SENATE FINANCE COMMITTEE REPORT

DATE: 4/15/92

FURTHER:

DATE TURNED INTO OFFICE: 5-6-92

The Finance Committee considered SENATE BILL NO. 242

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

and recommends:

[✓] replace with _____ CS SB 242 (FINANCE)

or [ ] adopt previous _____ CS _____ (_____)

[ ] attaches amendment(s)

[✓] same title
[ ] new title
[ ] technical title change (HB only)

[ ] adopts _____ Letter of Intent

[ ] further referral to the _____

[ ] do pass

[ ] do not pass

[ ] no recommendation

[✓] individual recommendations

NEW FISCAL NOTES: **Dept/Date**

[✓] **zero** fiscal notes DOA 5-4-92

[ ] fiscal notes _____

[ ] **appropriation**--no fiscal note

PREVIOUS FISCAL NOTES: **Dept/Date**

[✓] **zero** fiscal notes DCED 4-7-92

[ ] fiscal notes _____

DO PASS:

Dick Shultz

1. [illegible] no rec
Co-Chair: Signature/Recommendation

OTHER RECOMMENDATIONS:

[illegible] - No Rec.

[illegible] - No Rec

Keith Meloy NO REC

2. _____
Co-Chair: Signature/Recommendation

FISCAL NOTE

BILL NO. CSSB 242(HES)

STATE OF ALASKA
1992 LEGISLATIVE SESSION

Revision Date:

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

Sponsor: Collins

Requestor: Senate Finance Committee

Department Affected: Administration

BRU: Retirement and Benefits

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 FUND SOURCE	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 fiscal impact on the operating costs of the Division of Retirement and Benefits.

Prepared By: Gary Bader Gary M. Bader 5/4/92 Phone: 465-4470

Division: Retirement and Benefits Date: May 4, 1992

Approved by Commissioner: Nancy Bear Usera NBU Date: 5/4/92

Agency: Department of Administration

Distribution (by preparer): Legislative Finance, Legislative Sponsor, Requestor, OMB & Impacted Agency(ies).

Rev 10/90

STATE OF ALASKA
1992 LEGISLATIVE SESSION

FISCAL NOTE

No. 2
Bill Version: CSSB 242(HES
(S) Publish Date: 4-15-92

Revision Date:
Department Affected: Commerce & Econ. Dev.
Title: An Act relating to health insurance for small employers
BRU: Insurance
Component:
Sponsor: Senators Collins, Menard, Pearce
Requestor: Collins
COMPONENT SERIAL NO.

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 RESOURCE:	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 FUND SOURCE:	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: 0

ANALYSIS (Attach a separate page if necessary.)

Prepared By: Ken Sykes, Insurance Market Analyst
Phone: 465-2564
Division: Insurance
Date: 4/7/92
Approved by Commissioner: Glenn A. Olds
Agency: Department of Commerce & Economic Development
Date: 4.7.92

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

KS/dg11842D-1/040792a
(Rev. 12/91)

#2
RH
Adopted
5-6-92

AMENDMENT

OFFERED IN THE SENATE

TO: CSSB 242 (HES)

Page 21, line 15, before "but not more":

Delete "three"

Insert "two"

#1
Senate
7-LS0847\J.1
Ford
4 05/03/92
5- year
Adopted as amended 5-6-92

AMENDMENT

OFFERED IN THE SENATE BY SENATOR COLLINS

TO: CSSB 242(HES)

Page 2, after line 14:

Insert a new bill section to read:

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

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

Renumber the following bill sections accordingly.

Page 22, after line 3:

Insert a new bill section to read:

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

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

Renumber the following bill sections accordingly.

Page 22, after line 31:

Insert a new bill section to read:

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

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

(1) AS 21.03

(2) AS 21.06

(3) AS 21.09, except AS 21.09.090

(4) AS 21.18.010

(5) AS 21.18.030

(6) AS 21.18.040

(7) AS 21.18.120

(8) AS 21.21.321

(9) AS 21.36

(10) AS 21.42.345 - 21.42.365, and 21.42.375

(11) AS 21.51.120

(12) AS 21.53

(13) AS 21.54.020

(14) AS 21.69.400

(15) AS 21.69.520

(16) AS 21.69.600, 21.69.620, and 21.69.630

(17) AS 21.78

(18) AS 21.89.040

(19) AS 21.89.060

(20) AS 21.90."

Renumber the following bill sections accordingly.

Page 23, line 2:

Delete "sec. 4"

Insert "sec. 5"

Page 23, line 4:

Delete "sec. 4"

Insert "sec. 5"

Page 23, line 17:

Delete "sec. 4"

Insert "sec. 5"

Page 23, line 23:

Delete "sec. 4"

Insert "sec. 5"

Page 24, line 1:

Delete "sec. 4"

Insert "sec. 5"

Page 24, line 3:

Delete "sec. 4"

Insert "sec. 5"

Page 24, after line 5:

Insert new bill sections to read:

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

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

JT duncan
Adopted
6

Renumber the following bill section accordingly.

Page 24, line 6:

Delete "This"

Insert "Except as provided in sec. 13 of this Act, this"

CS FOR SENATE BILL NO. 242 ~~(HES)~~ (Fin)

IN THE LEGISLATURE OF THE STATE OF ALASKA

SEVENTEENTH LEGISLATURE - SECOND SESSION

BY THE SENATE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

Offered: 4/15/92
Referred: Finance

Sponsor(s): SENATORS COLLINS, Menard, Pearce

A BILL

FOR AN ACT ENTITLED

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

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

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

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

(2) prevent abusive rating practices;

(3) require disclosure of rating practices to purchasers;

(4) establish rules regarding renewability of coverage;

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

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

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

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

market.

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

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

Sec. 21.36.025. UNFAIR MARKETING PRACTICES PROHIBITED. A person may not violate the applicable provisions of AS 21.55.180.

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

(d) Except to the extent necessary to comply with AS 21.42.365 **and AS 21.55**, a person may not practice or permit unfair discrimination against a person who provides a service covered under a group disability policy that extends coverage on an expense incurred basis, or under a group service or indemnity type contract issued by a nonprofit corporation, if the service is within the scope of the provider's occupational license. In this subsection, "provider" means a state licensed physician, dentist, osteopath, optometrist, chiropractor, nurse midwife, advanced nurse practitioner, naturopath, physical therapist, or occupational therapist.

* **Sec. 4.** AS 21 is amended by adding a new chapter to read:

CHAPTER 55. SMALL EMPLOYER HEALTH INSURANCE.

ARTICLE 1. SMALL EMPLOYER HEALTH REINSURANCE ASSOCIATION.

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

Sec. 21.55.020. BOARD OF DIRECTORS; ORGANIZATION. (a) The board of directors of the association consists of nine individuals selected by participating members, subject to approval by the director. The director shall endeavor to appoint at least six board members who are also small employer insurers. If the director is unable to appoint six board members who are also small employer insurers, the director may fill the remaining seats with any insurer. In selecting members of the board, the director shall consider, among other things, whether all types of participating members are fairly represented.

(b) To the extent possible, one board member shall represent a health maintenance organization, one board member shall represent a hospital or medical service corporation, one

board members' principal health insurance business shall be in the small employer market, and one board member's principal health insurance business shall be in the large employer market. Members of the board may be reimbursed from the association for expenses incurred by them as members, but may not otherwise be compensated by the association for their services. The costs of conducting meetings of the association and its board of directors shall be borne by the association.

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

Sec. 21.55.030. GENERAL POWERS. The association may

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

(2) sue or be sued;

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

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

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

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

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

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

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

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

or to assist in other functions of the association;

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

Sec. 21.55.040. PLAN OF OPERATION. (a) The association shall submit to the director a plan of operation and amendments necessary or suitable to assure the fair, reasonable, and equitable administration of the association. The director may, after notice and hearing, approve the plan of operation if the director determines it to be suitable to assure the fair, reasonable and equitable administration of the program on a proportionate basis under the provisions of this section and it does not shift program costs to other insured persons or the state. The plan of operation and amendments become effective upon approval in writing by the director.

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

(c) The plan of operation must establish procedures for

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

calendar year from newly issued health benefit plans delivered or issued for delivery during the calendar year to small employers in this state by reinsuring insurers. In determining an assessment, if any, that is collected from a member, the following provisions apply:

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

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

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

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

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

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

program, the appropriateness of the premiums charged, and the level of insurer retention under the program and the costs of coverage for small employers; if the board fails to file a report with the director within 90 days following the end of the applicable calendar year, the director may evaluate the operations of the program and implement amendments to the plan of operation the director determines necessary to reduce future losses and assessments;

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

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

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

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

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

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

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

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

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

(2) one member who represents small employers;

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

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

(5) one member who represents agents or brokers.

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

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

(2) case management;

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

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

(5) other managed care provisions.

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

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

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

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

ARTICLE 2. SMALL EMPLOYER HEALTH INSURANCE PLANS.

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

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

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

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

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

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

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

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

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

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

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

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

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

employers;

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

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

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

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

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

(7) a small employer insurer shall

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

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

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

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

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

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

(2) the provisions of the health benefit plan

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

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

(C) relating to any preexisting condition provision.

(c) A small employer insurer shall

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

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

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

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

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

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

(d) The director may adopt regulations to implement the provisions of this section and to ensure that rating practices used by small employer insurers are consistent with the purposes of this act, including ensuring that differences in rates charged for health benefit plans by small

employer insurers are reasonable and reflect objective differences in plan design, not including differences due to the nature of the groups assumed to select particular health benefit plans.

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

(1) nonpayment of the required premiums;

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

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

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

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

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

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

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

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

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

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

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

that established service area.

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

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

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

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

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

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

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

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

(2) a health benefit plan must waive any time period applicable to a preexisting condition exclusion or limitation period with respect to particular services for the period of time an individual was previously covered by qualifying previous coverage that provided benefits with

respect to the services, provided that the qualifying previous coverage was continuous to a date not more than 30 days before the effective date of the new coverage; this paragraph does not preclude application of a waiting period applicable to all new enrollees under the health benefit plan;

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

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

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

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

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

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

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

geographic service area;

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

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

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

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

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

Sec. 21.55.170. CONDITIONS FOR CEASING TO DO BUSINESS. A small employer insurer or a welfare arrangement may cease doing business in the small employer market if the insurer or welfare arrangement provides notice of the decision to cease doing business in the small employer market to the division, the board, the policyholder or contract holder, and the employer, and coverage under a health benefit plan subject to this chapter is continued for one year after the date of the notice required under this section. A small employer insurer or a welfare arrangement that ceases doing business in the small employer marketplace may not reenter the small employer marketplace for a period of five years from the date of the notice required under this section.

Sec. 21.55.180. FAIR MARKETING STANDARDS. (a) A small employer insurer shall actively market health benefit plan coverage, including the basic and standard health benefit

plans, to eligible small employers in the state. If a small employer insurer denies coverage to a small employer on the basis of the health status or claims experience of the small employer or its employees or dependents, the small employer insurer shall offer the small employer the opportunity to purchase a basic health benefit plan and a standard health benefit plan.

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

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

(d) A small employer insurer

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

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

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

(e) The director may by regulation establish additional standards to provide for the fair

marketing and broad availability of health benefit plans to small employers in this state.

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

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

Sec. 21.55.250. DEFINITIONS. In this chapter,

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(17) "late enrollee" means an eligible employee or dependent who requests enrollment in a small employer's health benefit plan following the initial enrollment period for which the employee or dependent was eligible to enroll under the terms of the health benefit plan

except that an eligible employee or dependent may not be considered a late enrollee if

(A) the individual

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

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

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

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

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

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

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

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

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

(A) Medicare or Medicaid;

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

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

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

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

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

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

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

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

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

* Sec. 5. AS 21.86.260(a) is amended to read:

(a) Except as provided **in AS 21.55 and** in this chapter, this title does not apply to a health maintenance organization that obtains a certificate of authority under this chapter. This

subsection does not apply to an insurer licensed under AS 21.09 or a hospital or medical service corporation licensed under AS 21.87 except with respect to its health maintenance organization activities authorized by and regulated under this chapter.

* **Sec. 6.** AS 21.87.340 is amended to read:

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

(1) AS 21.03

(2) AS 21.06

(3) AS 21.09, except AS 21.09.090

(4) AS 21.18.010

(5) AS 21.18.030

(6) AS 21.18.040

(7) AS 21.18.120

(8) AS 21.21.321

(9) AS 21.36

(10) AS 21.42.345 - 21.42.365, and 21.42.375

(11) AS 21.51.120

(12) AS 21.53

(13) AS 21.54.020

(14) **AS 21.55**

(15) AS 21.69.400

(16) [(15)] AS 21.69.520

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

(18) [(17)] AS 21.78

(19) [(18)] AS 21.89.040

(20) [(19)] AS 21.89.060

(21) [(20)] AS 21.90.

* Sec. 7. PREMIUM RATE RESTRICTION. Regarding a health benefit plan subject to AS 21.55.110, enacted in sec. 4 of this Act, that is delivered or issued for delivery before July 1, 1992, a premium rate for a rating period may exceed the ranges set out in AS 21.55.120(a)(1) and (2), enacted in sec. 4 of this Act, through June 30, 1995; on or after July 1, 1995, the premium rate may not exceed the ranges set out in AS 21.55.120(a)(1) and (2). However, through June 30, 1995, the percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of

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

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

* Sec. 8. TRANSITION. (a) Within 180 days after the board is appointed under AS 21.55.020, enacted in sec. 4 of this Act, the board of directors of the Small Employer Health Reinsurance Association shall submit a small employer health benefit plan to the director of the division of insurance for approval. If the association fails to submit a suitable plan of operation, the director may, after notice and hearing, adopt reasonable regulations necessary or advisable to effectuate the provisions of this chapter. These regulations continue in force until modified by the director or superseded by a plan submitted by the association and approved by the director.

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

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

(d) The Health Benefit Plan Committee, enacted in sec. 4 of this Act, shall submit the required health benefit plans within 180 days after the members of the committee are appointed.

(e) Notwithstanding AS 21.55.070, enacted in sec. 4 of this Act, the board of directors of the Small Employer Health Reinsurance Association shall provide the report required under AS 21.55.070 to the director of the division of insurance annually until December 31, 1997.

* **Sec. 9.** This Act takes effect July 1, 1992.

Final

7-LS0847\M

CS FOR SENATE BILL NO. 242 (FINANCE)

IN THE LEGISLATURE OF THE STATE OF ALASKA

SEVENTEENTH LEGISLATURE - SECOND SESSION

BY THE SENATE FINANCE COMMITTEE

Offered:
Referred:

Sponsor(s): SENATORS COLLINS, Menard, Pearce

A BILL

FOR AN ACT ENTITLED

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

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

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

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

(2) prevent abusive rating practices;

(3) require disclosure of rating practices to purchasers;

(4) establish rules regarding renewability of coverage;

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

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

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

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

market.

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

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

Sec. 21.36.025. UNFAIR MARKETING PRACTICES PROHIBITED. A person may not violate the applicable provisions of AS 21.55.180.

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

(d) Except to the extent necessary to comply with AS 21.42.365 **and AS 21.55**, a person may not practice or permit unfair discrimination against a person who provides a service covered under a group disability policy that extends coverage on an expense incurred basis, or under a group service or indemnity type contract issued by a nonprofit corporation, if the service is within the scope of the provider's occupational license. In this subsection, "provider" means a state licensed physician, dentist, osteopath, optometrist, chiropractor, nurse midwife, advanced nurse practitioner, naturopath, physical therapist, or occupational therapist.

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

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

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

CHAPTER 55. SMALL EMPLOYER HEALTH INSURANCE.

ARTICLE 1. SMALL EMPLOYER HEALTH REINSURANCE ASSOCIATION.

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

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

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

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

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

Sec. 21.55.030. GENERAL POWERS. The association may

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

(2) sue or be sued;

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

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

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

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

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

members' risks by the association;

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

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

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

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

Sec. 21.55.040. PLAN OF OPERATION. (a) The association shall submit to the director a plan of operation and amendments necessary or suitable to assure the fair, reasonable, and equitable administration of the association. The director may, after notice and hearing, approve the plan of operation if the director determines it to be suitable to assure the fair, reasonable and equitable administration of the program on a proportionate basis under the provisions of this section and it does not shift program costs to other insured persons or the state. The plan of operation and amendments become effective upon approval in writing by the director.

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

(c) The plan of operation must establish procedures for

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

calendar year;

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

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

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

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

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

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

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

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

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

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

(2) one member who represents small employers;

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

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

(5) one member who represents agents or brokers.

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

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

(2) case management;

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

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

(5) other managed care provisions.

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

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

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

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

ARTICLE 2. SMALL EMPLOYER HEALTH INSURANCE PLANS.

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

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

(2) a covered individual or dependent is reimbursed, through wage adjustments

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(7) a small employer insurer shall

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

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

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

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

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

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

(2) the provisions of the health benefit plan

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

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

(C) relating to any preexisting condition provision.

(c) A small employer insurer shall

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

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

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

disclosure, except

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

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

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

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

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

(1) nonpayment of the required premiums;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

preceding the effective date of coverage;

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

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

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

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

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

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

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

provided in (3) of this section;

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

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

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

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

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

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

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

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

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

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

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

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

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

(d) A small employer insurer

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

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

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

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

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

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

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

Sec. 21.55.250. DEFINITIONS. In this chapter,

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(A) the individual

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

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

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

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

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

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

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

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

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

(A) Medicare or Medicaid;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) AS 21.03

(2) AS 21.06

(3) AS 21.09, except AS 21.09.090

(4) AS 21.18.010

(5) AS 21.18.030

(6) AS 21.18.040

(7) AS 21.18.120

(8) AS 21.21.321

(9) AS 21.36

(10) AS 21.42.345 - 21.42.365, and 21.42.375

(11) AS 21.51.120

(12) AS 21.53

(13) AS 21.54.020

(14) **AS 21.55**

(15) AS 21.69.400

(16) [(15)] AS 21.69.520

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

(18) [(17)] AS 21.78

(19) [(18)] AS 21.89.040

(20) [(19)] AS 21.89.060

(21) [(20)] AS 21.90.

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

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

(1) AS 21.03

(2) AS 21.06

(3) AS 21.09, except AS 21.09.090

(4) AS 21.18.010

(5) AS 21.18.030

(6) AS 21.18.040

(7) AS 21.18.120

(8) AS 21.21.321

(9) AS 21.36

(10) AS 21.42.345 - 21.42.365, and 21.42.375

(11) AS 21.51.120

(12) AS 21.53

(13) AS 21.54.020

(14) AS 21.69.400

(15) AS 21.69.520

(16) AS 21.69.600, 21.69.620, and 21.69.630

(17) AS 21.78

(18) AS 21.89.040

(19) AS 21.89.060

(20) AS 21.90.

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

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

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

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

submitted by the association and approved by the director.

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

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

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

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

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

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

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

#3

7-LS0847\J.2
Ford
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5-6-92
F.D. moved
Failed

AMENDMENT

OFFERED IN THE SENATE

BY SENATOR DUNCAN

TO: CSSB 242(HES)

Page 23, line 6, after "exceed":

Insert "the lower of

(1)"

Page 23, line 8:

Delete "(1)"

Insert "(A)"

Page 23, line 14:

Delete "(2)"

Insert "(B)"

Page 23, line 15 following "manual":

Insert "; and

(2) 135 percent of the premium rate charged to a small employer on January 1, 1992"

Alaska State Legislature
Senate

Official Business

P.O. BOX V
State Capitol
Juneau, Alaska 99811

M E M O R A N D U M May 5, 1992

SUBJECT: CSSB 242 (HES)

TO: Senator Pat Pourchot, Co-Chair
Senate Finance Committee

FROM: Senator Virginia Collins

Thank you for hearing CSSB 242 (HES) and for giving me the chance to respond to the matters brought up at the May 2, 1992 Senate Finance Committee meeting. Here is a summary of the main points that were discussed:

1. Sunset provision - The sunset provision contained in Amendment #1 allows the legislature to review the small employer health insurance law five years after the effective date and to determine whether the program should be continued.

Please note that CSSB 242 (HES) contains legislative review of the program. Section 8, subsection (e) provides for an annual report to the legislature. After December 31, 1997, the report would be prepared at least once every two years (see Sec. 21.55.070).

2. Size of small employer - Amendment #2 changes the minimum group size from three to two. (The maximum group size would be 25.)

3. Section 7 - premium rate restriction - I recommend that the premium rate restriction section not be deleted and that a retroactive premium rate not be added.

Section 7 conforms with model language drafted by the National Association of Insurance Commissioners (NAIC), a pro-consumer organization. It allows a transition phase for existing small employer health benefit plans -- that is, health benefit plans sold prior to the effective date of the bill.

The NAIC recognized the need to accommodate health benefit plans already on the books that are contractual and that

cannot be legally changed in the middle of the contract (see the prohibition against the passage of ex post facto law and the impairment of the obligation of contracts in the Alaska Constitution, Article I, Section 15).

The premium rates charged for health insurance benefit plans existing before the effective date of the law may, in some instances, be higher than the new premium pricing limits established by the bill. Section 7 limits the prices for new rating periods in existing, multi-year plans within the three-year transition phase. Premium increases are limited to the percentage change in the new business rate and any adjustment due to change in coverage (new and different benefits) or a change in case characteristics (change in industry or demographics of the small employer).

This does not give the insurance industry a three-year period to increase rates exorbitantly. Rather, effective July 1, 1992, all new small employer insurers would have to meet the premium pricing limit set forth in Sec. 21.55.120. Existing small employer insurers would have to be phased into the new rating restrictions in a manner, provided in Section 7, that does not violate existing contracts. Section 7 limits the rates for new rating periods within the existing contract.

* * * * * * *

Finally, let me emphasize that CSSB 242 (HES) allows small employer health insurance reform to exist without any cost to the state. The sunset and reporting provisions allow the legislature to review this reform, to determine whether it works, and to decide whether or not it should be continued.

STATE OF ALASKA

WALTER J. HICKEL, GOVERNOR

DEPARTMENT OF COMMERCE & ECONOMIC DEVELOPMENT

DIVISION OF INSURANCE

P.O. BOX D
JUNEAU, ALASKA 99811-0800
PHONE: (907) 465-2515

May 5, 1992

The Honorable Pat Pourchot
Alaska Senate
Senate Finance Committee
State Capital
Juneau, AK 99801-1182

Dear Senator Pourchot:

Re: CSSB 242(HES) - 7-LS0847/J

Thank you for your memorandum of May 4, 1992. As requested, we have evaluated the various questions provided and have the following comments:

Amendment #1. We have no problem with the revision to the sunset provision from three to five years.

Amendment #2. We have no problem with the revision to group minimum size from 3 to 2.

Section 7, Premium Rate Restriction. The provisions of Section 7 avoid cost shifting to the state but may result in some cost shifting to currently insured small employers. The actual effect at this time is incalculable. The sunset provision will provide for evaluation of the impact of legislation.

Section 8, Transition. We believe that the transition and sunset features are mutually exclusive.

Very truly yours,

David J. Walsh
Director

DS-H11LH

NFIB Alaska

National Federation of
Independent Business

POSITION PAPER

OF

NATIONAL FEDERATION OF INDEPENDENT BUSINESS
NFIB/ALASKA

TO

SENATE FINANCE COMMITTEE

MAY 2, 1992

IN
SUPPORT
OF

SB 242 - HEALTH INSURANCE FOR SMALL EMPLOYERS

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

The Guardian of
Small Business

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 SB 242.

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 problem. 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 cased 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 bushinesses 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 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.

POSITION PAPER

SB 242: "An Act relating to health insurance for small employers; and providing for an effective date."

With resolution of the issue noted below, the administration can support this legislation.

One of the more challenging issues facing this country and Alaska is the ever-increasing number of people unable to afford or even find health care insurance. This bill would address small employers who have been unable to purchase health care coverage for employees, especially when one employee has acquired a medical condition and become, in too many cases "uninsurable." The plan established in the bill assures availability of coverage, prevents picking and choosing employees in a group, assures renewability, and places a cap on premium increases.

AS 21.55.070 should be revised to include a sunset clause after three years to mandate an evaluation of the effect of the program on its target market as well as the overall health insurance market and to determine whether the program should be continued.

This legislation, with resolution of the above issue, will give the private health care insurance system an opportunity to address the challenge of providing health insurance for small employers, and the administration can support such legislation.

Nancy Bear Usera, Commissioner
Department of Administration

Theodore A. Mala, Commissioner
Department of Health and Social Services

Glenn A. Olds, Commissioner
Department of Commerce and Economic Development

Date: 4/27/92

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Alaska State Legislature
Senate

Official Business

P.O. BOX V
State Capitol
Juneau, Alaska 99811

M E M O R A N D U M April 22, 1992

SUBJECT: Sectional Analysis of CSSB 242 (HES)

TO: Members, Senate Finance Committee

FROM: Senator Virginia Collins

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 -

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.

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

Section 6 - Provides that a hospital or medical service corporation is subject to the small employer health insurance provisions contained in AS 21.55.

Section 7 - Transition section in regards to premium rate restriction.

Section 8 - 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 9 - Effective date.

Alaska State Legislature

During Session
State Capitol
Juneau, Alaska 99801-1182
(907) 465-2828

During Interim
3111 C Street, Suite 540
Anchorage, Alaska 99503
(907) 561-2040

Senator Virginia Collins

To: Senator Pat Pourchot, Co-Chair
Senate Finance Committee

From: Senator Virginia Collins

Re: Request for a hearing on CSSB 242 (HES) - Small Employer Health Insurance

Date: April 16, 1992

Please schedule CSSB 242 (HES) for a hearing before your committee.

The bill establishes the Small Employer Health Reinsurance Association as a mechanism providing health care for employees of small employers.

After several exhaustive hearings, the Senate Health, Education, and Social Services Committee passed out CSSB 242 (HES) with a zero fiscal note.

Thank you for your consideration of this request.

ALASKA STATE MEDICAL ASSOCIATION

4107 Laurel Street • Anchorage, Alaska 99508-5334 • (907) 562-2662

MAY 20 1991

May 15, 1991

The Honorable Virginia Collins
Alaska State Senate
P.O. Box V
Juneau, Alaska 99811

Senate Bill 242

Dear Senator Collins:

The Alaska State Medical Association recently adopted Resolution 91-11 addressing the development of immediate and concrete measures to deal with Alaska's uninsured and underinsured.

We believe Senate Bill 242 is legislation that addresses this concern. Therefore, the Alaska State Medical Association supports your efforts and offers our assistance in securing this legislation.

We applaud your efforts in attempting to find solutions for the small employer. Our only suggestion is the criteria for a small employer might be 50 or less.

Sincerely,

Ray Schalow
Executive Director

217 Second Street, Suite 201
Juneau, Alaska 99801
(907) 586-2323
FAX (907) 463-5515

ALASKA
★STATE★
CHAMBER
OF COMMERCE

May 14, 1991

Senator Virginia Collins
Pouch V State Capital
Juneau, Alaska 99811

Dear Senator Collins:

Many problems beset the business community throughout the nation and in Alaska, but few of these problems are more troublesome than the concern for the provision of affordable health insurance for employees and employers. As you have recognized in SB 242, the problem is particularly acute for the very small employer.

The Alaska State Chamber of Commerce would like to go on record in support of the intent of SB 242. We have reviewed the bill and it seems to be very straightforward and reasonable in terms of content. The only reason we are not providing an unequivocal endorsement of every section in the bill is that the arguments on the technical issues in insurance are beyond our scope. Let it suffice to say that if a structure such as you propose in SB 242 would solve the problem of availability of insurance, we are heartily supportive. The problems of cost are a good deal more complex and we look forward to a feasible remedy, at either the state or federal level.

Thank you for your concern and your willingness to initiate a positive approach to a portion of the insurance problems facing the private sector.

With Regards,

George Krusz
President

Aetna Health Plans
1501 4th Avenue, Suite 1600
Century Square
P.O. Box 91032
Seattle, WA 98111-9132
Fax: (206) 467-2087

James E. Hickey
Manager
(206) 467-2802

April 27, 1992

Senator Virginia Collins
Alaska State Legislature
Pouch V
Juneau, AK 99802

Dear Senator Collins:

Aetna has reviewed the amendments made to SB 242 as embodied in CS SB 242 H.E.S. The amendments are consistent with the National Association of Insurance Commissioner model legislation on small group reform.

Aetna supports this legislation in its current form. It will result in structural changes to the small employer health insurance market that will increase the availability of policies to this group of Alaskans. This reform must be made by statute, as it is necessary to impose a consistent and mandatory set of rules which are applicable to all companies that market small group policies. Otherwise, there is financial incentive by individual companies to avoid the highest insurance risks within this sector of the overall market.

SB 242 is complimentary to SB 74 in several respects. First, it is managed by an association of private insurers, with oversight by the Division of Insurance. This will result in a lesser administrative cost to the State than a publicly funded board. Second, it requires coverage for individuals when they change jobs or their employer changes insurers, even if they develop medical conditions which would lead for eventual loss of coverage under the current system. This should lessen the number of people which will seek coverage under SB 74, which provides an insurance option for individuals with pre-existing medical conditions. Third, it sets limits on the cost of insurance to moderate future increases. To the extent that these limits result in losses, the losses may be spread among all insurers through a new reinsurance mechanism.

Approximately 21% of Alaska's uninsured population are employed by small businesses which do not provide insurance coverage (16,000 residents). We believe that a significant portion of this group will be able to obtain health insurance over the next several years if SB 242 is adopted.

Sincerely,

Jim Hickey
Manager
Aetna Health Plans

ALASKA STATE MEDICAL ASSOCIATION

4107 Laurel Street • Anchorage, Alaska 99508-5334 • (907) 562-2662

April 27, 1992

Senator Virginia Collins
P.O. Box V
Juneau, AK 99811

Dear Senator Collins:

Our legislative affairs committee recently reviewed your Senate Bill 242 relating to health insurance for small employers. This bill if enacted would significantly improve access to health care. It would be of special benefit to those that are all too often "uninsurable" with pre-existing conditions that currently all too often make insurance unaffordable for themselves and very expensive for their co-workers. This bill appears to be well thought out and has our strong support as being part of the solution to the total problem of health care access and cost containment.

If I can be of any assistance to you regarding this bill, do not hesitate to contact me.

Sincerely yours,

Donald R. Lehmann, M.D., A.B.F.P.

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Small Insurers Seek to Block Plan to Widen Coverage

4-8-92 Critics Say 'Guaranteed Issue' Will Achieve Little and Raise Premiums

By Eugene Carlson
Staff Reporter of The Wall Street Journal

Small insurers are stepping up their campaign to block an increasingly popular proposal designed to widen access to health insurance, particularly in small companies. The fight is splitting the small-business community and the insurance industry.

The struggle focuses on "guaranteed issue," a requirement that all of an employer's workers must receive health insurance as long as one gets it—regardless of a particular employee's health risk. (Currently insurers can screen employees of small companies and then decide whether to offer coverage to a particular employee.) Advocates say guaranteed issue is crucial to assuring access to health insurance, a growing anxiety among workers in small companies. But critics say the proposal will sharply increase insurance costs of small business without doing much to improve employees' access to health coverage.

Five states have adopted guaranteed issue as part of a health-insurance legislative overhaul aimed at small businesses. Congress and several additional states are weighing the idea, also called "open enrollment." Major health insurers, the nation's largest small-business group and other proponents say that the package would expand coverage and stabilize future premium increases.

Opponents are chiefly small insurers and small-business organizations that sell health insurance to their members. They say it is unfair to burden small employers and their carriers with America's 2.3 million medically uninsurable individuals. They are recruiting full-time lobbyists to help them buttonhole everyone from state lawmakers to President Bush.

"It's my survival," explains Benny Thayer, chairman of the National Association of the Self-Employed in Washington, D.C. He worries that many of his 165,000 members with NASE-endorsed health policies will drop their coverage and their membership if guaranteed access pushes up insurance rates substantially.

Mr. Thayer has organized a coalition of small-business associations and insurers to seek an exemption from the universal coverage requirement. He also is writing letters to Sen. Lloyd Bentsen, a Texas Democrat who chairs the Senate Finance Committee, which is drafting health-insurance legislation.

And in January, the NASE hired Jim Morrison, a former Senate Democratic aide, to lead its lobbying effort around the U.S., especially where the guaranteed issue is gaining steam. The lobbyist has gone to Annapolis, Md., twice. Last week, he visited lawmakers in Jefferson City, Mo., and in Washington.

"There are about 13 brush fires out there," Mr. Morrison says. "I think Florida is too far gone to stop. Arizona is very far along. I understand there are problems in Colorado, Vermont and Delaware."

The Council of Smaller Enterprises in Cleveland is lobbying equally hard against guaranteed issue. "We're doing our best to talk to everyone who will listen" because big insurers are overselling the idea and small employers don't grasp the dollar trade-offs, says John Polk, executive director. COSE, a leading local small-business organization, brokers health-insurance coverage for about 8,500 small companies whose policies cover 150,000 employees and family members.

Besides pressing his case with Ohio state senators, Mr. Polk says that earlier this year he tried to explain the dangers of guaranteed issue to Mr. Bush and Health and Human Services Secretary Louis Sullivan at a Washington briefing.

"The cost of guaranteed issue to our members would be [premium] increases in the neighborhood of 13% to 15%. That translates to about $30 million for our members," Mr. Polk says. At National Health Insurance Co. in Grand Prairie, Texas, President Scott Smith says that guaranteed issue would drive up premiums 20% to 45%. The insurer bills about $160 million a year in premiums for policies marketed mostly by an association that mainly insures the self-employed.

"Open enrollment is a concept that's totally flawed," asserts Arthur Ferrara, president of Guardian Life Insurance Co. of America in New York, which insures many small concerns. "Politicians think it's a great idea. The people who think it's a bad idea are those who have to deliver the benefits and pay the bills."

Mr. Ferrara has been urging New York state legislators to reject guaranteed issue unless it is combined with a pool to cover serious health risks, with costs borne by every employer. "Without the pool," he continues, "we would probably have to abandon the market."

Proponents argue that guaranteed issue along with the rest of the overhaul package would make coverage more affordable and plentiful while eliminating what they consider to be small insurers' overly aggressive pricing policies. Among the supporters are the Health Insurance Association of America, the National Federation of Independent Business, the National Association of Insurance Commissioners and House and Senate leaders from both parties.

Other changes proposed by the Health Insurance Association of America—the major U.S. health insurance trade group—and some members of Congress include: 100% deductibility of health-insurance costs for self-employed persons; requirements that states offer inexpensive, no-frills health coverage; curbs on annual policy rate increases; and risk pools to help mitigate steep premium increases.

Aetna Life Insurance Co. of Hartford, Conn., estimates that guaranteed issue would increase small companies' health-insurance premiums by a maximum of 5%, according to Thomas Buchberger, the insurer's director of public-policy issues analysis. Aetna bills about $1 billion of health premiums annually to companies with fewer than 200 employees. Aetna is a unit of Aetna Life & Casualty Co.

Small companies should be willing to pay a small price now for greater future stability in their health-insurance costs, says John Motley, the NFIB's government affairs director.

Mr. Motley blames insurers and small-business groups opposed to guaranteed issue for refusing to cover people without good health records. "From my standpoint, they are part of the problem," he says. "They are cherry picking" those whom they choose to insure.

Critics of guaranteed issue contend that proponents want to protect their own interests, too. The proposal supposedly would "broaden coverage to uninsured and presently uninsurable consumers. About two years later, however, massive cancellations and/or drastic premium increases would follow," wrote Tim Ryles, Georgia's insurance commissioner, in a March 10 memo to state lawmakers.

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ALASKA
STATE
CHAMBER
OF COMMERCE

April 7, 1992

Senator Arliss Sturgulewski
Alaska State Legislature
State Capitol
Juneau, AK 99801-1182

Dear Senator Sturgulewski:

While a myriad of problems beset the business community in Alaska and throughout the nation, only a few are as troublesome as the concern for providing affordable health insurance for employees and employers. As is recognized in CSSB 242, the problem is particularly acute for the very small employer.

The Alaska State Chamber of Commerce is proud to go record in support of the intent of CSSB 242. We have reviewed the bill and it seems to be very straightforward and reasonable in terms of its content. While the technical issues in insurance are beyond our scope, we feel that the structure as proposed in CSSB 242 would solve the problem of availability of insurance and we are very supportive.

Thank you for your concern and your willingness to initiate a positive approach to solving a portion of the insurance problems facing the private sector, especially small business.

Sincerely,

Tom E. Roy
President

Commentary

Here's something we can really do: Health insurance reform in Juneau

There's one thing state legislators can do in Juneau this spring they will feel good about — pass something in the way of health insurance reform. Soaring medical and health insurance costs is now a serious problem for business — many small businesses just cannot afford to offer their employees as good a health benefits package as they would like — and for individuals, many who just cannot afford health insurance.

There are several bills in the legislature that could make a start at doing something on this. It's a national problem as well, and there are bills pending in congress, but several states have been able to tackle bits and pieces of the problem with some success, and Alaska should be one of those.

One interesting bill that should be of interest to business is a proposal by Senator Virginia Collins to require insurers to form a reinsurance association to cover high-risk employees of small businesses. Based on plans adopted in several other states, her proposal would possibly lower the cost of health insurance for small businesses, or at least would slow its increase and make those costs more predictable.

A second proposal is one by Senator Jay Kerttula that would form, under state auspices, an insurance pool for covering high-risk individuals. Kerttula's plan would require no state subsidy, being supported by premiums with deficits covered by major insurance companies selling in Alaska.

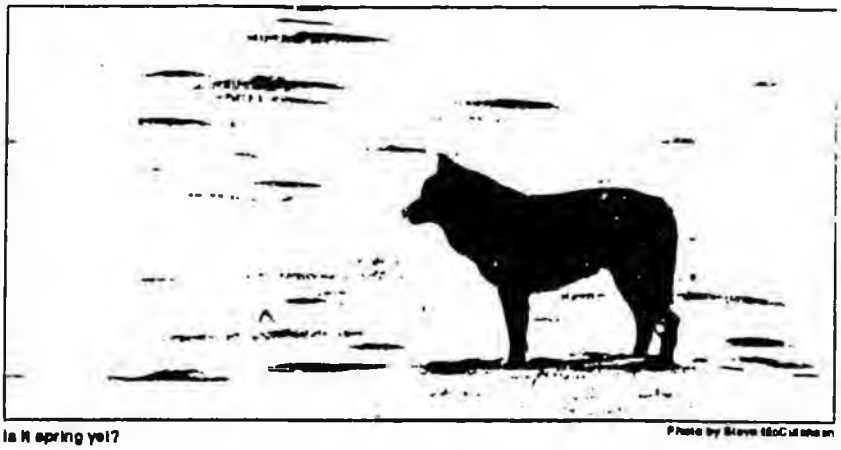
Those costs, of course, would be spread among their rates and paid by all of us. But it would make basic health coverage available to those who are now denied it, and the cost to all of us should be very marginal. That's better than the system we have now, which is to have these people go bare, without health coverage, then seek medical care only when there's an emergency.

There are other proposals. Senator Jim Duncan has an intriguing idea of combining all Alaska public employees, state, local and school district, into one vast health insurance pool that could bargain for better health coverage, and also include small business or high-risk groups, spreading the risk.

The medical community itself, to its credit, has tabled a plan that would see an insurance pool created and extending to all uninsured. Those now without coverage could buy into the pool at affordable rates, paying with the Permanent Fund dividend if nothing else.

With an estimated 40,000 to 90,000 Alaskans now without health coverage — the upper number about one-sixth of our population — we see the problem as serious indeed. But its one we can do something about this year.

In a year in which we face unpleasant tasks, like cutting the budget, health insurance reform is something lawmakers should be proud to take home to the voters.



Is it spring yet? Photo by Steve McCutcheon

Mental Health Trust lands: Will the settlement work?

By Sen. Jim Duncan

Last May, the Legislature accepted the governor's proposal for settling the Mental Health Lands Trust dispute. Unfortunately, it is now obvious that the proposal faces years of litigation and even then may not be approved by the courts. Meanwhile, an additional four million acres of land have been tied up in this lawsuit just when we desperately need new income-generating development.

The root of this problem goes back to territorial days. A barbaric federally imposed system convicted an Alaskan with any mental disability of the crime of being an insane person at large. Then these people, our family, friends, and neighbors, were taken to Morningside Hospital in Oregon. Many were never seen again.

One powerful reason for statehood was to end this abuse. We demanded the right and the resources necessary to care for our own here in Alaska. In response, the federal government granted the state one million acres of land. It was to be held in trust and managed to make money for our own mental health program.

These were the first lands taken from the federal government, and we chose them well. Ester Dome, Beluga coal, Kenai riverfront, Homer Spit, the Tanana and Haines forests, together with strategic lands in and around every growing community, became the Mental Health Lands Trust. Along with the land, we accepted the responsibility to manage it to benefit the mental health program.

Tragically, we failed to meet that responsibility. This was such good land that the state gave it away, traded it, sold it, or took it for itself as parks and refuges. Over a decade ago, the beneficiaries sued. The Alaska Supreme Court ordered the state to give back the land that was taken and pay for the land that was sold.

In 1991, I introduced Senate Bill 65 to establish a Mental Health Lands Trust Authority, to compensate the Mental Health Trust for the land that was not returnable and to give back all possible acreage from the original million acres.

My plan would have freed title to the mental health lands immediately and provided an income stream for mental health programs. My proposal was endorsed by the mental health beneficiary groups. SB 65 received much legislative scrutiny, but the governor's representatives offered a different proposal in the waning days of the legislative session.

Their proposal seemed simple and straightforward and, I think, was offered in good faith. Instead of paying for the land that could not be returned to the trust, the land would be exchanged for other state land of comparable value and income producing potential. A trust authority would be created to ensure that the land was properly managed to produce income. This authority would also recommend how the income should be spent.

Part of the administration's deal required the state to pledge or hypothecate a list of lands as security for the promise to exchange lands to the trust. So valuable are the original trust lands that four million acres, including Cook Inlet oil and gas lease lands, had to be pledged as security. Preparation of the hypothecated land roster took so long that the list was not available to the Legislature before the amended SB 65 was passed.

The deal was negotiated with the beneficiaries' attorneys in less than two weeks. It was presented to the Legislature with less than four days left in the session. Now, nearly a year later, we can see that accepting the administration's proposal made matters worse, not better.

In October, 1991, a coalition of environmental and sportfishing organizations sued to block the settlement. They have raised many serious questions about the legality of the proposal. Foremost among the issues raised, is that the settlement violates the statehood act and could even result in the state forfeiting millions of acres of our most valuable lands back to the federal government. It looks as if we have succeeded only in adding another lawsuit on top of the one already before the courts.

Of great concern is the statehood act. For the land exchange to work, we must be able to return the same kind of mineral rights we took from the trust. However, Section 6i of the statehood act forever prohibits the state from granting such mineral rights out of state hands. The penalty for violating Section 6i is the forfeiture of the lands back to the federal government.

Before we exchange these lands we must be certain it would not violate 6i. This question will be asked first in the Superior Court. Next, the Alaska Supreme Court will give its opinion. And only years from now, when the United States Supreme Court finally rules on this issue, can the terms of the settlement be implemented.

Meanwhile, our most promising five million acres of land will be tied up. The cloud on the title and the injunction on the original one million acres will remain. In addition, the four million acres of hypothecated lands must be preserved as security. Already timber sales on these lands have been stopped. The stoppage of mining and other development will soon follow.

Fortunately, there is hope. A new alternative is being discussed. Ironically, it is very similar to what I proposed in the original version of SB 65. It would return some land to the trust. It would continue the current allocation of six percent of the unrestricted general fund revenue to the trust. The trust would be managed by the trust authority established in SB 65. It does not rely on problematic land exchanges or require the state to come up with additional cash for a settlement. It is a serious proposal and should be given serious and immediate consideration.

Sen. Jim Duncan, a Democrat, represents Juneau in the state Senate.

THE ALASKA
JOURNAL OF COMMERCE

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Health insurance reform priorities: Small business, high-risk groups

By Tim Bradner
Alaska Journal of Commerce

The task force steered away from recommending a plan for universal coverage that would be available to all Alaskans, for reasons of cost. But if smaller target groups can be covered more effectively, such as small business employees or high-risk individuals, the pool of uninsured, estimated as high as 90,000 in Alaska, might be reduced to the point where universal coverage might be possible.

A state health care task force has targeted two proposals that will help small businesses control high and unpredictable employee health insurance costs and also extend affordable coverage to high-risk Alaskans who cannot now get medical insurance. While the Health Resources and Access Task Force did not endorse specific bills, some of its recommendations are embodied in bills now in the Legislature.

The task force presented its recommendations to the state Senate's Health, Education and Social Services Committee last week, and the committee started work sessions on legislation earlier this week. Similar legislation is in the state House.

One bill is Senate Bill 242, sponsored by Sen. Virginia Collins of Anchorage, that would require insurance companies selling health insurance in the Alaska market to join a reinsurance association that would offer special coverage of high risk employees of small businesses. Small business is defined as an employer with three to 25 employees. "Over 90 percent of the businesses in Alaska are considered small business, having 25 or fewer employees," Collins said.

With medical costs and health insurance premiums rising, many small firms can no longer offer comprehensive health insurance. Employees may have limited coverage, for example, but families would not be covered.

A second proposal is Senate Bill 74, sponsored by Sen. Jalmar Kerttula of Palmer, which would form a non-profit state Comprehensive Health Insurance Association to extend coverage to high-risk individuals. Twenty-four states have adopted similar programs, Kerttula said. Insurers selling in the Alaska market would be required to join the association, coverage to those considered high-risk could not be denied, and a cap would be placed on premiums.

The task force steered away from recommending a plan for universal coverage that would be available to all Alaskans, for reasons of cost. But if smaller target groups can be covered more effectively, such as small business employees or high-risk individuals, the pool of uninsured, estimated as high as 90,000 in Alaska, might be reduced to the point where universal coverage might be possible, said state Sen. Jim Duncan, a legislator active on the issue and a member of the health

Continued on Page 2

Required insurance pools should cover risks

Continued from Page 1

resource task force.

"Our studies show that 35,000 of the 90,000 uninsured are in families with income levels 350 percent or above the poverty line. If insurance can be made available at a reasonable cost, they should be able to pay for it themselves," Duncan said.

Collins' proposal, which is based on a model bill developed by the insurance industry's Health Insurance Association and America, creates the Small Employer Health Reinsurance Association, a non-profit entity, which all insurers selling in the small employer market would join. Pooling allows insurers to spread the cost of high risk groups throughout the market, rather than remain concentrated on one small employer group.

The plan would also cover employees changing jobs. "Once someone with a pre existing condition satisfies the pre-existing condition restriction, he or she is not required to satisfy requirements again when changing jobs or when the employer changes insurers," Collins said.

Key points of her proposal:

• Guaranteed availability: All small employer groups would be able to obtain private health insurance regardless of the health risk they represent.

• Coverage of whole groups: Coverage would be made available to entire employer groups; neither an employer nor an insurer would be able to exclude from the group's coverage individuals who present high medical risks.

• Renewability of coverage: At renewal time, employer groups or individuals in these groups would be assured that their coverage would not be canceled because of deteriorating health.

• Continuity of coverage: Once a person is covered in the small employer market and has satisfied a plan's pre-existing condition requirements, he or she would not have to meet those requirements again when changing jobs or when the employer changes carriers.

• Premium pricing limits: Insurance companies would be required to limit how much their rates could vary for groups similar in geography, demographic composition and plan design. A carrier's premiums for similar groups could not vary by more than 35 percent from the carrier's midpoint rate, as well as a 15 percent limit of how much a carrier's rates could vary by industry. Finally, increases would be held to no more than 15 percent above a carrier's trend, the year-to-year increase in the lowest new business rate.

Kerttula's SB-74 is somewhat similar, except that it would extend to all high-risk Alaskans, including those over 65. Membership of insurers in the association would consist of all licensed hospital or medical service corporations in the state that offer subscriber contracts for major medical coverage and all insurers licensed to offer health insurance in the state.

Kerttula's plan would see the association make available to high-risk Alaskans a medical coverage plan that includes hospital, physician, nursing home and other services. Coverage also would be offered to those who are high risk and 65 years or older, as a Medicare supplement plan.

To establish premiums, the five members of the association that have the largest numbers of individuals under plans with similar benefits will submit rate proposals for risk coverage equivalent to that under the state plan. Premiums for the state plan could not exceed 125 percent of the average of these five proposals.

'Three-quarters of uninsured Alaskans live in families of employed workers, and more than half of this group live in families of full-year, full-time workers.'

Kerttula said his bill is modeled on several different approaches used in other states and municipalities. Some 24 states have adopted similar programs, he said. "All state residents who are high risk would be eligible for insurance under this pool at a reasonable rate. Other states place a limit on the amount of premiums of between 125 percent and 200 percent of the average health insurance premiums in the state. Alaskans who have had their health insurance terminated once they have become high risk would be eligible for this insurance, also."

Kerttula said that, in theory, premiums would cover the majority of claims paid by the pool. In practice, premiums are generally insufficient because of the premium cap and the poor health of the uninsured. "A 1988 (federal) Government Accounting Office study concluded that for every $1 received in premiums by the current operating pools, $1.60 is paid out in claims. This bill takes the approach taken in most states with pools, to assess the pool members the excess costs in proportion to their share of the state health insurance market." And while high-risk pools in other states usually lose money—and losses can at times be large—the cost has generally been in the range of one percent of the total amount of premiums collected from all health insurance policies sold in those states, Kerttula said.

The cost would be worth it, Kerttula thinks: "Three-quarters of uninsured Alaskans live in families of employed workers, and more than half of this group live in families of full-year, full-time workers," Kerttula said. "This bill would provide low-cost employee and individual health insurance to people who are currently delaying health care until their health problems become severe."

Currently, health care consumers in Alaska are paying the cost of the uninsured another way. Hospitals, clinics and physicians pass the costs of patients who cannot pay onto all the rest of their patients, which is one major factor behind Alaska's high cost of medical care.

The Health Resources and Access Task Force was told that in 1990 Alaska's 10 top community hospitals had to pass $17 million in uncollectible charity cases onto patients who had insurance and could pay. That raised the cost of medical services and insurance.

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ALASKA STATE

HOSPITAL & NURSING HOME

ASSOCIATION

Senator Arlis Sturgulewski, Chair
Committee on Health, Education & Social
Services
Alaska State Senate
Capitol Building
Juneau AK 99811

Re: Support SB 242
Health Insurance Small
Employers

Dear Senator Sturgulewski:

Small businesses across the state, including this Association, badly need acess to affordable health insurance programs.

SB 242 provides a mechanism, at little cost to the state, and without building more bureaucracy to administer a program within the Division of Insurance that can begin this year making available to the Alaska small business health insurance that is:

** guaranteed available
** renewable
** provides continuity of coverage
** places limits on cost

We urge quick action in support of SB 242. This legislation will not resolve much broader health care cost and access issues that will be dealt with under SCR 10, but it is a very positive solid step towards making health insurance more accessible to Alaskans.

Sincerely,

Harlan R. Knudson
President/CEO

cc: Members, Senate HESS Committee
Senator Fischer
Senator Cotten
Senator Hoffman
Senator Menard

319 SEWARD STREET #11 • JUNEAU, AK 99801 • (907) 586-1790 • FAX (907) 463-3573

POSITION PAPER

SB 242: "An Act relating to health insurance for small employers; and providing for an effective date."

With resolution of the issues noted below, the administration can support this legislation.

One of the more challenging issues facing this country and Alaska is the ever-increasing number of people unable to afford or even find health care insurance. This bill would address small employers who have been unable to purchase health care coverage for employees, especially when one employee has acquired a medical condition and become, in too many cases "uninsurable." The plan established in the bill assures availability of coverage, prevents picking and choosing employees in a group, assures renewability, and places a cap on premium increases.

Section 2 should be broadened to prohibit violation of any provision of Chapter 55 by any person. The prohibition should not be limited to some licensed individuals or to one section of the law.

AS 21.55.020(a) should delete the director as an ex-officio member of the board. The director cannot be in a position of regulating the activities of the small employer health reinsurance association and be a member of its administrative arm.

AS 21.55.020(b) should delete the exception to the Division of Insurance's expenses. This program should be self-supporting. Furthermore, the division by statute is funded by fees for services provided.

AS 21.55.040 provides for the sharing of program gains. A legal opinion and perhaps a tax accountant's opinion should be secured to determine if reinsurers' sharing of gains would adversely affect the nonprofit status of the association and make it subject to taxation by the Internal Revenue Service.

AS 21.55.040 should require that the plan of operation establish procedures to be self-supporting and fiscally sound.

AS 21.55.050(a)(5) should allow the association to reimburse a reinsuring insurer if the insurer has paid the initial level of claims rather than when the insurer has incurred the initial level of claims. Reinsurers traditionally reimburse after the primary insurer has paid the loss, not when the primary insurer has reserved the loss.

AS 21.55.050(d)(8) should require reports no less often than quarterly and upon forms prescribed by the association and acceptable to the director. The association needs to have status reports of claim payments administrative expense on an ongoing basis rather than an annual basis.

AS 21.55.060 should delete the director as a member of the committee.

AS 21.55.060(b) may be in conflict with AS 21.36.090(d). AS 21.55 should be added as an exception to AS 21.36.090(d).

AS 21.55.070 should be revises to mandate legislative review of the program after three years to include the effect of the program on its target market as well as the overall health insurance market, and to determine whether the program should be continued.

AS 21.55.120 should be revised to assure no cost shifting to other insured persons or to the state.

AS 21.55.120(3)(C) should not limit use of the confidential information to determining a violation of Chapter 55. The information should be available in regard to any violation of AS 21. The exception should allow the director to initiate proceedings as provided by law and use the information, documents, and other information discovered or developed in a judicial or administrative proceding.

AS 21.55.140 provides no standard of review of forms for the director to follow. Without such standards, the director will not be in a position to disapprove use of forms.

AS 21.55.150(2) does not address situations in which the employer may fail to pay premium and coverage is cancelled or the employer drops coverage. It appears that a new pre-existing condition requirement would apply to such unfortunate employees. Consideration should be given to providing the employee an option to maintain coverage by paying the premium.

AS 21.55.180 should apply fair marketing standards to all persons, not just small employer insurers. Subsection (c) and (d) should address entities such as managing general agents and third-party administrators. Subsection (f) should apply to all persons.

AS 21.55.250 includes definitions of agent and broker which are already established in AS 21.90. It is probably unnecessary to include reference definitions here. The definition of premium appears to cover the same broad scope as the definition of premium in AS 21.90. The use of different terminology may create ambiguities. This definition may be unnecessary. The definition of small employer references "the preceding year." to avoid confusion, the phrase should clarify whether calendar year, fiscal year, or a rolling 365-day year is the applicable criteria.

This legislation, with resolution of the above issues, will give the private health care insurance system an opportunity to address the challenge of providing health insurance for small employers, and the administration can support such legislation.

Nancy Bear Usera, Commissioner
Department of Administration

Theodore A. Mala, Commissioner
Department of Health and Social Services

Glenn A. Olds, Commissioner
Department of Commerce and Economic Development

Date: 4-13-92

6091c
041392a

NFIB Alaska

National Federation of
Independent Business

April 7, 1992

The Honorable Virginia Collins
Alaska State Senate
Pouch V
Juneau, Alaska 99811

RE: SB 242: Health Insurance for small employers.

Dear Senator Collins:

The runaway cost of health insurance is an issue facing small employers in the state of Alaska. NFIB/Alaska has been following the work of the Health Resources and Access Task Force and the progress of SB 74, SB 83 and 242. Now that hearings are underway on these bills, the objective of this letter is to share with you some thoughts on SB 242.

The idea of a voluntary health insurance program is a viable means of providing health insurance to the uninsured population in Alaska. Small businesses are willing to provide health insurance to employees, as long as the cost is not prohibitive.

A voluntary approach is a more acceptable alternative than a legislative mandate that all employers must provide health insurance coverage for their employees. Some have suggested a "pay or play" approach to solve the problems. On a state and national level NFIB is very opposed to that concept. Enclosed is a copy of an article I wrote in opposition to that concept for the December 1991 issue of the Alaska Business Monthly Magazine.

NFIB/Alaska has and will continue to support all legislation that will help make privately administered health insurance more available and affordable for small businesses.

As a reminder, the following is the results of the 1991 and 1989 NFIB/Alaska poll of our members regarding health insurance:

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

1991

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%

1989

Should legislation be enacted requiring employers to provide basic health care insurance coverage for their employees?

Yes 8% No 87% Undecided 5%

I look forward to working with you on this and other issues of importance to the small business owners of NFIB/Alaska.

Sincerely,

Resa Jerrel

Resa Jerrel
State Director

Enclosure

cc: Senate Health, Education and Social Services Committee

THOMAS A. TURNER, CLU

MAR 13 1992

INSURANCE AND EMPLOYEE BENEFITS

Senator Virginia Collins
P.O. Box V
Juneau, AK 99811

March 10, 1992

Re: SB 242

Dear Senator Collins:

As the chairman of the Southern Alaska Life Underwriters Association Legislative Committee, I am writing to advise you of our strong support for your bill number 242. In reviewing all of the health insurance related submitted this session, yours offers the potential to benefit the greatest number of Alaskans. Unfortunately, most of these Alaskans do not have a well funded lobbying effort. Self employed individuals, small business owners and employees and their families make up this group. The one thing that they all have in common is one or more medical problems which deny them access to comprehensible medical coverage. These people fall through the cracks because they either make too much money or have too large a net worth to qualify for Medicaid.

We also support your legislation because it provides for a fiscally responsible mechanism to guarantee these Alaskans coverage. It is not a socialized all intrusive plan, as some have proposed, but a solid first step in meeting the needs of most Alaskans who desire adequate medical care.

Members of our organization will continue to be in contact with you throughout the session, and hope that we can assist you in getting this legislation passed.

Sincerely,

Thomas A. Turner, CLU
Chairman, Legislative Committee
Southern Alaska Life Underwriters
TT/jm

cc: Senator J. Kerttula

1400 WEST BENSON SUITE 350 ANCHORAGE, ALASKA 99503 (907)257-5216 FAX (907)279-5016

S·A·L·U
Southern Alaska Life Underwriters Association
P.O. Box 10-3956
Anchorage, Alaska 99510

MAR 17 1992

March 5, 1992

Chris Clark
Nanci Spear
c/o Senator Virginia Collins
P.O. Box V
Juneau, AK 99811

Dear Chris and Nanci,

Thank you both for your time and attention this past week. Our association appreciates your apparent concern on life and health insurance issues which are pending this session.

We support the concepts of Senator Collins' S.B. 242 and welcome your inquiries on this or any other health or life insurance issues which may need clarifications on our positions. Our national organization provides us with a tremendous backup of support for local legislative issues and we stand ready to offer to you our member's expertise and experiences should you need them.

We are also proponents of S.B. 74 (high risk, uninsurable pool) which we feel, when combined with S.B. 242, will go a long way to provide increased access to health care coverage for our clients, which of course are all Alaskan voters.

We hope that you will contact our Association for further input.

Sincerely,

Jeff Duzenbery

Jeff Duzenbery
President
(907) 258-5065 work
(907) 248-1336 home

Alaska State Legislature

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Senator Virginia Collins

CSSB 242 (HES)

Small Employer Health Insurance Reform

CSSB 242 (HES) 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, CSSB 242 (HES) 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.

UNINSURED ALASKA POPULATION

Total Uninsured Population
(Excluding Native Population) **76,627**

Uninsured earning less than 300% of poverty level 61.47% (47,106)
Uninsured earning more than 300% of poverty level: 38.53% (29,521)

Uninsured Children Under Age 19 **15,694** **(20.48%)**
(300% of Federal Poverty Level and below)

less than 100% of poverty level: 4,284 children
100 - 200% of poverty level 4,888 children
200 - 300% of poverty level 6,522 children

Uninsured Small Business Family Members **16,025** **(20.91%)**
- Firms with 25 employees
- Include full-time/full-year workers
- Does *not* include full time/part-year workers

Medically Uninsurable **4,000** **(5.22%)**
(I.e. "high risk" individuals)

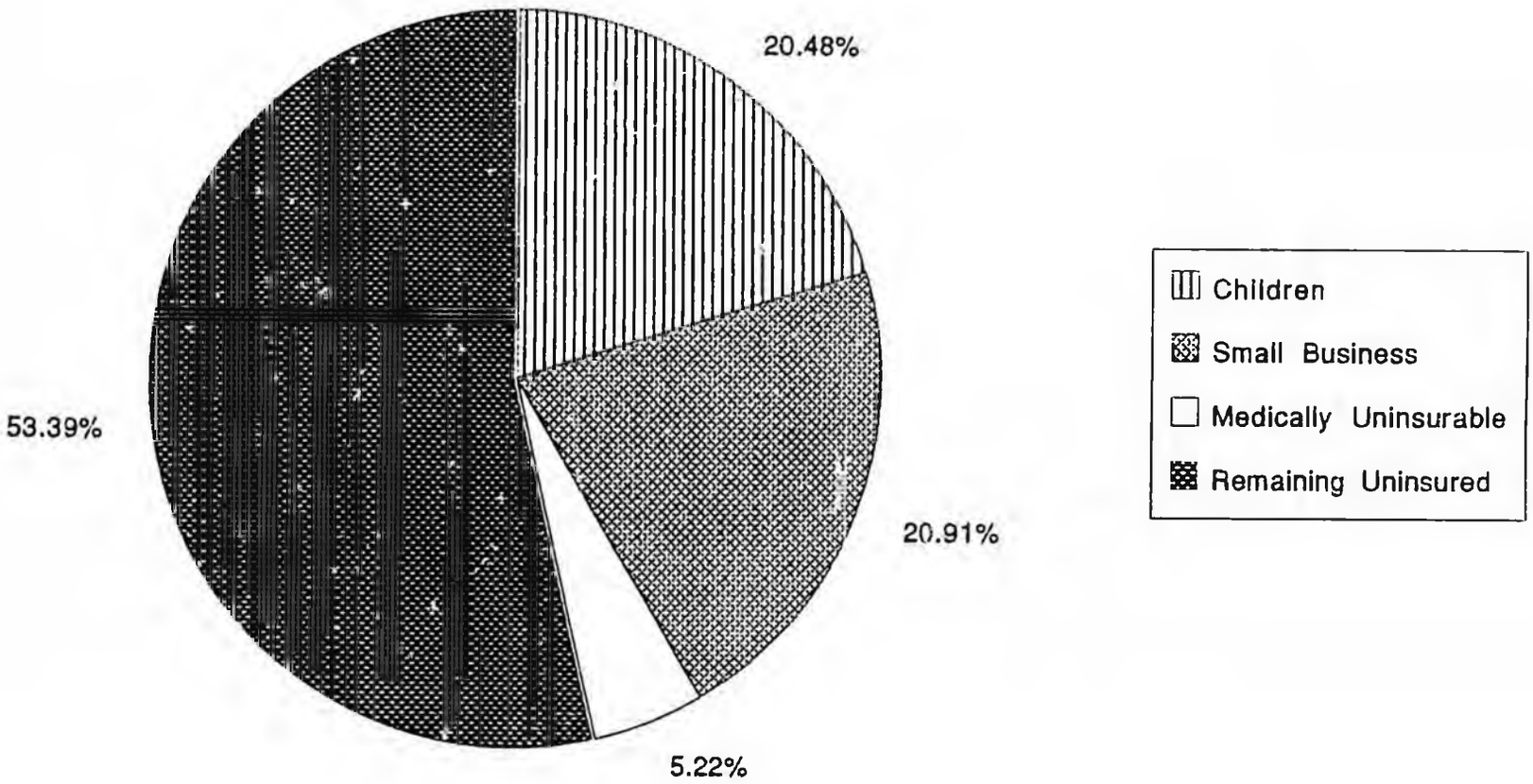
Above figures represent potential size of enrollee participant group for coverage provided under the terms of SB 74, SB 242 and SB 290. Actual enrollment will depend on specific benefit levels offered, participant premium/contribution levels, and participant cost-sharing provisions.

1992 Poverty Guidelines for Alaska

Size of family Unit	*Poverty Guideline (100%)*
1	$8500
2	$11,480
3	$14,460
4	$17,440
5 and above	extra $2,980 per member

Data Sources: Health Systems Research Inc. February 7, 1992 report; Aetna estimates

UNINSURED ALASKAN POPULATION



SMALL EMPLOYER MARKET REFORMS

	NAIC	CSSB 242 (HES)
Availability	Guaranteed issue	Guaranteed issue
Group Size	1-25	3-25
Case Characteristics	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
Rating Restrictions	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%.
Transitional Period	3 years	3 years
Renewal Rating	Trend plus 15% plus changes in case characteristics	Trend plus 15% plus changes in case characteristics
Renewability	Guaranteed renewable except "for cause"	Guaranteed renewable except "for cause"
Whole Groups	Must take whole group	Must take whole group
Continuity of Coverage	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	CSSB 242 (HES)
Reinsurance	Prospective with opt out. Insurers elect whether to participate in the reinsurance mechanism.	Mandatory prospective. Insurers must participate in the reinsurance mechanism.
Reinsurance Price	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	CSSB 242 (HES)
Health Benefit Plan Committee	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	No reference	Shifting program costs to other insureds, or to state not allowed.
Reporting	No reference	Annual report to Director, Legislature required first 5 years; thereafter every 2 years
Insurers With Restricted Charters, i.e., Fraternal Benefits Organizations	Not Included	Guarantees issue only to those permitted by charter.

CSSB 242 (HES)

Small Employer Health Insurance Reform

Highlights

	CSSB 242 (HES)
Availability	Guaranteed issue **Sec. 21.55.140(a)**
Group Size	3-25 **Sec. 21.55.250(25)**
Case Characteristics	Geography, age, sex, and other objective criteria but does not include claim experience, health status, or duration of coverage **Sec. 21.55.250(9)**
Rating Restrictions	An insurer's rates for similar groups may not vary from applicable index rate by more than 35% **Sec. 21.55.120(a)(1)**
Transitional Period	3 years **Sec. 7. PREMIUM RATE RESTRICTION (page 23, lines 1-15); Sec. 21.55.120(a)(2)**

	CSSB 242 (HES)
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 covered under a previous employer-based plan if the coverage was continuous **Sec. 21.55.150(2)**
Reinsurance	Mandatory prospective. Insurers must participate in the reinsurance mechanism. **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)**

	CSSB 242 (HES)
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)**

	CSSB 242 (HES)
Insurers With Restricted Charters, e.g., Fraternal Benefits Organizations	Guarantees issue only to those permitted by charter (e.g., the Lutheran Brotherhood) **Sec. 21.55.160(a)(4)**

NEW BILL IN
COMMITTEE 4-16-92

CS FOR SENATE BILL NO. 242 (HES)

IN THE LEGISLATURE OF THE STATE OF ALASKA

SEVENTEENTH LEGISLATURE - SECOND SESSION

BY THE SENATE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

Offered: 4/15/92
Referred: Finance

Sponsor(s): SENATORS COLLINS, Menard, Pearce

A BILL

FOR AN ACT ENTITLED

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

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

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

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

(2) prevent abusive rating practices;

(3) require disclosure of rating practices to purchasers;

(4) establish rules regarding renewability of coverage;

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

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

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

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

market.

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

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

Sec. 21.36.025. UNFAIR MARKETING PRACTICES PROHIBITED. A person may not violate the applicable provisions of AS 21.55.180.

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

(d) Except to the extent necessary to comply with AS 21.42.365 and AS 21.55, a person may not practice or permit unfair discrimination against a person who provides a service covered under a group disability policy that extends coverage on an expense incurred basis, or under a group service or indemnity type contract issued by a nonprofit corporation, if the service is within the scope of the provider's occupational license. In this subsection, "provider" means a state licensed physician, dentist, osteopath, optometrist, chiropractor, nurse midwife, advanced nurse practitioner, naturopath, physical therapist, or occupational therapist.

* **Sec. 4.** AS 21 is amended by adding a new chapter to read:

CHAPTER 55. SMALL EMPLOYER HEALTH INSURANCE.

ARTICLE 1. SMALL EMPLOYER HEALTH REINSURANCE ASSOCIATION.

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

Sec. 21.55.020. BOARD OF DIRECTORS; ORGANIZATION. (a) The board of directors of the association consists of nine individuals selected by participating members, subject to approval by the director. The director shall endeavor to appoint at least six board members who are also small employer insurers. If the director is unable to appoint six board members who are also small employer insurers, the director may fill the remaining seats with any insurer. In selecting members of the board, the director shall consider, among other things, whether all types of participating members are fairly represented.

(b) To the extent possible, one board member shall represent a health maintenance organization, one board member shall represent a hospital or medical service corporation, one

board members' principal health insurance business shall be in the small employer market, and one board member's principal health insurance business shall be in the large employer market. Members of the board may be reimbursed from the association for expenses incurred by them as members, but may not otherwise be compensated by the association for their services. The costs of conducting meetings of the association and its board of directors shall be borne by the association.

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

Sec. 21.55.030. GENERAL POWERS. The association may

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

(2) sue or be sued;

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

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

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

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

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

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

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

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

or to assist in other functions of the association;

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

Sec. 21.55.040. PLAN OF OPERATION. (a) The association shall submit to the director a plan of operation and amendments necessary or suitable to assure the fair, reasonable, and equitable administration of the association. The director may, after notice and hearing, approve the plan of operation if the director determines it to be suitable to assure the fair, reasonable and equitable administration of the program on a proportionate basis under the provisions of this section and it does not shift program costs to other insured persons or the state. The plan of operation and amendments become effective upon approval in writing by the director.

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

(c) The plan of operation must establish procedures for

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

calendar year from newly issued health benefit plans delivered or issued for delivery during the calendar year to small employers in this state by reinsuring insurers. In determining an assessment, if any, that is collected from a member, the following provisions apply:

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

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

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

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

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

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

program, the appropriateness of the premiums charged, and the level of insurer retention under the program and the costs of coverage for small employers; if the board fails to file a report with the director within 90 days following the end of the applicable calendar year, the director may evaluate the operations of the program and implement amendments to the plan of operation the director determines necessary to reduce future losses and assessments;

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

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

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

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

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

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

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

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

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

(2) one member who represents small employers;

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

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

(5) one member who represents agents or brokers.

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

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

(2) case management;

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

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

(5) other managed care provisions.

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

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

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

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

ARTICLE 2. SMALL EMPLOYER HEALTH INSURANCE PLANS.

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

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

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

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

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

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

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

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

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

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

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

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

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

employers;

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

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

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

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

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

(7) a small employer insurer shall

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

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

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

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

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

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

(2) the provisions of the health benefit plan

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

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

(C) relating to any preexisting condition provision.

(c) A small employer insurer shall

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

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

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

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

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

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

(d) The director may adopt regulations to implement the provisions of this section and to ensure that rating practices used by small employer insurers are consistent with the purposes of this act, including ensuring that differences in rates charged for health benefit plans by small

employer insurers are reasonable and reflect objective differences in plan design, not including differences due to the nature of the groups assumed to select particular health benefit plans.

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

(1) nonpayment of the required premiums;

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

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

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

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

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

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

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

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

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

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

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

that established service area.

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

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

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

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

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

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

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

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

(2) a health benefit plan must waive any time period applicable to a preexisting condition exclusion or limitation period with respect to particular services for the period of time an individual was previously covered by qualifying previous coverage that provided benefits with

respect to the services, provided that the qualifying previous coverage was continuous to a date not more than 30 days before the effective date of the new coverage; this paragraph does not preclude application of a waiting period applicable to all new enrollees under the health benefit plan;

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

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

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

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

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

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

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

geographic service area;

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

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

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

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

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

Sec. 21.55.170. CONDITIONS FOR CEASING TO DO BUSINESS. A small employer insurer or a welfare arrangement may cease doing business in the small employer market if the insurer or welfare arrangement provides notice of the decision to cease doing business in the small employer market to the division, the board, the policyholder or contract holder, and the employer, and coverage under a health benefit plan subject to this chapter is continued for one year after the date of the notice required under this section. A small employer insurer or a welfare arrangement that ceases doing business in the small employer marketplace may not reenter the small employer marketplace for a period of five years from the date of the notice required under this section.

Sec. 21.55.180. FAIR MARKETING STANDARDS. (a) A small employer insurer shall actively market health benefit plan coverage, including the basic and standard health benefit

plans, to eligible small employers in the state. If a small employer insurer denies coverage to a small employer on the basis of the health status or claims experience of the small employer or its employees or dependents, the small employer insurer shall offer the small employer the opportunity to purchase a basic health benefit plan and a standard health benefit plan.

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

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

(d) A small employer insurer

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

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

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

(e) The director may by regulation establish additional standards to provide for the fair

marketing and broad availability of health benefit plans to small employers in this state.

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

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

Sec. 21.55.250. DEFINITIONS. In this chapter,

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(17) "late enrollee" means an eligible employee or dependent who requests enrollment in a small employer's health benefit plan following the initial enrollment period for which the employee or dependent was eligible to enroll under the terms of the health benefit plan

except that an eligible employee or dependent may not be considered a late enrollee if

(A) the individual

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

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

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

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

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

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

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

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

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

(A) Medicare or Medicaid;

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

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

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

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

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

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

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

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

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

* **Sec. 5.** AS 21.86.260(a) is amended to read:

(a) Except as provided <u>in AS 21.55 and</u> in this chapter, this title does not apply to a health maintenance organization that obtains a certificate of authority under this chapter. This

subsection does not apply to an insurer licensed under AS 21.09 or a hospital or medical service corporation licensed under AS 21.87 except with respect to its health maintenance organization activities authorized by and regulated under this chapter.

* **Sec. 6.** AS 21.87.340 is amended to read:

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

(1) AS 21.03

(2) AS 21.06

(3) AS 21.09, except AS 21.09.090

(4) AS 21.18.010

(5) AS 21.18.030

(6) AS 21.18.040

(7) AS 21.18.120

(8) AS 21.21.321

(9) AS 21.36

(10) AS 21.42.345 - 21.42.365, and 21.42.375

(11) AS 21.51.120

(12) AS 21.53

(13) AS 21.54.020

(14) <u>AS 21.55</u>

<u>(15)</u> AS 21.69.400

<u>(16)</u> [(15)] AS 21.69.520

<u>(17)</u> [(16)] AS 21.69.600, 21.69.620, and 21.69.630

<u>(18)</u> [(17)] AS 21.78

<u>(19)</u> [(18)] AS 21.89.040

<u>(20)</u> [(19)] AS 21.89.060

<u>(21)</u> [(20)] AS 21.90.

* Sec. 7. PREMIUM RATE RESTRICTION. Regarding a health benefit plan subject to AS 21.55.110, enacted in sec. 4 of this Act, that is delivered or issued for delivery before July 1, 1992, a premium rate for a rating period may exceed the ranges set out in AS 21.55.120(a)(1) and (2), enacted in sec. 4 of this Act, through June 30, 1995; on or after July 1, 1995, the premium rate may not exceed the ranges set out in AS 21.55.120(a)(1) and (2). However, through June 30, 1995, the percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of

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

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

* Sec. 8. TRANSITION. (a) Within 180 days after the board is appointed under AS 21.55.020, enacted in sec. 4 of this Act, the board of directors of the Small Employer Health Reinsurance Association shall submit a small employer health benefit plan to the director of the division of insurance for approval. If the association fails to submit a suitable plan of operation, the director may, after notice and hearing, adopt reasonable regulations necessary or advisable to effectuate the provisions of this chapter. These regulations continue in force until modified by the director or superseded by a plan submitted by the association and approved by the director.

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

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

(d) The Health Benefit Plan Committee, enacted in sec. 4 of this Act, shall submit the required health benefit plans within 180 days after the members of the committee are appointed.

(e) Notwithstanding AS 21.55.070, enacted in sec. 4 of this Act, the board of directors of the Small Employer Health Reinsurance Association shall provide the report required under AS 21.55.070 to the director of the division of insurance annually until December 31, 1997.

* **Sec. 9.** This Act takes effect July 1, 1992.

SENATE BILL NO. 242

IN THE LEGISLATURE OF THE STATE OF ALASKA

SEVENTEENTH LEGISLATURE - FIRST SESSION

BY SENATOR COLLINS

Introduced: 4/5/91
Referred: L&C, HES, Finance

A BILL

FOR AN ACT ENTITLED

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

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

* **Section 1.** FINDINGS. The legislature finds that

(1) an unacceptable number of residents of this state are without appropriate health care because of the rapid increase in the cost of health care, the lack of access to health care, and the lack of availability of health insurance coverage;

(2) maintenance of proper coverage of employees and dependents of employees of small employers under a health benefit plan is important to ensuring the availability of appropriate health care for the residents of this state and provides more stability and predictability of both rate increases and coverage continuation.

* Sec. 2. AS 21 is amended by adding a new chapter to read:

CHAPTER 55. SMALL EMPLOYER HEALTH INSURANCE.

ARTICLE 1. SMALL EMPLOYER HEALTH REINSURANCE ASSOCIATION.

Sec. 21.55.010. CREATION; MEMBERSHIP. There is established a nonprofit incorporated legal entity to be known as the Small Employer Health Reinsurance Association. Membership consists of all licensed hospital or medical service corporations in the state that offer subscriber contracts for health benefits, all welfare arrangements, and all insurers licensed to transact health insurance in the state that offer a health benefit plan. All members shall maintain membership in the association as a condition of doing health insurance business, or being able to offer subscriber contracts, in the state.

Sec. 21.55.020. BOARD OF DIRECTORS; ORGANIZATION. (a) The board of directors of the association consists of nine individuals selected by participating members, subject to approval by the director. The director or the director's designee shall serve as a nonvoting ex officio member of the board. In approving members of the board, the director shall consider, among other things, whether all types of participating members are fairly represented.

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

Sec. 21.55.030. GENERAL POWERS. The association may

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

(2) sue or be sued;

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

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

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

(6) design the array of health coverage products for which reinsurance will be

provided and issue reinsurance policies;

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

(8) establish appropriate rates, rate schedules, rate adjustments, rate classifications, and other actuarial functions appropriate to the operation of the association;

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

(10) appoint from among members appropriate legal, actuarial, and other committees as are necessary to provide technical assistance in the operation of the association.

Sec. 21.55.040. PLAN OF OPERATION. (a) The association shall submit to the director a plan of operation and amendments necessary or suitable to assure the fair, reasonable, and equitable administration of the association. The plan of operation and amendments become effective upon approval in writing by the director. If the director has not approved or disapproved a plan of operation submitted by the association within 90 days after receiving the plan of operation, the plan of operation is considered approved by the director. If the association fails to submit a suitable plan of operation by a date that is 180 days after the effective date of this Act, or if at subsequent time the association fails to submit suitable amendments to the plan, the director may, after notice and hearing, adopt reasonable regulations necessary or advisable to effectuate the provisions of this chapter. These regulations shall continue in force until modified by the director or superseded by a plan submitted by the association and approved by the director.

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

(c) The plan of operation must

(1) establish procedures for the performance of the powers and duties of the association under this chapter;

(2) establish procedures for handling assets of the association and for an annual fiscal report to the director;

(3) establish the amount and method of reimbursing members of the board under AS 21.55.020;

(4) establish regular places and times for meetings of the board;

(5) establish procedures for records to be kept of all financial transactions of the association, its agents, and the board;

(6) provide that a member insurer aggrieved by a final action or decision of the association may appeal to the director within 30 days after the action or decision;

(7) establish procedures for the submission to the director of selections for the board;

(8) provide for reinsuring risks under the provisions of this section;

(9) provide for collecting assessments from all members to provide for claims reinsured by the association and for administrative expenses incurred or estimated to be incurred during the period for which the assessment is made;

(10) provide protection for guaranteed issue insurers from the financial risk associated with small employers that present poor credit risks;

(11) establish standards for the coverage of small employers that have high employee turnover;

(12) establish an appeals process for guaranteed issue insurers to seek relief when a guaranteed issue insurer has experienced an unfair share of administrative and credit risks;

(13) determine the adjusted average market premium prices for small employer health plans sold in this state;

(14) establish participation standards at issue and renewal for reinsured cases;

(15) establish and maintain a list of guaranteed issue insurers;

(16) establish standards for those conditions under which a guaranteed issue insurer would not be required to write business received from a particular agent or broker; and

(17) provide for selection of an administering insurer and establish the administering insurer's powers and duties;

(18) contain additional provisions necessary or proper for the execution of the powers and duties of the association.

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

(1) regarding a small employer health benefit plan, the association shall reinsure

the level of coverage provided;

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

(3) regarding the coverage provided to small employers, the insurer or welfare arrangement, or, to the extent permitted under 29 U.S.C. 1001 - 1459, other benefit arrangement shall be required to use high-cost case management, hospital precertification techniques, and other cost containment techniques as established by the association;

(4) regarding eligible employees, and their dependents, who are hired subsequent to the commencement of the employer's coverage by an insurer, welfare arrangement, or other benefit arrangement and who are not late enrollees, coverage may be reinsured by a nonguaranteed issue insurer within 60 days of the commencement of coverage under the plan;

(5) regarding eligible employees, and their dependents, who are hired subsequent to the commencement of the employer's coverage by a guaranteed issue insurer and who are not late enrollees, coverage may be reinsured by the guaranteed issue insurer

(A) within 60 days of the commencement of coverage under the plan; or

(B) commencing on a date established by the board but not later than 18 months after the association becomes operational on the first plan anniversary after the small employer coverage has been in effect with the small employer for at least three years and every third year anniversary thereafter;

(6) regarding eligible employees, and their dependents, who are employed by a small employer as of the date the employer's coverage by the guaranteed issue insurer commences, coverage may be reinsured

(A) within 60 days of the commencement of the employer's coverage with the insurer or welfare arrangement, or other benefit arrangement except in the case of late enrollees; or

(B) commencing on a date established by the board but not later than 18 months after the association becomes operational on the first plan anniversary after the small employer coverage has been in effect with the small employer for at least three years and every third year anniversary thereafter;

(7) regarding eligible employees and their dependents, a guaranteed issue insurer

may reinsure the entire employer group

(A) within 60 days of the commencement of the group's coverage under the plan;

(B) in the case where a new entrant to an employer group is reinsured under the provisions of (4) of this subsection, on the first plan anniversary after the new entrant became a member of the employer's plan; or

(C) commencing on a date established by the board but not later than 18 months after the association becomes operational on the first plan anniversary after the small employer coverage has been in effect with the small employer for at least three years and every third year anniversary thereafter;

(8) regarding employees or dependents reinsured under (4), (5), or (6) of this subsection, reinsurance may not be provided until $5,000 in benefit payments have been made for services provided during that calendar year for that reinsured employee or dependent; in this paragraph "benefit payments" include those payments that would have been reimbursed through reinsurance in the absence of the annual $5,000 deductible; the amount of the deductible shall be periodically reviewed by the board and may be adjusted for appropriate factors as determined by the board.

(b) If an employer group is covered under a plan other than a small employer health plan and the insurer chooses to reinsure the group subsequent to the initial coverage period, or if a new individual joins the group and the insurer wants to reinsure that individual, the insurer may not require the employer to change to a small employer health plan and the insurer shall allow the employer to maintain the same benefit plan and reinsure only the portion of the plan consistent with a small employer health plan.

(c) Except as provided in (d) of this section, premium rates charged for coverage reinsured by the association shall be established as follows:

(1) for whole group reinsurance coverage, 1.5 multiplied by the adjusted average market premium price established by the association for that classification or group with similar characteristics and coverage, for eligible employees, and dependents of eligible employees, of a small employer all of whose coverage is reinsured with the association, minus a ceding expense factor determined by the association;

(2) for individual reinsurance coverage, 5.0 multiplied by the adjusted average

market premium price established by the association for an individual in that classification or group with similar characteristics and coverage, with respect to an eligible employee, or the employee's dependents, minus a ceding expense factor determined by the association.

(d) Premium rates charged for reinsurance by the association to a health maintenance organization that is approved by the Secretary of Health and Human Services as a federally qualified health maintenance organization under 42 U.S.C. 300 and, as a health maintenance organization, is subject to requirements that limit the amount of risk that may be ceded to the association, may be modified to reflect the portion of risk that may be ceded to the association.

(e) If a health benefit plan coverage for a small employer is entirely or partially reinsured with the association, the premium charged to the small employer for a rating period for the coverage issued under this section may not be more than 1.5 times the adjusted average market premium price established by the association for that classification or group with similar characteristics and coverage.

(f) In determining the assessment, if any, that is collected from a member, the following provisions apply:

(1) following the close of a fiscal year, the administering insurer shall determine the net premiums, the association expenses for administration and the incurred losses, if any, for the year, taking into account investment income and other appropriate gains and losses; for purposes of this subsection, health benefit plan premiums earned by an insurer, welfare arrangement, or other benefit arrangement shall be established by adding paid claim losses and administrative expenses of the insurer, welfare arrangement, or other benefit arrangement; health benefit plan premiums and benefits paid by a member that are less than an amount determined by the board to justify the cost of collection may not be considered for purposes of determining an assessment; in this paragraph, "net premiums" means health benefit plan premiums less administrative expense allowances;

(2) a net loss for the year shall be covered first by assessment against members to the extent provided as follows:

(A) assessments shall first be apportioned by the board among all members in proportion to the member's respective share of the total premiums net of reinsurance premiums paid for coverage under this chapter earned in this state from health benefit plans covering small employers and to the extent permitted under 29 U.S.C.

1001 - 1459, apportioned among other benefit arrangements covering small employers during the calendar year coinciding with or ending during the fiscal year of the association, or apportioned on another equitable basis reflecting coverage of small employers as may be provided in the plan of operation; an assessment shall be made under this subparagraph against a health maintenance organization that is approved by the secretary of health and human services as a federally qualified health maintenance organization under 42 U.S.C. 300e, subject to an assessment adjustment formula adopted by the board and approved by the director for qualified health maintenance organizations that recognizes the restrictions imposed on qualified health maintenance organizations under federal law; the adjustment formula shall be adopted by the board and approved by the director before the first anniversary of the operation of the association;

(B) an assessment under (2)(A) of this subsection shall be capped at four percent of premiums charged for health benefit plans covering a small employer;

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

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

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

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

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

receiving a deferment shall remain liable to the association for the amount deferred; the director may attach conditions to a deferment.

Sec. 21.55.060. ADMINISTRATIVE PROCEDURE ACT. The association is exempt from the Administrative Procedure Act (AS 44.62).

Sec. 21.55.070. TAX EXEMPTION. The association is exempt from the payment of fees and taxes levied by the state or any of its political subdivisions except taxes levied on real or personal property.

Sec. 21.55.080. LIMITATION OF LIABILITY. A member of the association is not liable for civil damages resulting from an act or omission of the member on behalf of the association unless the member acts with gross negligence or intentional misconduct.

ARTICLE 2. SMALL EMPLOYER HEALTH INSURANCE PLANS.

Sec. 21.55.100. APPLICABILITY. (a) An individual or group health benefit plan is subject to the provisions of this chapter if the plan provides health care benefits covering one or more employees of a small employer and if one of the following conditions are met:

(1) all or a portion of the premium or benefits is paid by a small employer or a covered individual is reimbursed, through wage adjustments or otherwise, by a small employer for all or a portion of the premium; or

(2) the health benefit plan is treated by the employer or a covered individual as part of a plan or program for the purposes of 26 U.S.C. 106 or 26 U.S.C. 162 (Internal Revenue Code).

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

(c) Except as provided in this chapter, a health benefit plan offered to a small employer is not subject to a law that would

(1) inhibit an insurer, welfare arrangement, or other benefit arrangement from contracting with providers or groups of providers regarding health care services or benefits;

(2) impose a restriction on the ability to negotiate with providers regarding the level or method of reimbursing care or services provided under the health benefit plan;

(3) require an insurer, welfare arrangement, or other benefit arrangement to either

include a specific provider or class of provider when contracting for health care services or benefits, or to exclude a class of provider that is generally authorized by law to provide health care.

Sec. 21.55.110. UNDERWRITING AND RATING REQUIREMENTS. Health benefit plans covering small employers and, to the extent permitted under 29 U.S.C. 1001 - 1459, other benefit arrangements covering small employers, are subject to the following provisions:

(1) preexisting conditions provisions may not exclude or limit coverage for a period beyond 12 months following the individual's effective date of coverage and may only relate to conditions that had, during the six months immediately preceding the effective date of coverage, occurred in a manner that would cause an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment or for which medical advice, diagnosis, care, or treatment was recommended or received, or that related to a pregnancy existing on the effective date of coverage;

(2) in determining whether a preexisting condition limitation provision applies to an eligible employee or dependent, all health benefit plans shall credit the time the person was covered under a previous employer based health benefit plan provided by an insurer or welfare arrangement if the previous coverage was continuous to a date not more than 30 days before the effective date of the new coverage, exclusive of the applicable service waiting period under the health benefit plan;

(3) the health benefit plan and, to the extent permitted under 29 U.S.C. 1001 - 1459, other benefit arrangements covering small employers must be renewable with respect to all eligible employees or dependents at the option of the policyholder, contract holder, or small employer except for

(A) nonpayment of the required premiums by the policyholder, contract holder, or employer;

(B) noncompliance with health benefit plan provisions;

(C) a health benefit plan of an employer under which the total number of insured individuals covered under all of the health benefit plans of one employer is less than the total number of individuals or percentage of individuals required by participation requirements under a specific health benefit plan of that employer; or

(D) a health benefit plan issued by an insurer or welfare arrangement that

ceases doing business in the small employer market under AS 21.55.140;

(4) notwithstanding (3) of this section, a health benefit plan or coverage provided to an individual covered by a health benefit plan subject to the provisions of this chapter may be rescinded, cancelled, or not renewed for fraud, material misrepresentation, or concealment by an applicant, employee, dependent, or small employer or an agent of an applicant, employee, dependent, or small employer;

(5) an insurer or a welfare arrangement, and, to the extent permitted by 29 U.S.C. 1001 - 1459, a benefit arrangement may not exclude an eligible employee or dependent who would otherwise be covered under a health benefit plan on the basis of an actual or expected health condition of the person, except that an insurer, welfare arrangement, or other benefit arrangement may exclude a late enrollee for the greater of 18 months or the remainder of the three-year reinsurance period, as provided under AS 21.55.060;

(6) an insurer or a welfare arrangement doing business in the small employer market retains the authority to underwrite and rate small employer groups using accepted underwriting and actuarial practices; small employer groups that are declined because they fail to satisfy insurer or welfare arrangement underwriting requirements shall be notified by the insurer or welfare arrangement that the insurer or welfare arrangement will not issue a health benefit plan to the small employer, that the small employer is eligible for a small employer health plan provided by a guaranteed issue insurer, and shall be provided with a list, prepared by the board, containing the address, telephone number, and service area of all guaranteed issue insurers;

(7) a health benefit plan issued by a insurer, welfare arrangement, or, to the extent permitted by 29 U.S.C. 1001 - 1459, another benefit arrangement, may not limit or exclude, by use of a rider or amendment applicable to a specific individual, coverage by type of illness, treatment, medical condition, or accident, except for preexisting conditions or diseases as permitted under (1) of this section;

(8) a health benefit plan and, to the extent permitted by 29 U.S.C. 1001 - 1459, another benefit arrangement shall make coverage available to eligible employees of a small employer without a service waiting period, except that a small employer may impose a service waiting period for eligible employees of the small employer if the small employer chooses from the service waiting periods offered by the insurer or welfare arrangement; a service waiting period offered by an insurer or welfare arrangement may not exceed 90 days;

(9) the benefit structure of a health benefit plan subject to the provisions of this chapter may be changed by the insurer or welfare arrangement to make it consistent with the benefit structure contained in a health benefit plan being marketed to new groups;

(10) regarding a health benefit plan of an insurer or welfare arrangement, the premium rates charged or offered for a rating period for the same or similar coverage under a health benefit plan covering a small employer with similar case characteristics as determined by the insurer or welfare arrangement may not vary from the applicable midpoint rate by more than 35 percent of the applicable midpoint rate, as to

(A) a health benefit plan issued on or after July 1, 1991; and

(B) within three years after July 1, 1991, for a health benefit plan issued before July 1, 1991;

(11) regarding a health benefit plan issued before July 1, 1991, if an insurer or welfare arrangement charged or offered a premium rate for the same or similar coverage under a health benefit plan covering a small employer with similar case characteristics as determined by the insurer or welfare arrangement, and the premium rate exceeds the applicable midpoint rate by more than 35 points of the applicable midpoint rate, an increase in premium rates for a new rating period may not exceed the sum of

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

(B) an adjustment due to a change in case characteristics or plan design of the small employer, as determined by the insurer or welfare arrangement;

(12) a premium rate may not vary by more than 15 percent based on industry classification;

(13) subject to the provisions of (10), (11), and (12) of this section, an increase in a premium rate for a new rating period may not exceed the sum of

(A) a percentage change in the base premium rate measured from the first day of the prior rating period to the first day of the new rating period plus 15 percent, adjusted on a pro rata basis for a rating period greater or lesser than one year, of the base premium rate for the new rating period; and

(B) an adjustment due to a change in case characteristics or plan design of the small employer, as determined by the insurer or welfare arrangement;

(14) when offering for sale a health benefit plan to a small employer, an insurer or welfare arrangement shall make a reasonable disclosure as part of its solicitation and sales materials of

(A) the extent to which premium rates for a specific small employer are established or adjusted in part based on the actual or expected variation in claims costs or actual or expected variation in health condition of the employees and dependents of the small employer;

(B) the provisions concerning the insurer's or welfare arrangement's right to change a premium rate; and

(C) provisions relating to renewability of a policy or contract;

(15) compliance with the underwriting and rating requirements contained in this chapter shall be demonstrated through actuarial certification; insurers or welfare arrangements offering a health benefit plan to a small employer shall file annually with the director an actuarial certification stating that the underwriting and rating methods of the insurer or welfare arrangement

(A) comply with accepted actuarial practices;

(B) are uniformly applied to health benefit plans covering small employers; and

(C) comply with the provisions of this chapter.

Sec. 21.55.120. GUARANTEED ISSUE INSURERS. (a) Guaranteed issue insurers shall offer at least one small employer health plan to a small employer requesting a small employer health plan and shall provide at least the coverage of a small employer health plan to a small employer requesting the coverage.

(b) Guaranteed issue insurers may

(1) reinsure an individual with a group or may reinsure an entire group subject to the provisions of AS 21.55.060;

(2) as provided for in the association's plan of operation,

(A) require advance premium deposits for poor credit risks; and

(B) make special arrangements to cover an employee in a small employer group with exceptionally high employee turnover rates;

(3) appeal to the board for a finding that the guaranteed issue carrier is

experiencing an unfair share of administrative or credit risk; if the board determines that a guaranteed issue carrier has experienced an unfair burden, the board may grant the guaranteed issue carrier a decreased reinsurance price to offset administrative expenses or temporarily suspend the guaranteed issue insurer's requirement to guarantee issue.

Sec. 21.55.130. SMALL EMPLOYER HEALTH BENEFIT PLANS. (a) The board shall design small employer health benefit plans that are eligible for reinsurance by the association. The board shall establish the form and level of coverage to be made available by insurer or welfare arrangements, and to the extent permitted under 29 U.S.C. 1001 - 1459, other benefit arrangements in the small employer health benefit plans. In designing the small employer health benefit plans, the board shall also establish benefit levels, deductibles, coinsurance factors, exclusions, and limitations for the small employer health benefit plans. The form and level of coverage established by the board must specify those components of a health benefit plan offered by an insurer of a small employer that may be reinsured.

(b) A small employer health benefit plan may include cost containment features including, but not limited to

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

(2) case management benefit alternatives;

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

(4) reasonable benefit differentials applicable to participating and nonparticipating providers; and

(5) other provisions for the cost effective management of a small employer health benefit plan.

(c) The small employer health benefit plan established for use by health maintenance organizations must be consistent with the basic method of operation of health maintenance organizations.

(d) A small employer health benefit plan shall be submitted to the director for approval.

(e) After the director's approval of the small employer health benefit plans submitted by the board, an insurer or welfare arrangement, or, to the extent permitted by 29 U.S.C. 1001 - 1459, other benefit arrangements may certify to the director, in the form and manner prescribed

by the director, that the small employer health benefit plans filed by the insurer or welfare arrangement, or other benefit arrangement are in substantial compliance with the provisions in the corresponding approved board plan. Upon receipt by the department of certification described in this subsection, the insurer or welfare arrangement, or other benefit arrangement may use the certified plan until the director, after notice and hearing, disapproves the use of the plan.

Sec. 21.55.140. CONDITIONS FOR CEASING TO DO BUSINESS. An insurer or a welfare arrangement may cease doing business in the small employer market if the insurer or welfare arrangement provides notice of the decision to cease doing business in the small employer market to the division, the board, the policyholder or contract holder, and the employer, and coverage under a health benefit plan subject to this chapter is continued for one year after the date of the notice required under this section. An insurer or a welfare arrangement that ceases doing business in the small employer marketplace may not reenter the small employer marketplace for a period of five years from the date of the notice required under this section.

Sec. 21.55.250. DEFINITIONS. In this chapter,

(1) "adjusted average market premium price" means, as determined by the board, the arithmetic mean of all guaranteed issue insurer's premium rates for a given small employer health benefit plan sold to groups with similar case characteristics by all insurers or welfare arrangements selling small employer health benefit plans in the state;

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

(3) "base premium rate" means

(A) as to a health benefit plan covering one or more employees of a small employer, the lowest new business premium rate prescribed by the insurer or welfare arrangement for the same or similar coverage under a plan or arrangement covering a small employer with similar case characteristics; and

(B) as to an insurer or welfare arrangement not issuing a new health benefit plan to a small employer, the lowest rate charged a small employer for the same or similar coverage under a plan covering a small employer with similar case characteristics;

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

(5) "case characteristics" means with respect to a small employer, the geographic

area in which the employees reside, the age and sex of the individual employees and dependents, the appropriate industry classification as determined by the insurer or welfare arrangement, or other benefit arrangement, the number of employees and dependents and other objective criteria as may be established by the insurer or welfare arrangement, or other benefit arrangement;

(6) "dependent" means the spouse or child of an eligible employee, subject to applicable terms of the health benefit plan covering the employee;

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

(8) "financially impaired" means a member that is not insolvent but is

(A) determined by the director to be potentially unable to fulfill the member's contractual obligations; or

(B) placed under an order of rehabilitation or conservation by a court of competent jurisdiction;

(9) "guaranteed issue insurer" means an insurer that

(A) is one of the top 10 insurers based on total premium volume in the small employer market as determined by the board; and

(B) an insurer that informs the board that the insurer wishes to become a guaranteed issue insurer, except that an insurer wishing to become a guaranteed issue insurer shall notify the board of the insurer's intention to become a guaranteed issue insurer one year in advance of the insurer becoming a guaranteed issue insurer;

(10) "health benefit plan" means a hospital or medical expense policy, health, hospital, or medical service corporation contract, a plan provided by an insurer or welfare arrangement, and a health maintenance organization contract offered by an employer, but does not include a policy covering only accident, credit, dental, disability income, long-term care, hospital indemnity, Medicare supplement, specified disease, vision care, coverage issued as a supplement to liability insurance, worker's compensation insurance, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in a liability insurance policy or equivalent self-insurance;

(11) "initial enrollment period" means the period of time specified in the health benefit plan during which an individual is first eligible to enroll in a small employer health benefit plan; the period of time may not be less than 30 days nor more than 60 days commencing on the day following the end of a service waiting period required by the small employer of all employees before the employees are eligible to participate in a small employer health benefit plan;

(12) "insurer" has the meaning given in AS 21.90.900 and includes a health maintenance organization, a hospital service corporation, and a medical service corporation;

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

(A) the individual

(i) was covered under another employer provided health benefit plan at the time the individual was eligible to enroll;

(ii) states, at the time of the initial eligibility, that coverage under another employer health benefit plan was the reason for declining enrollment;

(iii) has lost coverage under another employer health benefit plan as a result of the termination of employment, the termination of the other plan's coverage, death of a spouse, or divorce or dissolution of marriage; and

(iv) requests enrollment within 31 days after the termination of coverage under another employer health benefit plan; or

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

(C) a court has ordered coverage to be provided for a spouse or minor child under a covered employee's plan and request for enrollment is made within 31 days after issuance of the court order;

(14) "member" means all insurers issuing health benefit plans, welfare arrangements and, to the extent permitted under 29 U.S.C. 1001 - 1459 (Employee Retirement

Income Security Act), other benefit arrangements providing health benefit plans in this state;

(15) "midpoint rate" means for a small employer with similar case characteristics and plan designs, as determined by the applicable insurer or welfare arrangement for a rating period, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate;

(16) "other benefit arrangement" means a health benefit plan offered by a small employer who is in whole, or in part, self-insured;

(17) "plan of operation" means the articles, bylaws, and operating rules of the association adopted by the board;

(18) "preexisting conditions provision" means a policy provision that excludes or limits coverage for charges or expenses incurred during a specified period following the insured's effective date of coverage as to a condition that, during a specified period immediately preceding the effective date of coverage, had manifested itself in a manner that would cause an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment, or for which medical advice, diagnosis, care, or treatment was recommended or received and includes a pregnancy existing on the effective date of coverage;

(19) "service waiting period" means a period of time after full-time employment begins before an employee is first eligible to enroll in an applicable health benefit plan offered by the small employer;

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

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

* **Sec. 3.** AS 21.86.260(a) is amended to read:

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

* **Sec. 4.** AS 21.87.340 is amended to read:

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

(1) AS 21.03

(2) AS 21.06

(3) AS 21.09, except AS 21.09.090

(4) AS 21.18.010

(5) AS 21.18.030

(6) AS 21.18.040

(7) AS 21.18.120

(8) AS 21.21.321

(9) AS 21.36

(10) AS 21.42.345 - 21.42.365

(11) AS 21.51.120

(12) AS 21.53

(13) AS 21.54.020

(14) **AS 21.55**

(15) AS 21.69.400

(16) [(15)] AS 21.69.520

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

(18) [(17)] AS 21.78

(19) [(18)] AS 21.89.040

(20) [(19)] AS 21.89.060

(21) [(20)] AS 21.90.

* Sec. 5. TRANSITION. Within 180 days after the board is organized under AS 21.55.020, enacted in sec. 2 of this Act, the board of directors of the Small Employer Health Reinsurance Association shall submit a small employer health benefit plan to the director of the division of insurance for approval. Notwithstanding AS 21.55.120(a), enacted in sec. 2 of this Act, a guaranteed issue insurer is not required to offer a small employer a health benefit plan until 60 days after the director of the division of insurance has approved a small employer health benefit plan.

* Sec. 6. This Act takes effect July 1, 1991.

02/C-192 .C.E.)FIN

FISCAL NOTE

STATE OF ALASKA
1992 LEGISLATIVE SESSION

BILL NO. SB 242

Revision Date: 12/27/91
Department Affected: Commerce & Econ. Dev.
Title: An Act relating to health insurance for small employers
BRU: Insurance
Component: Operations
Sponsor: Senator Collins
Requestor: Senator Collins
COMPONENT SERIAL NO. 0354

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 93	FY 94	FY 95	FY 96	FY 97	FY 98
PERSONAL SERVICES	0					
TRAVEL	6.0	1.5	1.5	1.5	1.5	1.5
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	6.0	1.5	1.5	1.5	1.5	1.5
CAPITAL	0	0	0	0	0	0
REVENUE FUND RESOURCE:	0	0	0	0	0	0

FUNDING: (Thousands of Dollars)

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

SB 242

POSITIONS:

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

Estimate of current year impact:

ANALYSIS (Attach a separate page if necessary.)

In the first year, a substantial number of meetings with industry will be required to assure that the operations of the association are satisfactorily established. Eight meetings are anticipated in the first year and two per year thereafter.

Prepared By: Donald P. Koch, Chief of Market Surveillance (10) Phone: 465-2577
Division: Insurance Date: 1/2/92
Approved by Commissioner: Glenn A. Olds for Ted Gallowayt Asst. Comm.
Agency: Department of Commerce & Economic Development Date: 1-10-92

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

DPK/dg19419D/122691b
(Rev. 12/91)

4-24-92

Updated
1992 version of
1991 note
superseded by
~~a~~ note
accompanying
HES bill.

FISCAL NOTE

STATE OF ALASKA **BILL NO.** SB 242
1991 LEGISLATIVE SESSION

Revision Date: 4/5/91 Department Affected: Commerce & Economic Dev.
Title: An Act relating to health insurance for small employers BRU: Insurance
Component: Operations
Sponsor: Senator Collins
Requestor: Senator Collins **COMPONENT SERIAL NO.** 0 3 5 4

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY 92	FY 93	FY 94	FY 95	FY 96	FY 97
PERSONAL SERVICES	0					
TRAVEL	6.0	1.5	1.5	1.5	1.5	1.5
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	6.0	1.5	1.5	1.5	1.5	1.5
CAPITAL						
REVENUE						

FUNDING: (Thousands of Dollars)

GENERAL FUND						
FEDERAL FUNDS						
OTHER						
TOTAL						

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

Estimate of current year impact:

ANALYSIS: (Attach a separate page if necessary.)

In the first year, a substantial number of meetings with industry will be required to assure that the operations of the association are satisfactorily established. Eight meetings are anticipated in the first year and two per year thereafter.

Prepared By: Donald P. Koch, Chief of Market Surveillance Phone: 465-2577
Division: Insurance Date: 4/18/91
Approved by Commissioner: Glenn A. Olds Asst. Comm.
Agency: Department of Commerce & Economic Development Date: 4-18-91

Distribution (by preparer): Legislative Finance, Legislative Sponsor, Requestor, OMB, & Impacted Agency(ies).

Rev 10/90
DPK/dg19419D/041891a

SB 242

SENATE COMMITTEE REPORT

DATE: 4/19/91

FURTHER: Finance

DATE TURNED INTO OFFICE: 15APR92

HESS Committee considered SENATE BILL NO. 242

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

and recommends it be replaced with

and recommended:

[✓] replace with _____ CS SB 242(HES) [✓] same title
[ ] or adopt _____ CS _____ [ ] new title
[ ] technical title change (HB only)

[ ] attached amendment(s) ~~and do pass~~
[ ] _____ letter of intent adopted

[ ] do pass

[ ] do not pass

[ ] no recommendation

[✓] individual recommendations

[ ] further referral to _____

ATTACHES NEW FISCAL NOTE(S):

Dept/Date:

[ ] fiscal note(s) _____

[ ] zero fiscal note(s) DCED 4-7-92/CS

[ ] appropriation-no fiscal note

APPROVES PREVIOUS:

Dept/Date:

[ ] fiscal note(s) _____

[ ] zero fiscal note(s) _____

[ ] Governor's bill w/fiscal note

SIGNING DO PASS:

OTHER RECOMMENDATIONS:

Amend Do Pass

Chair: Signature and Recommendation

SENATE COMMITTEE REPORT
FIRST COMMITTEE OF REFERRAL

DATE: 4/5/91

FURTHER: HESS
Finance

Date of 5-Day Notice: 4-11-91
(in accordance with Uniform Rule 23)

DATE TURNED INTO OFFICE: 4-19-91

L&C Committee considered SB 242

Health insurance for small employers; efd.

and recommended: and a majority of the committee recommends do pass

[ ] replace with _____ CS _____ [ ] same title [ ] new title

[ ] attached amendment(s)

[ ] _____ letter of intent adopted

[ ] do pass

[ ] do not pass

[ ] no recommendation

[✓] individual recommendations

[ ] further referral to _____

Ø Fiscal Note

ATTACHES NEW FISCAL NOTE(S):

Department(s)/Date:

[✓] fiscal note(s) COMMERCE/4-18-91

Department(s)/Date:

[ ] zero fiscal note(s) _____

[ ] appropriation-no fiscal note

[ ] Governor's bill w/fiscal note

SIGNING DO PASS:

OTHER RECOMMENDATIONS:

True Ronick - do pass

Chair: Signature and Recommendation