groups in order to make coverage obtainable and affordable by all.

It is definitely not business as usual in the health insurance industry. HIAA's proposed legislation will assure that no small employer, and no employee of a small employer, will be turned down for health insurance because of poor health. SB 242 will restore the concept of pooling risk across large groups, greatly limiting how much of the cost of poor health must be borne by the individual employer. Further, it will moderate significantly the sometimes dramatic premium increases now experienced by small employers at renewal time and reduce the incentive for employers to change carriers frequently.

Thank you for the opportunity to present HIAA's views.



Alaska State Legislature

Official Business

State Capitol
Juneau, AK 99801-1182

M E M O R A N D U M

May 7, 1992

SUBJECT: Sectional Analysis of CSHB 537 ()
TO: Members, House HESS Committee
FROM: Representative Bettye Davis

What follows is a sectional analysis of the above described bill. As a preliminary matter, please note that a sectional analysis of a bill should not be considered an authoritative interpretation of the bill and the bill itself is the best statement of its contents.

Section 1 - Purpose.

Section 2 - Adds a new section to AS 21.36 (Trade Practices and Frauds) that prohibits violations of the fair marketing standards established under Sec. 21.55.180.

Section 3 - Excludes AS 21.55 (Small Employer Health Insurance chapter) from the unfair discrimination provision of the Trade Practices and Fraud law (AS 21.36.090).

Section 4 - Reflects the 4-year sunset provision contained in Section 13. Deletes reference in AS 21.36.090(d) to AS 21.55.

Section 5 -

Sec. 21.55.010 - Creates the Small Employer Health Reinsurance Association as a nonprofit incorporated legal entity and requires membership of all insurers offering health benefit plans in the state.

Sec. 21.55.020 - Establishes the board of directors of the association and provides for specific board representation and organization.

Sec. 21.55.030 - General powers of the association.

Sec. 21.55.040 - Requires the association to submit a plan of operation to the director of the division of insurance. Requires members to comply with the plan and requires the plan to establish certain procedures.

Sectional Analysis

Sec. 21.55.050 - Establishes specific provisions that apply to reinsurance provided by a member to employees or dependents of employees of a small employer. Establishes a methodology for determining premium rates to be charged for reinsuring small employers and individuals covered under this section. Requires the association to report to the director of the division of insurance the association's net loss for the previous calendar year. Requires association to establish a formula by which to make assessments against reinsuring insurers. Sets provisions for determining assessments.

Sec. 21.55.060 - Establishes, in the association, the Health Benefit Plan Committee composed of members representing specific groups. Specifies what the committee must do and allows the committee to recommend certain cost containment features.

Sec. 21.55.070 - Requires the board to issue a report every two years on the effectiveness of the association.

Sec. 21.55.080 - Exempts the association from the Administrative Procedure Act (AS 44.62).

Sec. 21.55.090 - Exempts the association from payment of taxes, except for real or personal property taxes.

Sec. 21.55.100 - Provides immunity from civil actions filed against a member of the association for a negligent act on behalf of the association.

Sec. 21.55.110 - Establishes when an individual or health group benefit plan is subject to AS 21.55 and provides that other laws requiring coverage, reimbursement, utilization, or consideration of a specific health care practitioner do not apply to a health benefit plan provided to a small employer. Treats certain insurers as one insurer for purposes of applying the restrictions on health benefit plans issued under AS 21.55.

Sec. 21.55.120 - Establishes provisions restricting the premium rate for a health benefit plan. Requires small employer insurers to disclose certain information relating to premium rates and health benefit plans. Requires small employer insurers to describe in detail their rating practices and renewal underwriting practices, file an actuarial certification with the director of the division of insurance, and make certain information available to the director upon request. Allows the director to adopt regulations relating to rating practices.

Sec. 21.55.130 - Requires renewability of health benefit plans and provides under what conditions a plan would not be renewable. Prohibits certain small employer insurers who do not

renew a health benefit plan from writing a new business in the state for five years. Specifies when provisions apply to an insurer operating in an established geographic service area.

Sec. 21.55.140 - Except as provided under Sec. 21.55.160, requires small employer insurers to offer a basic health benefit plan and a standard health benefit plan. Requires insurers to file health benefit plans with the director of the division of insurance. Allows the director to disapprove those plans that do not comply with AS 21.55.

Sec. 21.55.150 - Requires health benefit plans for a small employer to contain certain provisions.

Sec. 21.55.160 - Exempts a small employer insurer from providing coverage under certain conditions.

Sec. 21.55.170 - Provides when a small employer insurer may cease to do business in the small employer market.

Sec. 21.55.180 - Establishes fair marketing standards for small employer insurers.

Sec. 21.55.250 - Definitions.

Section 6 - Provides that a health maintenance organization is subject to the small employer health insurance provisions in AS 21.55.

Section 7 - Reflects the 4-year sunset provision contained in Section 13. Deletes reference in AS 21.86.260(a) to AS 21.55.

Section 8 - Provides that a hospital or medical service corporation is subject to the small employer health insurance provisions contained in AS 21.55.

Section 9 - Reflects the 4-year sunset provision contained in Section 13 by deleting reference in AS 21.87.340 to AS 21.55.

Section 10 - Transition section in regards to premium rate restriction.

Section 11 - Transition section in regards to association's plan of operation, a small employer insurer's basic and standard health benefit plans, an insurer's filing net insurance premium earned from certain health insurance plans, and when the Health Benefit Plan Committee shall submit health benefit plans.

Section 12 - Sunset provision.

Section 13 - Sunset provision (takes effect July 1, 1996).

Section 14 - Effective date.

ALASKA STATE LEGISLATURE

3111 C STREET, SUITE 508
ANCHORAGE AK 99503
(907) 561-2039

STATE CAPITOL
JUNEAU AK 99801-1182
(907) 465-3875/4894



VICE CHAIR
HEALTH, EDUCATION
& SOCIAL SERVICES

COMMUNITY AND
REGIONAL AFFAIRS

INTERNATIONAL TRADE
AND TOURISM

CHAIR
CHILDREN'S CAUCUS

REPRESENTATIVE BETTYE DAVIS DISTRICT 14 SEAT B • EAST ANCHORAGE • MULDOON

SPONSOR STATEMENT FOR CSHB 537 Small Employer Health Insurance Reform

CSHB 537 promotes the availability of health insurance coverage for small employers and reforms the small employer health insurance market. Without requiring additional state expenditures, it provides:

- * Guaranteed availability - All small employer groups would be able to obtain private health insurance regardless of the health risk they represent (see Sec. 21.55.140(a)).
- * Coverage of whole groups - Coverage must be available to entire groups. Neither an employer nor an insurer could exclude individuals having high medical risks from the group's coverage (see Sec. 21.55.150(6)).
- * Renewability of coverage - Individuals in employer groups and employer groups themselves would be assured at the time of renewal that their coverage would not be canceled because of deteriorating health (see Sec. 21.55.130).
- * Continuity of coverage - Once a person is covered and has satisfied a plan's preexisting condition requirements, he or she would not have to meet those requirements again when changing jobs or when the employer changes carriers (see Sec. 21.55.150(2)).
- * Premium pricing limits - The bill limits how much insurance companies could vary their rates for groups similar in geography, demography, and plan design. It also limits increases in rates (see Sec. 21.55.120).

Based on model legislation drafted by the National Association of Insurance Commissioners, CSHB 537 would improve the overall fairness and efficiency of the small employer health insurance market. It enjoys support from the National Federation of Independent Business, the Alaska State Chamber of Commerce, the Alaska State Hospital and Nursing Home Association, and other organizations.

Sponsor statement

CSHB 537

Small Employer Health Insurance Reform

Highlights

	<u>CSHB 537</u>
<u>Availability</u>	Guaranteed issue Sec. 21.55.140(a)
<u>Group Size</u>	3-25 Sec. 21.55.250(25)
<u>Case Characteristics</u>	Geography, age, sex, and other objective criteria but does not include claim experience, health status, or duration of coverage Sec. 21.55.250(9)
<u>Rating Restrictions</u>	An insurer's rates for similar groups may not vary from applicable index rate by more than 35% Sec. 21.55.120(a)(1)
<u>Transitional Period</u>	3 years Sec. 7. PREMIUM RATE RESTRICTION (page 23, lines 1-15); Sec. 21.55.120(a)(2)

" highlights "

CSHB 537

Renewal
Rating

Trend plus 15% plus
changes in case
characteristics

Sec. 21.55.120(a)(3)

Renewability

Guaranteed renewable
except "for cause"

Sec. 21.55.130

Whole Groups

Must take whole group

Sec. 21.55.150(6)

Continuity of
Coverage

Plans must credit the
time a person was co-
vered under a previ-
ous employer-based
plan if the coverage
was continuous

Sec. 21.55.150(2)

Reinsurance

Mandatory prospect-
ive. Insurers must
participate in the
reinsurance mechan-
ism.

Sec. 21.55.010

Reinsurance
Price

150% for whole groups
500% for individuals

Sec. 21.55.050(b)

Cost Sharing

First \$5000 of claims

Sec. 21.55.050(a)(5)

CSHB 537

Assessments

5% of the premium of small employer market

Sec. 21.55.050(d)(6)

Industry Rating

A rate factor may not vary by more than 15% from arithmetic average of highest and lowest rate factors associated with all industry classifications.

Sec. 21.55.120(a)(6)

Reinsurance Board

9 members selected by participating members, subject to approval by director. At least six members shall be small employer insurers. At least one member shall be insurer principally in small employer market; one principally in large employer market; one to represent a health maintenance organization, one to represent a hospital or medical service corporation.

Sec. 21.55.020

Health Benefit Plan Committee

7 members selected by director. Includes representatives of insurers, small employers, employees of small employers, health care providers, and agents or brokers.

Sec. 21.55.060(a)

CSHB 537

Insurers With
Restricted
Charters, e.g.,
Fraternal
Benefits Or-
ganizations

Guarantees issue only
to those permitted by
charter (e.g., the
Lutheran Brotherhood)

Sec. 21.55.160 (a) (4)

SMALL EMPLOYER MARKET REFORMS

	<u>NAIC</u>	<u>CSHB 537 ()</u>
21.55.140(a) 14 <u>Availability</u>	Guaranteed issue	Guaranteed issue
21.55.250(25) 21 <u>Group Size</u>	1-25	2-25
21.55.250(9) 19 <u>Case Characteristics</u>	Geography, age, sex, size of employer, and other objective criteria but does not include claim experience, health status or duration of coverage	Geography, age, sex, size of employer, and other objective criteria but does not include claim experience, health status or duration of coverage
21.55.120(a)(1) 10 <u>Rating Restrictions</u>	Within a class of business, the rates for similar groups may not vary from the index rate by more than 25%. The index rate for any insurer's class of business may not exceed another class of business by more than 20%.	An insurer's rates for similar groups may not vary from applicable index rate by more than 35%.
21.55.120(a)(2) 10 Sec. 16 24 <u>Transitional Period</u>	3 years	3 years
21.55.120(a)(3) 10, 11 <u>Renewal Rating</u>	Trend plus 15% plus changes in case characteristics	Trend plus 15% plus changes in case characteristics
21.55.130 13 <u>Renewability</u>	Guaranteed renewable except "for cause"	Guaranteed renewable except "for cause"
21.55.150(6) 15 <u>Whole Groups</u>	Must take whole group	Must take whole group
21.55.150(2) 15 <u>Continuity of Coverage</u>	Plans must credit the time a person was covered under a previous employer-based plan if the coverage was continuous	Plans must credit the time a person was covered under a previous employer-based plan if the coverage was continuous

NAIC

CSHB 537 ()

Reinsurance

Prospective with opt out. Insurers elect whether to participate in the reinsurance mechanism.

Mandatory prospective. Insurers must participate in the reinsurance mechanism.

Reinsurance

150% for whole groups
500% for individuals

150% for whole groups
500% for individuals

Cost Sharing

First \$5000 of claims and 10% of next \$50,000 in claims

First \$5000 of claims

Assessments

5% of the premium of small employer market

5% of the premium of small employer market

Minimum Participation Requirements

Consideration of dual participation required

Not included

Class of Business Rating

Included

Not included

Industry Rating

Maximum 15% above lowest rate factor associated with any industry classifications.

A rate factor may not vary by more than 15% from arithmetic average of highest and lowest rate factors associated with all industry classifications.

Reinsurance Board

Eight members, with Insurance Director as ex-officio member. Director appoints. Members to include representatives of small employers and insurers, with at least 5 representatives of reinsuring carriers.

Nine members, selected by participating members, approved by Director. At least two-thirds of members shall be small employer insurers. At least one member shall be insurer principally in small employer market; one principally in large employer market; one to represent HSO, HSC, or MSO; one to represent HMO; one to represent other benefit arrangement.

NAIC

CSHB 537 ()

Health Benefit
Plan Committee

21.55.060(a)
8

Appointed either by Governor or Director. Includes representatives of insurers, small employers and employees, and health care providers.

Appointed by Director. Same representatives as NAIC model, but also includes representative of agents and brokers.

Cost Shifting

21.55.040(a)
4

No reference

Shifting program costs to other insureds, or to state not allowed.

Reporting

21.55.070
9
(and)
Sec. 11 (e)
25

No reference

Annual report to Director, Legislature required first 5 years; thereafter every 2 years

Insurers With
Restricted
Charters, i.e.,
Fraternal
Benefits
Organizations

21.55.160(a)(4)
16

Not Included

Guarantees issue only to those permitted by charter.

Provision for
Sunset

Sec. 13
25

Not Included

Four years (July 1, 1996)

NFIB Alaska

National Federation of
Independent Business

POSITION PAPER

OF

NATIONAL FEDERATION OF INDEPENDENT BUSINESS
NFIB/ALASKA

TO

HOUSE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

MAY 8, 1992

IN
SUPPORT
OF

HB 537 - HEALTH INSURANCE FOR SMALL EMPLOYERS

State Office
9159 Skywood Lane
Juneau, AK 99801
(907) 789-4278



The Guardian of
Small Business

NFIB Position

Chairman, members of the Committee, my name is Resa Jerrel, and I am the State Director for the National Federation of Independent Business - NFIB/Alaska. I am happy to be here today in support of HB 537.

BACKGROUND

NFIB/Alaska is comprised of 4,730 small and independent business owners. The legislative agenda of NFIB/Alaska is determined by our ballot. The ballot is our annual poll of our members on a series of issues deemed critical to small business. A majority vote, of the members in response to the poll, sets our policy and position on legislative issues.

For the record the following are the results of the 1991 NFIB/Alaska ballot questions regarding health insurance:

Should legislation be passed in order to create a voluntary health insurance plan which would be administered by private insurance companies and which would pool small businesses together so they could purchase employee health insurance at group rates?

Yes 72.2% No 17% Undecided 10.8%

If this pooling of employers in order to purchase health insurance was available, would you participate

Yes 50.2% No 19.3% Undecided 30.5%

Should employers be allowed the option of having their employees pay part of the premium cost of health insurance purchased through the above pooling plan?

Yes 90% No 5.2% Undecided 4.8%

The NFIB Foundation Survey nationwide first found health insurance listed as a key concern for small business in 1986 when it was cited as the number one problem for small business owners out of 75 potential problems. Again in 1990, 92% of small business owners characterized health insurance as a "serious problem". The NFIB Foundation recently released Survey, Problems and Priorities, it listed the cost of health insurance as still the number one problem. No other difficulty was close. Sixty-one (61) percent ranked the problem "critical," the most extreme assessment it could be given.

Further surveys have found that small business owners want to offer health insurance as a fringe benefit out of both a sense of family obligation and competitive necessity.

The ability of the small business owner to provide insurance is greatly influenced by the high costs of premiums and profitability of the business. For many small business the skyrocketing annual premium increases, small profit margins, struggling regional economies, and restricted cash flow all contribute to the increasing difficulty small business owners have in purchasing health insurance. If the cost of purchasing or continuing to provide health insurance continues increasing, small business owners will be forced to increase employee contributions, cut benefits, or in some cases drop coverage altogether.

Small business are most severely impacted by adverse selection, the demographics of the work force of small business (such as, age and gender of employees and the hours they work), higher employee turnover resulting in unpredictable participation rates, and a lack of expertise and clout in purchasing plans. By virtue of their size, small businesses have very little access to cost containment mechanisms available to large firms such as self-insurance. Being unable to obtain the benefits of self-insurance they must comply with expensive state mandates, pay state premium taxes and shoulder a larger portion of the carrier's administrative expenses.

SMALL BUSINESS MARKET REFORM

Small business owners desire to build on the existing health care system. SB 242 is a voluntary health insurance program to provide more accessibility, renewability, predictability and stability for small businesses. It is a viable means of providing health insurance to the uninsured population in Alaska.

State mandates cumulatively can raise the cost of health insurance for small businesses. SB 242 has a provision that state mandates do not apply to health benefit plans provided to small employers. This will allow the insurance industry to design and market hopefully affordable health insurance policies. A lower cost plan would have great appeal to firms that currently do not offer health insurance coverage. Small businesses are willing to provide health insurance to employees, as long as the cost is not prohibitive.

It also, requires the small employer insurers to disclose information relating to premium rates and health benefit plans.

It requires insurers to describe in detail their rating practices and renewal underwriting practices. Providing this information will help small business owners to be better informed. The Congressional Budget Office believes that "giving consumers the information they need to make more informed decisions might enhance both the quality and cost-effectiveness of care."

SUGGESTIONS

NFIB/Alaska appreciates the Sponsor's effort to encompass firms with 3 - 25 employees. Unfortunately, this still leaves the one person firm or the "mom and pop" firms out in the cold. NFIB/Alaska realizes that there are problems in covering these smaller firms, but we urge the committee to explore ways to include this group of business owners.

Thank you for the opportunity to comment on this legislation. NFIB/Alaska has and will continue to support this and other legislation that will help make privately administered health insurance more available and affordable for small businesses.

HOUSE COMMITTEE REPORT

5/8

(7)
Date Referred: February 18, 1992

FURTHER REFERRALS:

Labor & Commerce
Finance

Date of Committee Action: 5-8-92

The HEALTH, EDUCATION AND SOCIAL SERVICES Committee considered:

HB 537

HOUSE BILL NO. 537

GROUP HEALTH INS. FOR SMALL EMPLOYERS

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

RECOMMENDATIONS:

be replaced with CS HB 537 (AES) the same title

have attached amendments(s)

do pass

do not pass

no recommendations

individual recommendations

additional referral to the _____ Committee

ADOPTS: _____ letter of Intent

ATTACHES NEW FISCAL NOTE(S): (Dept)

APPROVES PREVIOUS: (Dept/Date)

fiscal impact _____

fiscal note(s) _____

zero fiscal note Admin, Commerce

zero fiscal note(s) _____

SIGNING DO PASS	DP	OTHER RECOMMENDATIONS	DNP	NR	AM
<i>[Signature]</i>	✓				
<i>[Signature]</i>	✓				
Betty Davis	✓				
<i>[Signature]</i>	✓				
Chris Davis	✓				

[Signature]
CO-CHAIRMAN'S SIGNATURE

**STATE OF ALASKA
1992 LEGISLATIVE SESSION**

BILL NO. HB 537

Revision Date: 2/18/92 Department Affected: Commerce & Economic Dev.
 Title: An Act relating to health BRU: Insurance
insurance for small employers Component: Operations
 Sponsor: Rep. B. Davis
 Requestor: _____ COMPONENT SERIAL NO.

0	3	5	4
---	---	---	---

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 93	FY 94	FY 95	FY 96	FY 97	FY 98
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	0	0	0	0	0	0
CAPITAL	0	0	0	0	0	0
REVENUE FUND SOURCE:	0	0	0	0	0	0

FUNDING: (Thousands of Dollars)

GENERAL FUND						
FEDERAL FUNDS						
OTHER FUND SOURCE:						
TOTAL	0	0	0	0	0	0

POSITIONS:

FULL-TIME	0	0	0	0	0	0
PART-TIME						
TEMPORARY						

Estimate of current year impact: _____

ANALYSIS: (Attach a separate page if necessary.)

Prepared By: Joan Brown *abrown* Administrative Officer Phone: 465-2597
 Division: Insurance Date: 5/8/92
 Approved by Commissioner: Glenn A. Olds *Glenn Olds* Asst Comm
 Agency: Commerce & Economic Development Date: 5.8.92

Distribution (by preparer): Leg. Fin., Legislative Sponsor, Requestor, OMB/DER, Gov. Legis. Ofc., & Impacted Agency(ies).

FISCAL NOTE

BILL NO. CSHB 537 (HES)

DRAFT

STATE OF ALASKA
1992 LEGISLATIVE SESSION

Revision Date: _____
Title: An Act relating to health insurance for small employers; and providing for an effective date.

Department Affected: Administration
BRU: Retirement and Benefits

Sponsor: B. Davis
Requestor: House HESS Committee

Component: Retirement and Benefits
COMPONENT SERIAL NO. 64

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY 93	FY 94	FY 95	FY 96	FY 97	FY 98
PERSONAL SERVICES	0	0	0	0	0	0
TRAVEL	0	0	0	0	0	0
CONTRACTUAL	0	0	0	0	0	0
SUPPLIES	0	0	0	0	0	0
EQUIPMENT	0	0	0	0	0	0
LAND & STRUCTURES	0	0	0	0	0	0
GRANTS, CLAIMS	0	0	0	0	0	0
MISCELLANEOUS	0	0	0	0	0	0
TOTAL OPERATING	0	0	0	0	0	0

CAPITAL	0	0	0	0	0	0
---------	---	---	---	---	---	---

REVENUE FUND SOURCE:	0	0	0	0	0	0
----------------------	---	---	---	---	---	---

FUNDING: (Thousands of dollars)

GENERAL FUND	0	0	0	0	0	0
FEDERAL FUNDS	0	0	0	0	0	0
OTHER FUNDSOURCE	0	0	0	0	0	0
TOTAL	0	0	0	0	0	0

POSITIONS

FULL-TIME:	0	0	0	0	0	0
PART-TIME:	0	0	0	0	0	0
TEMPORARY:	0	0	0	0	0	0

Estimate of current year impact: none

ANALYSIS: (attach a separate page if necessary.) This bill would have no impact on the operating expenses of the Division of Retirement and Benefits.

Prepared By: Gary Bader *Gary M. Bader*
Division: Retirement and Benefits

Phone: 465-4470
Date: May 6, 1992

Approved by Commissioner: Nancy Bear Usura *NBE*
Agency: Department of Administration

Date: 5/6/92

Distribution (by preparer): Legislative Finance, Legislative Sponsor, Requestor, OMB & Impacted Agency(ies).
Rev 10/90 Page 1 of 1

7-LS2074G✓
Ford
5/7/92

CS FOR HOUSE BILL NO. 537 ()
IN THE LEGISLATURE OF THE STATE OF ALASKA
SEVENTEENTH LEGISLATURE - SECOND SESSION

BY

Offered:
Referred:

Sponsor(s): REPRESENTATIVES B.DAVIS, Baker, Parnell

A BILL

FOR AN ACT ENTITLED

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

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

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

5 (1) promote the availability of health insurance coverage to small employers regardless
6 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 be offered
12 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 insurance

1 market.

2 (b) It is not the purpose of this Act to shift the cost of providing health insurance to small
3 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 person may
6 not violate the applicable provisions of AS 21.55.180.

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 AS 21.55, a person
9 may not practice or permit unfair discrimination against a person who provides a service covered
10 under a group disability policy that extends coverage on an expense incurred basis, or under a
11 group service or indemnity type contract issued by a nonprofit corporation, if the service is within
12 the scope of the provider's occupational license. In this subsection, "provider" means a state
13 licensed physician, dentist, osteopath, optometrist, chiropractor, nurse midwife, advanced nurse
14 practitioner, naturopath, physical therapist, or occupational therapist.

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

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

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

24 CHAPTER 55. SMALL EMPLOYER HEALTH INSURANCE.

25 ARTICLE 1. SMALL EMPLOYER HEALTH REINSURANCE ASSOCIATION.

26 Sec. 21.55.010. CREATION; MEMBERSHIP. A nonprofit incorporated legal entity to
27 be known as the Small Employer Health Reinsurance Association is established. Membership
28 consists of all insurers licensed to transact health insurance in the state that offer a health benefit
29 plan. All members shall maintain membership in the association as a condition of doing health
30 insurance business, or being able to offer subscriber contracts, in the state.

31 Sec. 21.55.020. BOARD OF DIRECTORS; ORGANIZATION. (a) The board of

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

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

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

19 Sec. 21.55.030. GENERAL POWERS. The association may

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

22 (2) sue or be sued;

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

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

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

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

31 (7) establish rules, conditions, and procedures pertaining to the reinsurance of

- 1 members' risks by the association;
- 2 (8) establish actuarial functions appropriate to the operation of the association;
- 3 (9) assess members under the provisions of this chapter and make advance interim
- 4 assessments as may be reasonable and necessary for organizational and interim operating
- 5 expenses; interim assessments shall be credited as offsets against regular assessments due
- 6 following the close of the calendar year;
- 7 (10) appoint appropriate legal, actuarial, and other committees as are necessary
- 8 to provide technical assistance in the operation of the association, design of a policy or contract,
- 9 or to assist in other functions of the association;
- 10 (11) borrow money to accomplish the purposes of the association; notes or other
- 11 evidence of indebtedness of the association that are not in default are investments for insurers
- 12 and may be carried as admitted assets.
- 13 Sec. 21.55.040. PLAN OF OPERATION. (a) The association shall submit to the
- 14 director a plan of operation and amendments necessary or suitable to assure the fair, reasonable,
- 15 and equitable administration of the association. The director may, after notice and hearing,
- 16 approve the plan of operation if the director determines it to be suitable to assure the fair,
- 17 reasonable and equitable administration of the program on a proportionate basis under the
- 18 provisions of this section and it does not shift program costs to other insured persons or the state.
- 19 The plan of operation and amendments become effective upon approval in writing by the director.
- 20 (b) All members of the association shall comply with the plan of operation.
- 21 (c) The plan of operation must establish procedures for
- 22 (1) handling and accounting of program assets and money of the association and
- 23 for an annual fiscal report to the director;
- 24 (2) reinsuring risks under the provisions of this section;
- 25 (3) collecting assessments from all members to provide for claims reinsured by
- 26 the association and for administrative expenses incurred or estimated to be incurred by the
- 27 association;
- 28 (4) selection of an administering insurer and establish the administering insurer's
- 29 powers and duties; and
- 30 (5) provisions necessary or proper for the execution of the powers and duties of
- 31 the association.

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

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

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

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

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

15 (5) the association may not reimburse a reinsuring insurer regarding the claims
16 of a reinsured employee or dependent until the insurer has paid an initial level of claims for the
17 employee or dependent of \$5,000 in a calendar year for benefits covered by the association;

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

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

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

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

27 (c) If a health benefit plan coverage for a small employer is entirely or partially reinsured
28 with the association, the premium charged to the small employer for a rating period for the
29 coverage issued under this section shall meet the premium rate requirements established under
30 AS 21.55.120.

31 (d) On or before March 1 of each year, the board shall determine and report to the

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

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

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

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

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

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

1 calendar year;

2 (6) if the board determines that the assessments needed to fund the losses incurred
3 by the association in the previous calendar year will exceed five percent of total premiums earned
4 in the previous year from health benefit plans delivered or issued for delivery to small employers
5 in this state by reinsuring insurers, the board shall evaluate the operation of the program and
6 report its findings, including any recommendations for changes to the plan of operation, to the
7 director within 90 days following the end of the calendar year in which the losses were incurred;
8 the evaluation must include an estimate of future assessments, the administrative costs of the
9 program, the appropriateness of the premiums charged, and the level of insurer retention under
10 the program and the costs of coverage for small employers; if the board fails to file a report with
11 the director within 90 days following the end of the applicable calendar year, the director may
12 evaluate the operations of the program and implement amendments to the plan of operation the
13 director determines necessary to reduce future losses and assessments;

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

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

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

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

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

1 receiving a deferment shall remain liable to the association for the amount deferred; the director
2 may attach conditions to a deferment; a member receiving a deferment may not reinsure an
3 individual or group as provided under this section until the assessment is paid.

4 (e) The board, as part of the plan of operation, shall establish a methodology for
5 determining premium rates to be charged by the program for reinsuring small employers and
6 individuals under this section. The methodology must include a system for classification of small
7 employers that reflects the types of case characteristics commonly used by small employer
8 insurers in the state. The methodology must provide for the development of base reinsurance
9 premium rates that shall be multiplied by the factors set out in (b) of this section to determine
10 the premium rates for the association. The base reinsurance premium rates shall be established
11 by the board, subject to the approval of the director, and shall be set at levels that reasonably
12 approximate gross premiums charged to small employers by small employer insurers for health
13 benefit plans with benefits similar to the standard health benefit plan. The board shall review
14 the methodology established under this subsection to ensure that the methodology reasonably
15 reflects the claims experience of the program. Changes to the methodology may be proposed by
16 the board, and are subject to approval by the director.

17 Sec. 21.55.060. HEALTH BENEFIT PLAN COMMITTEE. (a) The health benefit plan
18 committee is established in the association. The committee is composed of seven members
19 selected by the director as follows:

- 20 (1) three members who are representatives of participating insurers;
- 21 (2) one member who represents small employers;
- 22 (3) one member who represents employees of small employers; and
- 23 (4) one member who represents health care providers; and
- 24 (5) one member who represents agents or brokers.

25 (b) The committee shall recommend benefit levels, cost sharing levels, exclusions and
26 limitations for the basic and standard health benefit plan offered under AS 21.55.140. The
27 committee shall also design a basic health benefit plan and a standard health benefit plan that
28 contain benefit and cost sharing levels that are consistent with the basic method of operation and
29 the benefit plans of health maintenance organizations, including restrictions imposed by federal
30 law. The plans recommended by the committee may include the following cost containment
31 features:

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

9 Sec. 21.55.070. REQUIRED REPORT. The board shall study and report at least once
10 every two years to the director and to the legislature on the effectiveness of this chapter. The
11 report must analyze the effectiveness of the chapter in promoting rate stability, product
12 availability, and coverage affordability. The report may contain recommendations for actions to
13 improve the overall effectiveness, efficiency, and fairness of the small group health insurance
14 marketplace. The report must address whether insurers, agents, brokers, managing general agents,
15 and third-party administrators are fairly and actively marketing or issuing health benefit plans to
16 small employers in fulfillment of the purposes of the chapter. The report may contain
17 recommendations for market conduct or other regulatory standards or action.

18 Sec. 21.55.080. ADMINISTRATIVE PROCEDURE ACT. The association is exempt
19 from the Administrative Procedure Act (AS 44.62).

20 Sec. 21.55.090. TAX EXEMPTION. The association is exempt from the payment of fees
21 and taxes levied by the state or any of its political subdivisions except taxes levied on real or
22 personal property.

23 Sec. 21.55.100. LIMITATION OF LIABILITY. A member of the association is not
24 liable for civil damages resulting from an act or omission of the member on behalf of the
25 association unless the member acts with gross negligence or intentional misconduct.

26 ARTICLE 2. SMALL EMPLOYER HEALTH INSURANCE PLANS.

27 Sec. 21.55.110. APPLICABILITY. (a) An individual or group health benefit plan is
28 subject to the provisions of this chapter if the plan provides health care benefits covering
29 employees of a small employer and if one of the following conditions are met:

- 30 (1) any portion of the premium or benefits is paid by a small employer;
- 31 (2) a covered individual or dependent is reimbursed, through wage adjustments

1 or otherwise, by or on behalf of a small employer for all or a portion of the premium; or

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

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

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

16 Sec. 21.55.120. PREMIUM RATE RESTRICTIONS DISCLOSURES; REPORTS;
17 CONFIDENTIALITY. (a) A premium rate for a health benefit plan subject to this chapter is
18 subject to the following provisions:

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

22 (2) regarding a health benefit plan issued before July 1, 1992, if premium rates
23 charged or offered for the same or similar coverage under a health benefit plan covering a small
24 employer with similar case characteristics as determined by the insurer exceeds the applicable
25 index rate by more than 35 percent, an increase in premium rates for a new rating period may
26 not exceed the sum of

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

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

31 (3) the percentage increase in the premium rate charged to a small employer for

1 a new rating period may not exceed the sum of the following:

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

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

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

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

20 (5) a premium rate for a health benefit plan shall comply with the requirements
21 of this section notwithstanding an assessment paid or payable by small employer insurers under
22 AS 21.55.050(d);

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

27 (7) a small employer insurer shall

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

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

3 (8) for the purposes of this subsection, a health benefit plan that utilizes a
4 restricted provider network may not be considered similar coverage to a health benefit plan that
5 does not utilize a restricted provider network;

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

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

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

15 (2) the provisions of the health benefit plan

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

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

19 (C) relating to any preexisting condition provision.

20 (c) A small employer insurer shall

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

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

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

1 disclosure, except

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

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

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

6 (d) The director may adopt regulations to implement the provisions of this section and
7 to ensure that rating practices used by small employer insurers are consistent with the purposes
8 of this act, including ensuring that differences in rates charged for health benefit plans by small
9 employer insurers are reasonable and reflect objective differences in plan design, not including
10 differences due to the nature of the groups assumed to select particular health benefit plans.

11 Sec. 21.55.130. RENEWABILITY OF COVERAGE. (a) A health benefit plan subject
12 to this chapter shall be renewable with respect to all eligible employees and dependents at the
13 option of the small employer, except for

14 (1) nonpayment of the required premiums;

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

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

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

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

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

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

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

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

2 or

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

4 (b) A small employer insurer that elects not to renew a health benefit plan under (a)(5)
5 of this section may not write new business in the small employer market in this state for a period
6 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 geographic
8 service area of the state, the provisions in this section apply only to the insurer's operations in
9 that established service area.

10 Sec. 21.55.140. REQUIRED OFFER OF COVERAGE. (a) Except as provided under
11 AS 21.55.160, a small employer insurer shall, as a condition of transacting business in this state
12 with small employers, offer to small employers at least two health benefit plans. One health
13 benefit plan offered by a small employer insurer shall be a basic health benefit plan and one plan
14 shall be a standard health benefit plan. A small employer insurer shall issue a basic health
15 benefit plan or a standard health benefit plan to an eligible small employer that applies for either
16 plan, agrees to make the required premium payments, and agrees to satisfy the other reasonable
17 provisions of the health benefit plan not inconsistent with this chapter.

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

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

24 Sec. 21.55.150. REQUIRED HEALTH BENEFIT PROVISIONS. A health benefit plan
25 covering a small employer must include the following provisions:

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

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

1 preceding the effective date of coverage;

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

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

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

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

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

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

28 (6) if a small employer insurer offers coverage to a small employer, the small
29 employer insurer shall offer coverage to all of the eligible employees of a small employer and
30 their dependents; a small employer insurer may not offer coverage to only certain individuals in
31 a small employer group or to only part of the group, except in the case of late enrollees as

1 provided in (3) of this section;

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

5 Sec. 21.55.160. EXEMPTION FROM REQUIRED OFFER OF COVERAGE. (a) A
6 small employer insurer is not required to offer coverage or accept applications under
7 AS 21.55.140(a)

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

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

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

16 (4) if the certificate of authority or bylaws of the insurer do not permit the insurer
17 to issue coverage on a marketwide basis; an insurer described in this subparagraph shall comply
18 with AS 21.55.140 regarding small employers that meet the requirements of the insurer's
19 certificate of authority or bylaws; this subparagraph does not apply to insurers who limit coverage
20 based on health status or health risk.

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

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

29 Sec. 21.55.170. CONDITIONS FOR CEASING TO DO BUSINESS. A small employer
30 insurer or a welfare arrangement may cease doing business in the small employer market if the
31 insurer or welfare arrangement provides notice of the decision to cease doing business in the

1 small employer market to the division, the board, the policyholder or contract holder, and the
2 employer, and coverage under a health benefit plan subject to this chapter is continued for one
3 year after the date of the notice required under this section. A small employer insurer or a
4 welfare arrangement that ceases doing business in the small employer marketplace may not
5 reenter the small employer marketplace for a period of five years from the date of the notice
6 required under this section.

7 Sec. 21.55.180. FAIR MARKETING STANDARDS. (a) A small employer insurer shall
8 actively market health benefit plan coverage, including the basic and standard health benefit
9 plans, to eligible small employers in the state. If a small employer insurer denies coverage to
10 a small employer on the basis of the health status or claims experience of the small employer or
11 its employees or dependents, the small employer insurer shall offer the small employer the
12 opportunity to purchase a basic health benefit plan and a standard health benefit plan.

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

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

30 (d) A small employer insurer

31 (1) shall provide reasonable compensation, as provided under the plan of operation

1 of the program, to an agent, broker, managing general agent, or third-party administrator, if any,
2 for the sale of a basic or standard health benefit plan;

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

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

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

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

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

16 Sec. 21.55.250. DEFINITIONS. In this chapter,

17 (1) "actuarial certification" means a written statement by a member of the
18 American Academy of Actuaries or another individual acceptable to the director indicating that
19 based on the person's examination, including a review of the appropriate records, actuarial
20 assumptions, and methods used by the insurer in establishing premium rates for applicable health
21 insurance plans that a small employer insurer is in compliance with the provisions of
22 AS 21.55.120;

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

26 (3) "agent" has the meaning given in AS 21.90.900;

27 (4) "association" means the Small Employer Health Reinsurance Association
28 created in AS 21.55.010;

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

1 (6) "basic health benefit plan" means a lower cost plan offered under
2 AS 21.55.140;

3 (7) "board" means the board of directors of the association;

4 (8) "broker" has the meaning given in AS 21.90.900;

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

9 (10) "committee" means the health benefit plan committee established in
10 AS 21.55.060;

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

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

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

24 (14) "health benefit plan" means a hospital or medical expense policy, health,
25 hospital, or medical service corporation contract, a plan provided by an insurer or welfare
26 arrangement, and a health maintenance organization contract offered by an employer, but does
27 not include a policy covering only accident, credit, dental, disability income, long-term care,
28 hospital indemnity, fixed indemnity, Medicare supplement, specified disease, vision care,
29 coverage issued as a supplement to liability insurance, worker's compensation insurance,
30 automobile medical payment insurance;

31 (15) "index rate" means for small employers with similar case characteristics and

1 plan designs as determined by the insurer for a rating period, the arithmetic average of the
2 applicable base premium rate and the corresponding highest premium rate;

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

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

10 (A) the individual

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

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

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

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

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

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

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

1 (20) "plan of operation" means the plan of operation of the association adopted
2 by the board under AS 21.55.040;

3 (21) "qualifying previous coverage" and "qualifying existing coverage" mean
4 benefits or coverage provided under

5 (A) Medicare or Medicaid;

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

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

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

15 (23) "reinsuring insurer" means a small employer insurer participating in the
16 reinsurance association under AS 21.55.010;

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

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

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

1 (27) "standard health benefit plan" means a health benefit plan developed under
2 AS 21.55.140;

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

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

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

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

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

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

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

- 25 (1) AS 21.03
26 (2) AS 21.06
27 (3) AS 21.09, except AS 21.09.090
28 (4) AS 21.18.010
29 (5) AS 21.18.030
30 (6) AS 21.18.040
31 (7) AS 21.18.120

- 1 (8) AS 21.21.321
 2 (9) AS 21.36
 3 (10) AS 21.42.345 - 21.42.365, and 21.42.375
 4 (11) AS 21.51.120
 5 (12) AS 21.53
 6 (13) AS 21.54.020
 7 (14) AS 21.55
 8 (15) AS 21.69.400
 9 (16) [(15)] AS 21.69.520
 10 (17) [(16)] AS 21.69.600, 21.69.620, and 21.69.630
 11 (18) [(17)] AS 21.78
 12 (19) [(18)] AS 21.89.040
 13 (20) [(19)] AS 21.89.060
 14 (21) [(20)] AS 21.90.

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

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

- 22 (1) AS 21.03
 23 (2) AS 21.06
 24 (3) AS 21.09, except AS 21.09.090
 25 (4) AS 21.18.010
 26 (5) AS 21.18.030
 27 (6) AS 21.18.040
 28 (7) AS 21.18.120
 29 (8) AS 21.21.321
 30 (9) AS 21.36
 31 (10) AS 21.42.345 - 21.42.365, and 21.42.375

- 1 (11) AS 21.51.120
2 (12) AS 21.53
3 (13) AS 21.54.020
4 (14) AS 21.69.400
5 (15) AS 21.69.520
6 (16) AS 21.69.600, 21.69.620, and 21.69.630
7 (17) AS 21.78
8 (18) AS 21.89.040
9 (19) AS 21.89.060
10 (20) AS 21.90.

11 * **Sec. 10. PREMIUM RATE RESTRICTION.** Regarding a health benefit plan subject to
12 AS 21.55.110, enacted in sec. 5 of this Act, that is delivered or issued for delivery before July 1, 1992,
13 a premium rate for a rating period may exceed the ranges set out in AS 21.55.120(a)(1) and (2), enacted
14 in sec. 5 of this Act, through June 30, 1995; on or after July 1, 1995, the premium rate may not exceed
15 the ranges set out in AS 21.55.120(a)(1) and (2). However, through June 30, 1995, the percentage
16 increase in the premium rate charged to a small employer for a new rating period may not exceed the
17 sum of

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

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

26 * **Sec. 11. TRANSITION.** (a) Within 180 days after the board is appointed under AS 21.55.020,
27 enacted in sec. 5 of this Act, the board of directors of the Small Employer Health Reinsurance
28 Association shall submit a small employer health benefit plan to the director of the division of insurance
29 for approval. If the association fails to submit a suitable plan of operation, the director may, after notice
30 and hearing, adopt reasonable regulations necessary or advisable to effectuate the provisions of this
31 chapter. These regulations continue in force until modified by the director or superseded by a plan

1 submitted by the association and approved by the director.

2 (b) Notwithstanding AS 21.55.140(a), enacted in sec. 5 of this Act, a small employer insurer is
3 not required to offer a small employer a basic or standard health benefit plan until 180 days after the
4 director of the division of insurance has approved a basic and a standard small employer health benefit
5 plan under AS 21.55.140, except that, if the Small Employer Health Reinsurance Association has not
6 adopted a plan of operation, a small employer insurer is not required to offer a basic or standard health
7 benefit plan until the date a plan of operation is adopted as provided under AS 21.55.040.

8 (c) By September 1, 1992, a small employer insurer shall file with the director the insurer's net
9 insurance premium earned from health benefit plans delivered or issued for delivery to small employers
10 in this state in the previous calendar year.

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

13 (e) Notwithstanding AS 21.55.070, enacted in sec. 5 of this Act, the board of directors of the
14 Small Employer Health Reinsurance Association shall provide the report required under AS 21.55.070
15 to the director of the division of insurance annually until December 31, 1997.

16 * Sec. 12. AS 21.36.025 and AS 21.55 are repealed.

17 * Sec. 13. Sections 4, 7, 9, and 12 of this Act take effect July 1, 1996.

18 * Sec. 14. Except as provided in sec. 13 of this Act, this Act takes effect July 1, 1992.