SB

242

FISCAL NOTE

STATE OF ALASKA
1991 LEGISLATIVE SESSION

BILL NO. SB 242

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. 0354

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).

FISCAL NOTE

Bill Version: SB 242

(S) Publish Date: 4/19/91

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Alaska State Legislature

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Senator Virginia Collins

MEMORANDUM

TO: Senator Arliss Sturgulewski, Chair
Senate Health & Social Services Committee

FROM: Senator Virginia Collins VC

DATE: September 10, 1991

RE: September 17th committee hearing

My office was informed last week that a hearing on SB 242 had been set for the 17th.

Since I am scheduled to meet with a number of people from HIAA in Chicago on the 23rd through the 25th of September and intend to discuss SB 242 and health care issues, it occurred to me that the bill should be heard in your committee after I have had this meeting.

I respectfully request that SB 242 be postponed until a later date during the interim.

Please call me at 561-2040 if you have any questions.

SENATE BILL 242

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

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    Metropolitan Life
    Principal Mutual Life Insurance Company
    Alaska State Hospital & Nursing Home Association

Alaska State Legislature

SENATE

Official Business

SENATOR VIRGINIA COLLINS

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

SPONSOR STATEMENT

Senate Bill 242

Senate Bill 242, "An Act relating to health insurance for small employers; and providing for an effective date."

As the cost of health care has increased, an unacceptable number of Alaska residents are currently without appropriate health care coverage. Small employers find it very difficult to obtain affordable coverage, if any coverage at all. Over 90% of the businesses in Alaska are considered small businesses, having 25 or fewer employees.

The Health Insurance Association of America, an association of 300 private health insurance companies providing insurance for 95 million Americans, developed a model bill to address the issue of small employer health insurance coverage. Senate Bill 242 is HIAA's model bill.

The focus of the bill is to make certain changes in the small employer insurance market to provide more accessibility, renewability, predictability, and stability for the small employer who has 3 to 25 employees.

This bill creates the Small Employer Health Reinsurance Association, a private nonprofit legal entity. All insurers in the small employer insurance market make up the membership. The Association allows insurers to treat all individuals in a group the same way. High risks are spread broadly through the market rather than concentrated in one small employer group. Managed care and other cost containment provisions may be incorporated into the small employer health plans. Once someone with a preexisting condition satisfies the preexisting condition restriction, he or she is not required to satisfy requirements again when changing jobs or when the employer changes insurers. Premium costs are capped and reinsurance association loss assessments are capped.

The Small Employer Health Reinsurance Association is a self-supported association. The only cost to the State is for travel by the Director of the Division of Insurance. That cost is minimal.

Your support and co-sponsorship of Senate Bill 242 would be appreciated.

LIST OF BILL SECTION HEADINGS

SB 242

*Sec. 1. Findings (page 1)
*Sec. 2. AS 21 New chapter
ARTICLE 1 - Small Employer Health Reinsurance Association (pages 1-9)

Sec. 21.55.010. Creation; Membership (page 2)
Sec. 21.55.020. Board of Directors; Organization (page 2)
Sec. 21.55.030. General Powers (pages 2-3)
Sec. 21.55.040. Plan of Operation (pages 3-4)
Sec. 21.55.050. Health Care Reinsurance (pages 4-9)
Sec. 21.55.060. Administrative Procedure Act (page 9)
Sec. 21.55.070. Tax Exemption (page 9)
Sec. 21.55.080. Limitation of Liability (page 9)

ARTICLE 2 - Small Employer Health Insurance Plan (pages 9-18)

Sec. 21.55.100. Applicability (page 9)
Sec. 21.55.110. Underwriting and Rating Requirements (pages 10-13)
Sec. 21.55.120. Guaranteed Issue Insurers (pages13-14)
Sec. 21.55.130. Small Employer Health Benefit Plans (pages 14-15)
Sec. 21.55.140. Conditions for Ceasing to Do Business (page 15)
Sec. 21.55.250. Definitions (pages 15-18)

*Sec. 3. AS 21.86.260(a) amended regarding health maintenance organization (page 19)
*Sec. 4. AS 21.87.340 amended regarding Other Provisions Applicable (page 19)
*Sec. 5. Transition (page 20)
*Sec. 6. Effective date (page 20)

DIVISION OF LEGAL SERVICES

LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

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MEMORANDUM April 12, 1991

SUBJECT: Small employer health insurance - (SB 242)

TO: Senator Virginia Collins

FROM: Michael F. Ford
Legislative Counsel

The following is a section by section analysis of SB 242:

Section 1 - Findings.

Section 2 -

Sec. 21.55.010 - Establishes the Small Employer Health Reinsurance Association and requires certain insurers to be members.

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

Sec. 21.55.030 - Establishes the 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. Allows the director to adopt regulations to implement AS 21.55 if the association fails to submit a suitable plan of operation. Requires members to comply with the plan and establishes specific components of the plan.

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. Imposes certain restrictions on reinsurance of group plans other than small employer health benefit plans and establishes limits for premiums charged for reinsured coverage and for coverage provided by a health maintenance organization. Provides for member assessments, by the administering insurer.

Sec. 21.55.060 - Exempts the association from the Administrative Procedure Act.

Sec. 21.55.070 - Exempts the association from payment of taxes, except for real or personal property taxes.

Sec. 21.55.080 - Provides immunity from civil actions filed against a member of the association for a negligent act on behalf of the association.

Sec. 21.55.100 - Establishes when an individual or group health benefit plan is subject to AS 21.55 and provides that other laws requiring coverage, reimbursement, utilization, or consideration of a specific health care provider do not apply to a health benefit plan provided to a small employer. Exempts a health benefit plan offered to a small employer from certain restrictions contained in other laws.

Sec. 21.55.110 - Establishes underwriting and rating requirements applicable to health benefits plans covering small employers.

Sec. 21.55.120 - Requires a guaranteed issue insurer to offer at least one small employer health benefit plan and that the plan provide certain coverage. Allows a guaranteed issue insurer to reinsure, make special premium arrangements, or appeal unfair administrative or credit risk.

Sec. 21.55.130 - Requires the board to design small employer health benefit plans that are eligible for reinsurance by the association, including the form and level of coverage. Provides that a plan may include certain cost containment features. Requires the plan be submitted to the director of the division of insurance for approval.

Sec. 21.55.140 - Establishes certain conditions that must be met before an insurer or welfare arrangement may cease doing business in the small employer market.

Sec. 21.55.250 - Definitions.

Section 3 - Provides that a health maintenance organization is subject to the small employer health insurance provisions contained in AS 21.55.

Section 4 - Provides that a hospital or medical service corporation is subject to the small employer health insurance provisions contained in AS 21.55.

Section 5 - Transition section.

Section 6 - Effective date.

MFF:plm
91-250.plm

SENATE HEALTH, EDUCATION, AND SOCIAL SERVICES
COMMITTEE
NOTES AND QUESTIONS TO SB 242
16 September 1991

*1 - See attached definition.

*2 - Does the legislature wish, as a matter of public policy, to allow the association to design health coverage products or does the Legislature wish to examine models that set out basic health care plans and incorporate them into the bill. (i.e., the National Association of Insurance Commissioners will be making public a model bill in December)

*3 - The director of the division of insurance is required to approve the plan of operation for the Association. However, if the Association does not submit a plan, the director is required to adopt regulations governing the operation of the association.

Should the director be required to take action that the Association fails to take?

While the association is made exempt from the Administrative Procedures Act, the director of the division of insurance is not, therefore regulations that the director is required to adopt under this section still must go through the administrative process.

If the director adopts regulations, then the association can modify them by submitting a new plan to the director. That new plan must then be approved by the director again. Should it be made clear in the legislation than action taken by the director as regards the association is subject to the APA, even though the bill exempts the association itself from the APA.

*4. Should the director be an arbiter for the association? The bill provides that a member may appeal to the director from association action or decision.

*5. Is there an industry standard for poor credit risks? What does this mean?

*6. Under what circumstances does the bill envision a guaranteed issue insurer would not be required to write business received from a particular agency or broker?

*7. What kind of plan does the bill envision being reinsured here.?

*8. Should the legislature, as a matter of public policy, enumerate a standard of cost-containment beyond which the association may not go. i.e., can the association limit choice of physicians?

*9. , *10,*11 - see footnote #5 in sectional analysis.

*12. Should the bill cap the amount of the deductible or should be board be able to change the amount? Does this section authorize the board to change the amount of the deductible without going through the director?

*13. Are the premium rates in this section the rates charged by the reinsurance association to the insurer or the rates charged by the insurer to the employer?

*14. Who is responsible for paying for the program if the costs exceed the four percent assessments to the members? NOTE: Connecticut adopted a five percent assessment as well as a provision for an additional assessment if the five percent is insufficient.

*15. Should the director, rather than the board, be allowed to grant deferments. Does this create liability on the part of the state to make up the difference if the insurer doesn't pay?

*16. Does the Legislature wish to use this standard of proof for exempting from liability for acts or omissions on the part of a member of the association?

*17. Does the Legislature intend to exempt current statutory requirements for services and payments to providers from this bill? See Footnote 7.

*18. Does the Legislature wish to give the Association the

authority to limit access to providers by insured?

*19 The effect of this section may be to prevent persons from seeking medical care in the six months prior to being covered.

*20. Should pregnancies be exempt from coverage? A consensus of public policy is that pregnant women who receive medical care during pregnancy have healthier babies for a much lower long-term cost of care.

*21. This subsection does not make it clear if a plan may be changed at any time or only upon renewal.

* 22. An example of possible premium spread among individuals with similar case characteristics under this bill is as follows:

Allowable variation in monthly premium based on industry classification (15 percent variation) - low, $127.50; midpoint $150.00; high $172.50. Highest possible premium (35 percent above high risk business group midpoint) - $232.87. Lowest possible premium (35 percent below low risk business group midpoint) - $82.87. Spread between lowest premium and highest premium among individuals with similar case characteristics - 280 percent. (From National Academy for State Health Policy Access and the Uninsured: A guide for the States)

NOTE: TEXT IN BOLDFACE FOR CLARITY AND EMPHASIS ONLY. ASTERIXED NUMBERS IN PARENTHESES REFER TO QUESTIONS.

SECTIONAL ANALYSIS
SENATE HEALTH, EDUCATION, & SOCIAL SERVICES COMMITTEE

SENATE BILL 242

12 September 1991

SECTIONAL ANALYSIS:

Section 1: Legislative Findings.

Section 2: AS 21.55.010 - creates small Employers Health Reinsurance Association.
Membership consists of all

licensed hospital or medical service corporations
all welfare arrangements (*1)
all insurers licensed to transact health insurance

AS 21.55.020 - **Board of Directors** - 9 members, selected by participating organizations subject to approval by the director

Members shall represent:

health maintenance organizations (1)
hospital or medical service corporation (1)
small employer market health insurance business (at least 6)
large employer market health insurance business (1)

Sec. 21.55.030: **Powers of the Association:** association may exercise the powers granted to insurers under the laws of the state except that the association **may not issue insurance**.

sue or be sued, enter into contracts with insurers, similar associations in other states, or with other persons for the performance of administrative functions.

establish administrative and accounting procedures
take legal action as necessary

design the array of health coverage products for which reinsurance will be provided and issue reinsurance policies. (*2)

establish rules

establish rates, rate schedules, etc.

assess members for operating expenses

appoint members to provide technical assistance in the operation of the association.

Sec. 21.55.040 requires the association to submit a plan of operation (or amendments to the plan) to the director for approval. The director must approve the plan in writing within 90 days, if the plan has not been disapproved within 90 days it **is considered approved.** (*3)

If the association fails to submit a plan within 180 days of the effective date of this act, the director may adopt reasonable regulations necessary. **These regulations continue in force until modified by the director or superseded by a plan submitted by the association and approved by the director.**

The **plan of operation must:**

establish procedures for

performance of duties of the association
assets and annual report
reimbursement of board members
place & times for meetings of boards

recordkeeping of financial transactions
appeal to director from association action or decision(*4)
selection of board members (*to be submitted to director)*
reinsuring risks
collecting assessments from all members for costs and claims

provide protection for guaranteed issue insurers[1] from the financial risk associated with small employers that present poor credit risks[2] that present **poor credit risks** (*5)

establish standards for coverage of small employers that have **high employee turnover**

establish **appeals process** for guaranteed issue insurers to seek relief when a guaranteed issue insurer has experienced an unfair share of administrative and credit risks

determine the adjusted average market premium prices[3] for small employer health plans sold in this state.

establish participation standards at issue and renewal for reinsured cases

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[1] "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 (a year in advance).

[2] "Small employer" means a business whose total employed work force consists of, on at least 50 percent of its working days during the preceding year, more than two but not more than 25 eligible employees.

[3] "adjusted average market premium price" means, *as determined by the board,* the arithmetic mean of all GII'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.

establish and maintain a list of guaranteed issue insurers

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(*6)

additional provisions necessary for execution of powers and duties. etc.

Sec. 21.55.050 a member **may only reinsure coverage of an eligible employee of a small employer (or dependent)** *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. (*7)**

(3) regarding the coverage provided to small employers, insurer or welfare arrangement[4] 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 (*8)

(4) regarding eligible employees and their dependents, hired after the beginning of the employers coverage, *may* be reinsured by a nonguaranteed issue insurer **within 60 days** of the beginning of coverage under the plan.

(5) eligible employees and their dependents who are hired after the start of the employer's coverage by a **guaranteed issue insurer**

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[4] "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.

and who are not late enrollees, coverage *may* be reinsured by the GII: (*9)

(A) within **60 days** of the commencement of coverage under the plan, **or**

(B) beginning 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) eligibles employed as of the date the employer's coverage begins *may* be reinsured

(A) within **60 days** of the beginning of the employer's coverage **or**

(B) beginning 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.(*10)

(7) regarding eligibles, a GII *may* reinsure the entire employer group

(A) within **60 days** of the beginning of the group's coverage

(B) in the case where a new entrant to an employer group is reinsured under the provisions of (4) of this section, on the first plan anniversary after the new entrant became a member of the

employer's plan; **or**

(C) beginning 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.[5] (*11)

(8) employees or dependents reinsured under (4),(5),or (6) may not be provided reinsurance until $5,000 in benefit payments has been made in that calendar year. *In this paragraph "benefit payments" include those payments that would have been reimbursed through reinsurance in the absence of the annual $5000 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. (*12)

(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 after 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 in (d), **premium rates charged for coverage reinsured by the association** shall be established as follows:

(1) for whole group reinsurance coverage, **1.5 x the**

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[5] Legal Services has provided the following example: Assuming the association plan becomes operational July 1, 1992, then the first plan anniversary after coverage has been in effect for three years would be July 1, 1996. Therefore coverage would commence not later than 18 months after July 1, 1996, on a date set by the board.

adjusted average market premium price[6] for that group, minus a ceding expense factor determined by the association. (*13)

(2) for individual reinsurance coverage, **5.0 x the adjusted average market premium price** for an eligible employee or dependent, minus a ceding expense factor determined by the association.

(d) **premium rates charged to a HMO,** which may be limited in the amount of risk that may be ceded to it, may be modified to reflect that portion of risk.

(e) If a health benefit plan is entirely or partially reinsured with the association, the premium charged to the small employer **may not be more than 1.5 times the adjusted average market premium price.**

(f) **Assessing the members:**

(1) after the close of the fiscal year, the administering insurer determines net premiums (health benefit plan premiums less administrative expense allowances)

(2) net loss is covered first by assessment against members

(A) apportioned by the board among all members in proportion to the member's respective share of the total net premiums, **except that HMOs assessments must be adjusted to recognize the restrictions imposed by federal law.**

(B) assessments under (2)(A) **shall be capped at four percent of premiums charged for health benefit plans** (*14)

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[6] "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.

(3) any excess funds from assessments shall be held in an interest bearing account and used to offset future losses, **future losses include a reserve for incurred but not reported claims.**

(4) members shall report claim payments and administrative expenses annually

(5) the plan must include provision for **interest penalty for late payment** of assessments

(6) a member may request a **deferment of assessment** from the director, which the director may grant if the opinion of the director is that the assessment would endanger the ability of the member to fulfill the member's contractual obligations. (*15)

(7) if an assessment is deferred, that amount may be assessed against other members of the association. The member receiving the deferment is still liable for the amount deferred.

Sec. 21.55.060. The association is **exempt from the Administrative Procedures Act.**

Sec.21.55.070. 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. 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. (*16)

ARTICLE 2. SMALL EMPLOYER HEALTH INSURANCE PLANS.

Sec. 21.55.100. (a) An individual or group health benefit plan is subject to the provisions of this chapter if the plan provides health care benefits to one or more employees of a small employer and if one of the following conditions is met:

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

-a covered individual is reimbursed 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 offer of **coverage of a health care service or benefit** or the reimbursement, utilization, or consideration of specific category of a **licensed or certified health care practitioner** do not apply [7] (*17)

(c) Except as provided in this chapter, a health benefit plan offered to a small employer is **not subject to a law that would:**

(2) **inhibit an insurer from contracting with providers or groups of providers for health care services or benefits** (*18)

(3) **restrict the ability to negotiate with providers regarding the level or method of reimbursing care or services provided under the health benefit plan**

(4) **require inclusion or exclusion of a specific provider or class of provider when contracting for health care services.**

Sec. 21.55.110 Underwriting and Rating Requirements. Health plans are subject to the following provisions:

(1) preexisting conditions provisions may not exclude or limit coverage for longer than 12 month **and** may only relate to conditions that -

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7 Current law prohibits discrimination among health care providers - providers is defined as a state licensed physician, dentist, osteopath, optometrist, chiropractor, nurse midwife, advanced nurse practitioner, naturopath, physical therapist, or occupational therapist (AS 21.36.090). An insurer must offer treatment for alcohol and drug abuse and payment of the costs of mammograms and may offer reimbursement for the cost of acupuncture.

during the six months immediately preceding the effective date of the coverage,

occurred in a manner that would cause an ordinarily prudent person to seek medical care **or** (*19)

for which medical care was recommended or received,**or**

that related to a pregnancy existing on the effective date of coverage.

(2) health benefit plans shall credit the time the person was covered under a previous employer based health benefit plan if the previous coverage was continuous to a date not more than 30 days before the effective date of the new coverage when determining whether a preexisting condition limitation applies.

(3) the health plan must be renewable except for:

(A) nonpayment of premiums
(B) noncompliance with plan provisions
(C) employers that have fewer employees than are required by the plan, **or**
(D) a plan issued by an insurer that ceases doing business in the small employer market as outlined in Sec 21.44.1408.

(4) a health benefit plan may be cancelled by the insurer for fraud or misrepresentation

(5) an insurer **may not** exclude an eligible individual who would otherwise be covered on the basis of an actual or expected health condition **except that**

- *a late enrollee may be excluded for the greater of 18 months or the remainder of the three year reinsurance period.*

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8 An insurer may cease doing business in the small employer market if notice is provided to the affected parties one year in advance. Such an insurer may not reenter the market for five years.

(6) an insurer doing business in the small employer market retains the authority to underwrite and rate small employer groups using accepted underwriting and actuarial practices

- small groups that are declined because they fail to satisfy underwriting requirements shall be notified they will not be issued health benefit plans, **and**

-that the small employer is eligible for a plan provided by a guaranteed issue insurer, and shall be given a list of all guaranteed issue insurers.

(7) a health benefit plan **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.** (See subsection 1)

(8) plans shall be made available without a **service waiting period,** unless a small employer chooses a service waiting period offered by the insurer; a service waiting period may not exceed 90 days.

(9) the **benefit structure of a plan may be changed by the insurer to make it consistent with the benefit structure contained in a health benefit plan being marketed to new groups.** (*21)

(10) **rates for the same or similar coverage may not vary from the applicable midpoint rate by more than 35 percent of the applicable midpoint rate.**[9] **(*22)**

(11) if a plan was previously issued, and the premium rate exceeds the applicable midpoint rate by more than 35 points, an increase in premium rates for a new rating period may not exceed the sum of

(A) the percent of change from the previous rating period to the new rating period, **plus**

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9 "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.

(B) an adjustment due to a change in case characteristics or plan design, **as determined by the insurer**

(12) **a premium rate may not vary by more than 15 percent based on industry classification.**

(13) subject to (10), (11), and (12) above, **an increase in a premium rate for a new rating period may not exceed the sum of:**

(A) the percent of change from the previous rating period to the new rating period **plus 15 percent** (adjusted pro rata 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, **as determined by the insurer.**

(14) when offering a health benefit plan an insurer shall make reasonable disclosure of

(A) how premium rates are established or adjusted.

(B) the provisions concerning the insurer's right to change a premium rate.

(C) renewability of a policy

(15) requires insurers to file annually certification stating that accepted actuarial practice are complied with, are uniformly applied, and comply with this chapter.

Sec. 21.55.120 GUARANTEED ISSUE INSURERS. (a) Guaranteed issue insurers shall offer at least one plan and shall provide at least the coverage to a small employer requesting the plan or the coverage.

(b) guaranteed issue insurers may

(1) reinsure an individual with a group or may reinsure an entire group, and

(2) as provided in the association's plan

(A) **require advance premium deposits for poor credit risks**

(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 GII is experiencing an unfair share of administrative or credit risk,

Sec. 21.55.130 SMALL EMPLOYER HEALTH BENEFIT PLANS. (a) The board designs the small employer benefit plans eligible for reinsurance by the association and shall establish **benefit levels, deductibles, coinsurance factors, exclusions, and limitations.**

(b) A plan may contain **cost containment features to include:**

(1) utilization review
(2) case management
(3) selective contracting with hospitals and health care providers
(4) reasonable benefit differentials applicable to participating and nonparticipating providers
(5) other provisions.

(c) HMO plans must be consistent with HMO requirements.

(d) A small employer health benefit plan must be approved by the director.

(e) After the director's approval of the plans submitted by the board, an insurer must certify that the plans are in **substantial compliance** with the provisions in the corresponding approved board plan. An insurer may then use that 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 must provide notice of intent to cease to do business in the small employer market **one year in advance** and may not reenter the small employer marketplace for five years.

Sec 21.55.250. DEFINITIONS - please refer to bill.

SEC 3. provides that a health maintenance organization is subject to the small employer health insurance provisions contained in AS 21.55.

SEC 4. provides that a hospital or medical service corporation is subject to the small employer health insurance provisions contained in AS 21.55

SEC 5. transition - requires board to submit a plan to the director within 180 days of organization. Allows 60 days after approval of plan for a guaranteed issue insurer to offer a small employer a health benefit plan.

SEC 6. Effective date.

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

March 30, 1992

SUBJECT: CSSB 242 ( )

TO: Members, Senate HESS Committee

FROM: Senator Virginia Collins

What follows is a side-by-side comparison between model legislation drafted by the National Association of Insurance Commissioners (NAIC) and CSSB 242 ( ).

SMALL EMPLOYER MARKET REFORMS

	NAIC	CSSB 242 ( )
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 ( )
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, with Insurance Director as ex-officio member. Director appoints. 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 be HSO, HSC, or MSO; one to be HMO; one to represent other benefit arrangement.

	NAIC	CSSB 242 ( )
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, but also includes Director as member.
Insurers With Restricted Charters, i.e., Fraternal Benefits Organizations	Not Included	Guarantees issue only to those permitted by charter.

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

Health Care Access

CSSB 242 (3/28/92 Draft)

Small Employer Health Insurance

If the national rates of uninsured workers hold true in Alaska, then more than 40,000 Alaskans employed by small employers work without health insurance benefits from their employers.

SB 242 was introduced last year to help this segment of uninsured Alaskans. It was based on last year's model legislation drafted by the Health Insurance Association of America (HIAA). It made certain changes in the small employer health insurance market in order to provide more accessibility, renewability, predictability, and stability for the small employer having 3 to 25 employees.

Last December, several months after HIAA had issued its model bill, the National Association of Insurance Commissioners (NAIC) released its model legislation for small group market reform. CSSB 242 (3/28/92 Draft) is based on the NAIC model. The purpose of this bill is to:

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

* prevent abusive rating practices and require the disclosure of rating practices to purchasers;

* establish rules on renewability of coverage;

* establish limitations on preexisting condition exclusions;

* provide for the development of basic and standard health benefit plans offered to all small employers; and,

* establish the Small Employer Health Reinsurance Association.

Under the bill, the state only pays for the cost of travel by the Director of the Division of Insurance. For a minimal cost, CSSB 242 (3/28/92 Draft) goes a long way in helping a significant portion of Alaska's uninsured population.

SB242

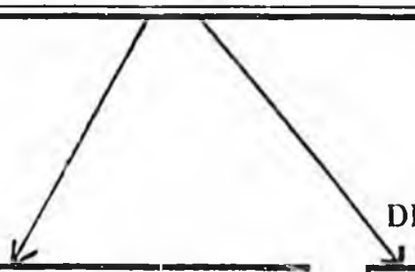
HEALTH INSURANCE FOR SMALL EMPLOYERS
(A NON-PROFIT LEGAL ENTITY)

MEMBERS OF THE HEALTH REINSURANCE ASSOCIATION

LICENSED HOSPITAL OR MEDICAL SERVICE CORPORATIONS
WELFARE ARRANGEMENTS / MULTIPLE EMPLOYER ARRANGEMENT
LICENSED ALASKA HEALTH INSURERS OFFERING A HEALTH PLAN

BOARD OF DIRECTORS

NINE INDIVIDUALS SELECTED BY MEMBERS *
DIRECTOR OR DESIGNEE IS NON-VOTING EX-OFFICIO MEMBER



*** PROPOSED REPRESENTATION**

HMO REPRESENTATIVE
HOSPITAL OR MEDICAL SERVICE CORPORATION
SIX MEMBERS FROM SMALL BUSINESS HEALTH INSURERS
ONE MEMBER FROM LARGE BUSINESS HEALTH INSURERS

DIRECTOR OF INSURANCE

APPROVES BOARD MEMBERS
APPROVES PLAN OF OPERATION
REVIEWS ANNUAL REPORT
HEARS APPEALS BY MEMBERS

COST

SELF-SUPPORTED ASSOCIATION
(ONLY COST TO STATE:
DIRECTOR OF INSURANCE TRAVEL)

SB242

PURPOSE

TO MAKE CERTAIN CHANGES IN THE EMPLOYER INSURANCE MARKET TO PROVIDE MORE: ACCESSABILITY, RENEWABILITY, PREDICTABILITY, AND STABILITY.

TO ENSURE FAIR ACCESS TO AND CONTINUITY OF COVERAGE FOR SMALL EMPLOYERS AND THEIR EMPLOYEES.

HIGHLIGHTS

GUARANTEED ACCESS TO COVERAGE: ALL SMALL EMPLOYER GROUPS WOULD BE ABLE TO OBTAIN BASIC COVERAGE REGARDLESS OF RISK.

COVERAGE OF WHOLE GROUPS: NEITHER AN EMPLOYER NOR AN INSURER WOULD BE ABLE TO EXCLUDE FROM GROUP COVERAGE, HIGH RISK INDIVIDUALS.

RENEWABILITY OF COVERAGE: AT RENEWAL TIME COVERAGE WOULD NOT BE CANCELLED DUE TO DETERIORATING HEALTH.

CONTINUITY OF COVERAGE: ONCE INDIVIDUAL MEETS PREEXISTING CONDITION RESTRICTIONS, HE OR SHE WOULD NOT HAVE TO MEET AGAIN WHEN CHANGING JOBS OR CARRIERS.

PREMIUM PRICING LIMITS: INSURERS WOULD BE REQUIRED TO LIMIT HOW MUCH THEIR RATES COULD VARY FOR GROUPS SIMILAR IN GEOGRAPHY, DEMOGRAPHIC COMPOSITION AND PLAN DESIGN.

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 March 30, 1992

SUBJECT: Sectional Summary of CSSB 242 (3/28/92 Draft)

TO: Members, Senate HESS 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 or summary 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 - Delineates the purpose of the bill.

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 of the bill.

Section 3 -

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 the director of the division of insurance and 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 three years on the effectiveness of the association.

Sec. 21.55.080 - Exempts the association from the Administrative Procedure Act.

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

Section 5 - Provides that a hospital or medical service corporation is subject to the small employer health insurance provisions contained in AS 21.55.

Section 6 - Transition section in regards to premium rate restriction.

Section 7 - 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 8 - Effective date.

Alaska State Legislature

SENATOR ARLISS STURGULEWSKI, Chairman
SENATOR PAUL FISCHER, Vice Chairman
SENATOR SAM COTTEN
SENATOR LYMAN HOFFMAN
SENATOR CURT MENARD

P.O. BOX V
ROOM 427
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(907) 465-3762

Senate Committee on
Health, Education and Social Services

MEMORANDUM 14 April 1992

TO: Senate HESS Committee Members

FROM: Senator Arliss Sturgulewski, Chair

Following are recommendations regarding the amendments proposed by the division of insurance and others.

DO NOT RECOMMEND ADOPTION:
Pages 1-6 of amendments offered by div of insurance.
These amendments combine the associations of SB 74 & SB 242

RECOMMEND ADOPTION:
Page 7 of amendments offered by div of insurance.
Provides additional options for deductibles. Clarifies Medigap coverage available only to high risk residents covered by Medicare. Clarifies state plan coverage must be made available to eligible high risk residents.

DO NOT RECOMMEND ADOPTION:
Page 8-12 of amendment offered by division of insurance.
Establishes a benefit committee to decide benefits offered by pool rather than outlining benefits to be covered in statute.

DO NOT RECOMMEND ADOPTION:
Page 13 of amendments offered by division of insurance.
This amendment is a clarifying amendment following adoption of amendments on pages 8-13.

RECOMMEND ADOPTION:

Page 14 of amendments offered by division of insurance.
prohibits coverage where workers' compensation policy is available.

DO NOT RECOMMEND ADOPTION:
Page 15 of amendments offered by division of insurance.
This amendment is a clarifying amendment following adoption of amendments on pages 8-13.

RECOMMEND ADOPTION
Pages 16 & 17 of amendments offered by division of insurance.
clarifies that persons eligible for other health benefits are ineligible for this program.

Page 18 is a duplicate.

RECOMMEND ADOPTION
Page 19 of amendments offered by division of insurance.
Clarifying amendment regarding licensed persons.

RECOMMEND ADOPTION
Page 20 of amendments offered by division of insurance.
Clarifying amendment.

RECOMMEND ADOPTION
Page 21 of amendments offered by division of insurance
Provides guidance as to what may constitute a medical condition.

RECOMMEND ADOPTION
Page 22 of amendments offered by division of insurance.
Sets out requirements for legislative review of plan.

OTHER SUGGESTIONS:

RECOMMEND ADOPTION:
Page 2, Line 5.

after "division of Insurance, add: "at least two board members shall be consumers appointed by the director of the division of insurance"
(offered by Kerttula)

RECOMMEND ADOPTION:
Page 2, line 17 through 23:

The association should have the power to receive funds from other sources.

RECOMMEND ADOPTION
Page 8, Line 17:

HIAA, Aetna, and the division of insurance all agree that the percentage amount that can be charged for premiums should be higher than 125% and probably should be 150%. (HIAA - 200%)

the division of insurance suggests that the director, by regulation, be able to add eligibility requirements.[1]

Page 12, Lines 6 through 14

here again, the director is responsible for duties that may be more appropriately assigned to the association itself.

Page 14, Line 5

Sen. Kerttula offered amendment deleting "for medical reasons" from this line. Both HIAA and Aetna object to this deletion on the grounds that the purpose of this legislation is to ensure that unhealthy individuals can get insurance. Sen. Kerttula's position is that persons are often denied insurance because of the class of persons they belong to.

Staff has no recommendation.

Page 14, Line 10:

add: (c) have been refused by two insurers to issue insurance except at a rate exceeding the state high risk plan rate (offered by Kerttula) HIAA objects to adoption of this amendment.

Staff has no recommendation.

---

[1] NOTE: the association itself is exempt from the administrative procedures act, but there are several references in the legislation to the ability of the director of the division of insurance to promulgate regulations affecting the operation of the association. There should be a policy decision made as to how much control the director has over the association.

AMENDMENT #1

OFFERED IN THE SENATE BY SENATOR COLLINS

TO: CSSB 242 (3/28/92 Draft)

Page 14, line 23, before "than 30 days":

Delete [LESS], insert: more

Page 22, line 26, after "AS 21.55.120(a)(1)":

Insert: and (2)

Page 22, line 27, before "of":

Delete [2], insert: 3

Page 22, line 28, after "AS 21.55.120(a)(1)":

Insert: and (2)

AMENDMENT #2

OFFERED IN THE SENATE BY SENATOR COLLINS

TO: CSSB 242 (3/28/92 Draft)

Page 8, line 1, after "composed of":

Delete [THE DIRECTOR AND SIX], insert: seven

Page 8, line 5, after "employers;"

Delete [AND]

Page 8, line 6, after "providers":

Insert: ; and

(5) one member who represents agents or brokers

AMENDMENT #3

OFFERED IN THE SENATE BY SENATOR COLLINS

TO: CSSB 242 (3/28/92 Draft)

Page 8, line 23, after "every":

Delete [THREE], insert: two

Page 23, line 24, after "appointed.":

Insert: (e) Notwithstanding AS 21.55.070, enacted in Sec. 3 of this Act, the board of directors of the Small Employer Health Reinsurance Association shall study and report, as required under AS 21.55.070, annually until July 1, 1997 to the director of the division of insurance on the effectiveness of AS 21.55.

AMENDMENT #4

OFFERED IN THE SENATE BY SENATOR COLLINS

TO: CSSB 242 (3/28/92 Draft)

Page 14, line 4, after "insurer":

Insert: as provided under AS 21.06.180-.210

AMENDMENT #5

OFFERED IN THE SENATE BY SENATOR COLLINS

TO: CSSB 242 (3/28/92 Draft)

Page 2, line 14, after "selected":

Insert: by participating members, subject to approval

Page 2, line 31, after "filled":

Insert: by participating members, subject to approval

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 7, 1992

SUBJECT: Amendment to CSSB 242 (3/28/92 Draft)

TO: Members, Senate HESS Committee

FROM: Senator Virginia Collins

Attached please find Amendment #1 to the above bill.

It corrects one mistake and several omissions that occurred during drafting.

AMENDMENT #1

OFFERED IN THE SENATE **BY SENATOR COLLINS**

TO: CSSB 242 (3/28/92 Draft)

Page 14, line 23, before "than 30 days":

Delete [LESS], insert: more

Page 22, line 26, after "AS 21.55.120(a)(1)":

Insert: and (2)

Page 22, line 27, before "of":

Delete [2], insert: 3

Page 22, line 28, after "AS 21.55.120(a)(1)":

Insert: and (2)

SENATE AMENDMENT

BY: Division of Insurance

TO: Page 2, line 3 SENATE BILL NO. CSSB 242 G

TO: _____ HOUSE BILL NO. _____

After: "PROHIBITED"

Insert: "A person may not violate the provisions of AS 21.55."

Delete: "An insurer, agent, or broker, may not violate the applicable provisions of AS 21.55.180."

SPONSOR STATEMENT: All persons should be prohibited from violating any provision of this chapter.

SENATE AMENDMENT

BY: Division of Insurance

TO: Page 2, line 17 SENATE BILL NO. CSSB 242 G

TO: _____ HOUSE BILL NO._ _____

After: "insurer"

Delete: "The director or the director's designee shall serve as an ex officio member of the board."

SPONSOR STATEMENT: As regulator providing oversight of the organization, the director cannot be on the board.

SENATE AMENDMENT

BY: Division of Insurance

TO: Page 2, line 25 SENATE BILL NO. CSSB 242 G

TO: _____ HOUSE BILL NO. _____

After: "board"

Delete: "other than the director or the director's designee"

SPONSOR STATEMENT: The program should involve cost shifting to other insured persons or the state. Division of Insurance activities are supported by fees. Under AS 21.06.250, the division must collect fees for services provided.

SENATE AMENDMENT

BY: Division of Insurance

TO: Page 3, line 31 SENATE BILL NO. CSSB 242 G

TO: _____ HOUSE BILL NO. _____

After: "program"

Insert: "on a equitable and proportionate basis under the provisions of this section, is fiscally sound, and does not shift program costs to other insured persons or the state."

Delete: "and provides for the sharing of program gains and losses on a equitable and proportionate basis under the provisions of this section."

SPONSOR STATEMENT: Reference to gain may make the program and/or its investment income taxable under IRS rules and the Federal Tax Code. The program should involve no cost shifting to other insured persons or to the state.

SENATE AMENDMENT

BY: Division of Insurance

TO: Page 4. line 30 SENATE BILL NO. CSSB 242 G

TO: _____ HOUSE BILL NO. _____

After: "has"

Insert: "paid"

Delete: "incurred"

SPONSOR STATEMENT: Reinsurers traditionally provide reimbursement only after the payment has been made by the insurer. "Incurred" would provide reimbursement when a claim is made or reserved by the insurer even if no payments had been or would be made.

SENATE AMENDMENT

BY: Division of Insurance

TO: Page 7, line 4 SENATE BILL NO. CSSB 242 G

TO: _____ HOUSE BILL NO. _____

After: "state"

Insert: "as required by the board no less often that quarterly on forms prescribed by the board and acceptable to the director"

Delete: "on an annual basis on a form prescribed by the director"

SPONSOR STATEMENT: The board should have data on payments and administrative expense more frequently than once a year in order to allow proactive steps to be taken to address changes in trend, frequency, severity, market share, etc.

SENATE AMENDMENT

BY: Division of Insurance

TO: Page 8, line 1 SENATE BILL NO. CSSB 242 G

TO: _____ HOUSE BILL NO. _____

After: "of"

Delete: "the director and six"

SPONSOR STATEMENT: As regulator providing oversight of the organization, the director cannot be on the committee.

SENATE AMENDMENT

BY: Division of Insurance

TO: Page 2, line 4 SENATE BILL NO. CSSB 242 G

TO: _____ HOUSE BILL NO. _____

After: "AS 21.55.180."

Insert: "* Sec. _ . AS 21.36.060(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 providers's occupational license. In this subsection, 'provider' means a state licensed physician, dentist, osteopath, optometrist, chiropractor, nurse midwife, advanced nurse practitioner, physical therapist, or occupational therapist."

SPONSOR STATEMENT: Cost containment provisions provided in the bill should not be in conflict with an Unfair Trade Practice or Fraud.

SENATE AMENDMENT

BY: Division of Insurance

TO: Page 12, line 16 SENATE BILL NO. CSSB 242 G

TO: _____ HOUSE BILL NO. _____

After: "(C)"

Insert: "the director may initiate precedings as provided by law and may use the information, documents, and other information discovered or developed in a judicial or administrative proceeding."

Delete: "if the information is relied upon in determining that a violation of this chapter occurred."

SPONSOR STATEMENT: Clarifies that the information or documentation may be used for all judicial or administrative remedies available to the director.

SENATE AMENDMENT

BY: Division of Insurance

TO: Page 13, line 30 SENATE BILL NO. CSSB 242 G

TO: _____ HOUSE BILL NO. _____

After: "director"

Insert: "under AS 21.42 the basic health benefit plans and the standard health benefit plans to be used by the insurer."

Delete: ",in a form and manner prescribed by the director, the basic health benefit plans and the standard health benefit plans to be used by the insurer. A health benefit plan filed under this subsection may be used by a small employer insurer beginning 30 days after it is filed unless the director disapproves its use."

SPONSOR STATEMENT: Provides consistent handling for prior approval of forms and provides standards for disapproval of forms.

SENATE AMENDMENT

BY: Division of Insurance

TO: Page 17. line 4

SENATE BILL NO. CSSB 242 G

TO: _____

HOUSE BILL NO. _____

After: "agent"

Insert: ", broker, managing general agent, or third party administrator"

Delete: "or broker"

SPONSOR STATEMENT: Includes other licensees who may participate in the sale of health benefit plans.

SENATE AMENDMENT

BY: Division of Insurance

TO: Page 17, line 8 SENATE BILL NO. CSSB 242 G

TO: _____ HOUSE BILL NO. _____

After: "agent"

Insert: ", broker, managing general agent, or third party administrator"

Delete: "or broker"

SPONSOR STATEMENT: Includes other licensees who may participate in the sale of health benefit plans.

SENATE AMENDMENT

BY: Division of Insurance

TO: Page 17, line 13 SENATE BILL NO. CSSB 242 G

TO: _____ HOUSE BILL NO. _____

After: "agent"

Insert: ", broker, managing general agent, or third party administrator"

Delete: "or broker"

SPONSOR STATEMENT: Includes other licensees who may participate in the sale of health benefit plans.

SENATE AMENDMENT

BY: Division of Insurance

TO: Page 17, line 15 SENATE BILL NO. CSSB 242 G

TO: _____ HOUSE BILL NO. _____

After: "agent"

Insert: ", broker, managing general agent, or third party administrator"

Delete: "or broker"

SPONSOR STATEMENT: Includes other licensees who may participate in the sale of health benefit plans.

SENATE AMENDMENT

BY: Division of Insurance

TO: Page 17, line 22 SENATE BILL NO. CSSB 242 G

TO: _____ HOUSE BILL NO. _____

After: "this"

Insert: "chapter by a person"

Delete: "section by a small employer insurer or an agent or broker"

SPONSOR STATEMENT: Broadens as an unfair trade practice any violation of Chapter 55 by any person.

SENATE AMENDMENT

BY: Division of Insurance

TO: Page 8, line 22 SENATE BILL NO. CSSB 242 G

TO: _____ HOUSE BILL NO. _____

After: "REPORT."

Insert: "(a) The board shall study and report at least once every three years to the legislature on the effectiveness of this chapter. The report must analyze the effectiveness of the chapter in promoting rate stablility, 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 legislative or other regulatory action.

(b) Upon receipt of a report from the board, the legislature must review the program to determine the effect of the program on its target market, the effect of the program on the overall health insurance market, and whether the program should be continued."

Delete: "The board shall study and report at least once every three years to the director on the effectiveness of this chapter. The report must analyze the effectiveness of the chapter in promoting rate stablility, 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 and agents or brokers 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."

SPONSOR STATEMENT: Legislative review of the program after three years should 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.

7-LS0847\J
Ford
4/14/92

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:
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 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 calendar year, 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) **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.

7-LS0847\G
Ford
3/28/92

CS FOR SENATE BILL NO. 242 ( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

SEVENTEENTH LEGISLATURE - SECOND SESSION

BY

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. 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.

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

Sec. 21.36.025. UNFAIR MARKETING PRACTICES PROHIBITED. An insurer, agent, or broker, may not violate the applicable provisions of AS 21.55.180.

* Sec. 3. 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 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. The director or the director's designee shall serve as an ex officio member of the board. 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 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.

(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 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 and provides for the sharing of program

gains or losses on an equitable and proportionate basis under the provisions of this section. 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 incurred 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 an 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 the director and six 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.

(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 three years to the director 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 and agents or brokers 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) if the information is relied upon in determining that a violation of this chapter occurred.

(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, in a form and manner prescribed by the director, the basic health benefit plans and the standard health benefit plans to be used by

the insurer. A health benefit plan filed under this subsection may be used by a small employer insurer beginning 30 days after it is filed unless the director disapproves its use.

(c) The director at any time may, after providing notice and an opportunity for a hearing to a small employer insurer, 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 less 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 or broker 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 or broker 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 or broker, if any, for the sale of a basic or standard health benefit plan;

(2) or agent or broker 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 small employer insurer or an agent or broker 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) "premium" means money paid by a small employer and eligible employees as a condition of receiving coverage from a small employer insurer and includes fees or other contributions associated with the health benefit plan;

(22) "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;

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

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

(25) "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;

(26) "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, 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;

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

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

(29) "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. 4. 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. 5. 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. 6.** PREMIUM RATE RESTRICTION. Regarding a health benefit plan subject to AS 21.55.110, enacted in sec. 3 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)(2), enacted in sec. 2(3) 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)(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. 7. TRANSITION. (a) Within 180 days after the board is appointed under AS 21.55.020, enacted in sec. 3 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. 3 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. 3 of this Act, shall submit the required health benefit plans within 180 days after the members of the committee are appointed.

* Sec. 8. 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 represen 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 small employers;

(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;

(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.

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.

Pg2, Line 2 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.

Pg2 Line 18 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.

Pg 2 Line 25 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.

Pg 3 Line 31, Pg 4, Line 1 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.

Pg 3, Line 27 AS 21.55.040 should require that the plan of operation establish procedures to be self-supporting and fiscally sound.

Pg 4, Line 29 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.

Pg 7 Line 1

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.

Pg8, Line1

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

P8, Line 7

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).

Pg8, Line 22

AS 21.55.070 should be revised 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.

Pg9, Line 28

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

Pg10, Line 26

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.

Pg 13, Line 22

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.

Pg 14, Line 19

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.

Pg 16, Line 20

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.

Pg 18 lines 7+16

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.

Pg 21, line 21

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

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Dep ment of Commerce
& Economic Development / POSITION PAPER

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

The department is in favor of 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. Persons going from one employer to another who have acquired a medical condition find themselves, in too many cases, uninsurable.

Certain underlying conditions need to be met to satisfy public expectations of a health insurance market that can continue to be provided by private health insurers. These include: guaranteed access to coverage; coverage for entire groups, renewability of coverage; limits on pricing; and continuity of coverage. This legislation addresses these issues by establishing a reinsurance mechanism comprised of all entities writing health care coverages in Alaska. Through this mechanism, coverage is made available that provides that the preexisting conditions restriction is applicable to a person only one time. Once a covered person has satisfied the plans preexisting condition restriction, he or she would not have to again face the restrictions when changing employers or insurance company. The plan contained in the bill assures availability of coverage, prevents picking and choosing of employees in a group, assures renewability and places a cap on premium increases.

This legislation gives the private health care insurance system an opportunity to address these challenges.

Asst. Comm.

Glenn A. Olds, Commissioner

Date: 4-18-91

GAO/DK/dgl9415D
041891b

STATE OF ALASKA

WALTER J. HICKEL, GOVERNOR

DEPARTMENT OF COMMERCE & ECONOMIC DEVELOPMENT

7th FLOOR FRONTIER BLDG.
3601 C STREET, SUITE 740
ANCHORAGE, ALASKA 99503-5934
PHONE: (907) 562-3626

DIVISION OF INSURANCE

December 20, 1991

Ms. Melissa Fouse
Office of Sen. Arlis Sturgelewski
3111 C Street, Suite 550
Anchorage, AK 99503

Re: Notes and Questions to SB 242

In accordance with the above-referenced questionnaire dated September 16, 1991, the Division of Insurance provides the following responses:

2) Does the legislature wish, as a matter of public policy, to allow the association to design health coverage products or does the Legislature wish to examine models that set out basic health care plans and incorporate them into the bill.
   We advise the legislature to adopt NAIC's model bill on health coverage products.

3) The director of the division of insurance is required to approve the plan of operation for the Association. However, if the Association does not submit a plan, the director is required to adopt regulations governing the operation of the association.

   Should the director be required to take action that the Association fails to take?
   The director should not be required to design the program if the association fails to take action.

4) Should the director be an arbiter for the association? The bill provides that a member may appeal to the director from association action or decision.
   The director should not be an arbiter.

5) Is there an industry standard for poor credit risks? What does this mean?
   This bill is addressing people who do not necessarily pay their bills and there is no specific industry standard standard for poor credit risks to my knowledge.

6) Under what circumstances does the bill envision a guaranteed issue insurer would not be required to write business received from a particular agency or broker?
   An insurer always has the right to reject business from a broker or agent who has proved not to pay the bills to the insurer.

7) What kind of plan does the bill envision being reinsured here?
The plan would be one established by the Association, to be called the Small Employer Health Benefit Plan. It is difficult to say what this plan would look like, as it would be a product of the Association with input from the director of the Division of Insurance.

8) Should the legislature, as a matter of public policy, enumerate a standard of cost-containment beyond which the association may not go, i.e., can the association limit choice of physicians?
Technically, the Association could limit the choice of physicians if it is a pure preferred provider agreement arrangement. However, the Association can protect itself against such by modifying the contract to a scheduled benefit arrangement, which means the member would only pay a specific amount for a specific treatment.

12) Should the bill cap the amount of the deductible or should the board be able to change the amount? Does this section authorize the board to change the amount of the deductible without going through the director?
The board should be able to change the amount of the deductible. However, the board would have to gain approval from the director of the Division of Insurance to change the deductible.

13) Are the premium rates in this section the rates charged by the reinsurance association to the insurer or the rates charged by the insurer to the employer?
The bill addresses the premium rates charged to the insurer as well as those charged to the employer. At present, the reinsurance association could charge the insurer up to 1.5 times the rates established by the association for whole group or up to 5 times the standard rates for an individual. The insurer can charge the employer a maximum of 1.5 times the rates, also established by the association.

14) Who is responsible for paying for the program if the costs exceed the four percent assessments to the members?
If insufficient funds exist after the assessment of four percent, the Association will have to pick up loans or modify the contracts accordingly so that the bills can be paid. Technically, there is no one else responsible for paying for the program if the costs exceed the four percent assessment to the members.

15) Should the director, rather than the board, be allowed to grant deferments. Does this create liability on the part of the state to make up the difference if the insurer doesn't pay?
It is not recommended that the state be responsible to make up the difference if the insurer doesn't pay. The director, in coordination with the board, may be allowed to grant deferments.

16) Does the Legislature wish to use this standard of proof for exempting from liability for acts or omissions on the part of a member of the association?
This is an issue that the Legislature should address.

17) Does the Legislature intend to exempt current statutory requirements for services and payments to providers from this bill?

It doesn't appear that the Legislature intends to exempt current statutory requirements for services and payments to provider from this bill.

18) Does the Legislature wish to give the Association the authority to limit access to providers by insured?

This decision would have to be made by the board and the director, versus by the Legislature.

19) The effect of this section may be to prevent persons from seeking medical care in the six months prior to being covered.

This bill does not allow a service waiting period in excess of 90 days. The six months pertain to pre-existing conditions and would not pay service for such.

20) Should pregnancies be exempt from coverage?

Pregnancy should not be exempt from coverage.

21) This subsection does not make it clear if a plan may be changed at any time or only upon renrewal.

While it is not clearly addressed, plans generally are changed only upon renewal and would be a standard condition that the board as well as the director would request.

22) An example of possible premium spread among individuals with similar case characteristics under this bill is as follows:

Allowable variation is monthly premium based on industry classification (15 percent variation) - low, $127.50; midpoint $150.00; high $172.50. Highest possible premium (35 percent above high risk business group midpoint) - $232.87. Lowest possible premium (35 percent below risk business group midpoint) - $82.87. Spread between lowest premium and highest premium among individuals with similar case characteristics - 280 percent.

This is not entirely clear. At present, an insurer still could charge 1.5 times the standard rate and it does not clearly address a discount for good experience.

I hope this clarifies the issues you brought to our attention. Please feel free to contact me if you need to discuss the matter further.

Sincerely,

Thelma Snow Walker

Thelma Snow Walker
Deputy Director

TSW/ngk
0522Y

MEMORANDUM State of Alaska

TO: Thelma Snow Walker, Deputy Director
Division of Insurance

DATE: December 20, 1991

FILE NO:

TELEPHONE NO:

THRU:

SUBJECT: SB 242 Introduced by Senator Collins on 4/5/91

FROM: Christian F. Ulmann
Insurance Market Analyst

This memo serves as an addition to our position paper on the named SB 242 dated 4/18/91.

This bill seems to have been created with focus on AVAILABILITY. This goal is fully achieved by the structure of such bill.

However, the AFFORDABILITY is a matter which needs to be further discussed. After further study, we are in a position to offer some observations and suggestions:

This bill will most likely increase the average cost of group health insurance. Such is possible because even insurers which are not guaranteed issue insurers will be assessed by the proposed SMALL EMPLOYER HEALTH REINSURANCE ASSOCIATION (SEHRA) for claims reinsured by SEHRA and administrative expenses ([Sec. 21.55.040 Plan of Operation (c) (9)]). Further, if a health benefit plan coverage for a small employer is entirely or partially reinsured by SEHRA, the premium charged to the small employer may not be more than 1.5 times the adjusted average market premium price established by SEHRA for that classification or group with similar characteristics and coverage ([Sec. 21.55.050 Health Care Reinsurance (e)]). SEHRA will charge the insurer a premium for whole group reinsurance of 1.5 times the adjusted average market premium price established by SEHRA and up to 5 times the same for an individual. If such amounts do not cover the loss expenses for SEHRA, then assessment on the members will be made.

At the present time, we observe that group and community-rated plans are more expensive than individual coverage. Some insurers have made good groups of insureds their target. These insurers offer an individual policy for much less money. As a result, we have seen that some employers offer their employees the option of buying from them an individual policy if such employee qualifies.

This means that some employees have no coverage, others do. This practice would not be stopped by this bill, but rather would enhance it. There is another very important issue; apparently it is assumed that nothing in the marketplace is subject to change but the contrary is true. We see more and more rather large groups that would also be subject to assessment by SEHRA, leaving the marketplace by becoming self-insured. Just imagine the impact it would have on the assessments if the State employees would become self-insured. An employer would be forced in some cases not to provide insurance at all or buy individual policies for the employees. While this is pretty much the same scenario we have today, at least there is no burden of assessments. In any scenario this assessment approach creates a severe injustice by only assessing the insured and not assessing the self-insured group. We are not assured that the assessments would affect a Multiple Employers Trust Arrangment whereas the policy is issued and delivered in another state. This could be significant for assessment purposes. Further, it must be kept in mind that any system that increases the cost of insurance to the insurance buying population results in people leaving the marketplace and increases the number of uninsured. This again has the effect of increased cost shifting from the uninsured population to the insured population.

Recommendations

While we believe that expanded group insurance is part of the solution, we suggest a reconsideration of the top premiums to be charged to the employer. This might be possible by capping the maximum increase at 30 %. Also the assessment approach might be modified by creating additional revenue sources for SEHRA, i.e., employer tax, change in tobacco/alcohol tax, etc.

We also must keep in mind that this bill will put the insurance industry in the driver seat and the industry is not assuming any risk by being subject to this arrangment.

CU/cjk
0337k

HIAA

Health Insurance Association of America

May 17, 1991

The Honorable Arliss Sturgulewski
Alaska State Senator
P. O. Box V
Juneau, AK 99811

Dear Senator Sturgulewski:

Thank you very much for the courtesies you and the members of the Senate HESS Committee afforded me during both hearings on SB-242.

During the May 15 hearing, Mr. Skaggs recommended that during the committee's interim study on SB-242, they review the different premiums to be charged varying size small employer groups under SB-242. While the request appears simple on the surface, it is not -- in fact, it is impossible. The promise of guaranteed availability included within SB-242, relies on a reinsurance mechanism for those small employer groups or the individuals within those groups which otherwise would be considered uninsurable risks. The reinsurance mechanism in SB-242 provides access to individuals within the groups not previously eligible for insurance, similar to Mr. Skaggs' son. The Small Employer Reinsurance Association Board created by SB-242 is charged with the responsibility of designing the health plans and the benefits contained in those plans which would be eligible for reinsurance. As the reinsurance association board will not be formed until SB-242 is enacted, it is not possible to assume what the premiums for the health plans will be, let alone the varying premium prices by group size.

SB-242 increases access to insurance by guaranteeing availability to groups and individuals within those groups who were previously considered medically uninsurable. SB-242 also requires premium pricing limits, that is, the amount insurers may vary their rates for groups similar in geography, demographic composition and plan design. The rates will vary by insurance company as the rating limitations are based on each insurance company's variance from the midpoint of their similar type groups.

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Also during the May 15 hearing, the recent MacNeil-Lehrer report on access to care was mentioned. HIAA President Carl Schramm was one of the panel discussing access to care. Enclosed is a copy of the videotape of that television presentation.

HIAA submitted an article for the JAMA issue devoted to access, however, rather than including it in the May special issue, JAMA has indicated that it will publish it later this summer. A copy of that article is also enclosed.

If I can be of any further assistance to you, or the committee during its interim study on SB-242, please do not hesitate to contact me.

Sincerely,

Jan Andrea Meisels
State Affairs Associate

JAM:mlp

cc: Senator Virginia Collins
Gordon Evans

HIAA

Health Insurance Association of America

May 17, 1991

Mr. Sam Skaggs
709 Gold Street
Juneau, AK 99801

Dear Mr. Skaggs:

Thank you very much for your support of the HIAA small employer market reform legislation -- Alaska SB-242. Our proposal incorporates a comprehensive set of small group market reforms that we believe can be achieved in the context of a viable private marketplace. The changes SB-242 require provide substantially more predictability and protection to the purchasers of coverage:

Guaranteed availability -- all small employer groups would be able to obtain private health insurance regardless of the health risk they present;

Coverage of whole groups -- coverage would be made available to entire employer groups, with neither an employer nor an insurer being able to exclude from the groups' coverage individuals who present high medical risks;

Renewability of coverage -- employer groups and/or individuals in these groups, at renewal time, 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 satisfied a plan's preexisting condition restrictions, he or she would not have to meet those requirements again when changing jobs or when the employer changes carriers; and

Premium pricing limits -- insurance carriers would be required to limit how much their rates could vary for groups similar in geography, demographic composition and plan design.

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Under our proposal, as a small employer of between 3-25 employees, your cerebral palsied child would be eligible for insurance due to the guaranteed availability portion of our proposal which increases accessibility to insurance to small groups that have otherwise medically uninsurable risks. Your son's coverage, included in your employer plan, would most likely be reinsured by the guaranteed issue carrier. Only the benefits included in the health plans designed by the Small Employer Health Reinsurance Association are eligible for reinsurance. As the Small Employer Health Reinsurance Association Board will not be formed until the legislation is enacted, it is not possible to determine what benefits would be included in the health plans, and, therefore, it is not possible to know the proposed plan premium rates until the board has designed them. Therefore, it is not possible for the Senate HESS Committee, during its interim study, to review the various premium rates for differing size small employers' policies under SB-242.

Again, on behalf of the Health Insurance Association of America, we are very appreciative of your testimony in support of SB-242. If you have any questions regarding SB-242, please do not hesitate to contact me directly or through our Alaska-retained counsel, Gordon Evans.

Sincerely,

Jan Andrea Meisels
State Affairs Associate

JAM:mlp

cc: Senator Virginia Collins
Senator Arliss Sturgulewski
Gordon Evans

HIAA

Health Insurance Association of America

April 23, 1991

Ms. Melissa Fouse
Senior Advisor
Office of Senator Arliss Sturgulewski
Alaska State Legislature
P. O. Box V
Juneau, AK 99811

Dear Melissa:

Thank you for meeting with Gordon Evans and myself when I was in Juneau last week, regarding SB-242. I hope that you have had time to review the bill and my written statement which describes, section-by-section, the provisions contained in SB-242. The Health Insurance Association of America and its 300 member companies believe Senator Collins' bill is the most appropriate mechanism to provide Alaska's small employers and their employees with guaranteed availability, renewability and rate predictability of health insurance rates. The Alaska Division of Insurance has given SB-242 a strong recommendation for passage this session, and has placed a fiscal note of only $6,000 in the first and $1,500 in each of the following years. SB-242 does not require the establishment of a government bureaucracy to set health care provider rates, but it does provide coverage for medically necessary care.

I hope that you have had the opportunity to discuss our legislation with Senator Sturgulewski and to discuss with her the possibility of cosponsoring SB-242. If you have any questions regarding the legislation, please feel free to contact me at the telephone number listed below or our local, retained counsel, Gordon Evans.

Sincerely,

Jan Andrea Meisels
State Affairs Associate

JAM:mlp

cc: Gordon Evans

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HIAA

ON HEALTH CARE FINANCING FOR ALL AMERICANS

SIMPLIFIED NUMERICAL RATING LIMIT ILLUSTRATIONS

Year 1991

Typical Employer[1] - Carrier XYZ is selling a health plan to a typical employer at a midpoint premium rate that amounts to $200 per month, per employee (i.e., this figure would be an average of the premiums for some single persons and some families). The employer pays, on average, 80 percent of the premium ($160); the employee pays 20 percent of the premium ($40).

Low Risk Employer - While a second employer has similar demographic, area, and industrial composition as the typical employer, it has, on, average a very low health risk. Because the employer is low risk, Carrier XYZ agrees to sell coverage at a rate which is 35 percent below the midpoint rate of $200 per employee. In this instance, the health plan would cost $130 per month, per employee. Of this amount, 80 percent ($104) is contributed by the employer and 20 percent ($26) is contributed by the employee.

High Risk Employer - A third employer has demographic, area, and industrial compositions similar to the above employers but has a very high medical risk. Carrier XYZ may charge this employer no more than $270 per month, per employee for the same health plan (35 percent above the midpoint rate of $200). Of this amount, $216 (80 percent) is contributed by the employer and $54 (20 percent) is contributed by the employee.

Year 1992

Assumption: Carrier XYZ's "trend" (the percentage increase in their lowest new business rate[2] from 1991 to 1992) is 12 percent.

Typical Employer - Although the typical employer's workforce remained the same, a number of employees became seriously ill during 1991 and submitted major claims. From 1991 to 1992, carrier XYZ may increase the typical employer's rates by no more than 15 percent above "trend." Therefore, the rate charged to the typical employer in 1991 would be no more than $254 per employee (12 percent+15 percent above the midpoint rate of $200). Of this amount, $51 is contributed by the employee and $203 is contributed by the employer.

High Risk Employer - While the high risk employer's workforce also remained the same, several additional employees became seriously ill and submitted major claims. Since the high risk employer is already at the top of carrier XYZ's rating limit, XYZ can increase the high risk employer's rates by no more than the trend. Therefore, the rate charged to the high risk employer in 1992 could be no more than $302 per month, per employee for the health plan (35 percent above the group's 1992 mid-point rate of $224), which amounts to an increase from 1991 to 1992 of no more than trend (12 percent). Of this amount, $60 is contributed by the employee and $242 is contributed by the employer.

Health Insurance Association of America

1025 Connecticut Avenue N.W., Washington, DC 20036 — 202-223-7780 — FAX 202-223-7897

[1] By "typical" we mean a small-employer group that does not contain an unusually large number of cases with high or low medical risk. For example, a small employer group that has been covered by a carrier for several years is often going to be a typical employer. On the other hand, a small employer group that is newly covered is more apt to be considered low risk since in the first year or so health plan costs are often lower (due to preexisting condition limits, for example).

[2] This is believed the best measure of a carrier's general yearly increase in premiums.

June 1991

HIAA

Health Insurance Association of America

STATEMENT OF HIAA

ON

SMALL GROUP MARKET REFORM

SENATE BILL 242

PRESENTED BY

JAN ANDREA MEISELS

STATE AFFAIRS ASSOCIATE

BEFORE THE

ALASKA SENATE COMMITTEE ON LABOR AND COMMERCE

April 19, 1991

6052 Hackers Lane
Agoura, California 91301
818-991-6817

I am Jan Andrea Meisels, State Affairs Associate, Health Insurance Association of America. HIAA is a trade association of 300 private health insurance companies which provide health insurance for 95 million Americans. HIAA actively supports SB-242.

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

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

As the complexities of the small employer market have grown, and the likelihood of individuals' being separated from the financing system has increased, there is a growing perception

that even if they have coverage, they stand a reasonable chance of losing it if they change employers, or if they have poor claims experience.

Madam Chairperson and members of the committee, we have now reached the point where substantial small employer market changes are needed if we are to serve the longer-term interests of small employers and meet the concerns of policymakers. SB-242 incorporates a comprehensive set of small group market reforms that HIAA believes can be achieved in the context of a viable private marketplace. The essence of SB-242 is to make certain changes in the market so that it provides substantially more predictability and protection to the purchasers of coverage. Let me emphasize that to work, these changes will have to apply to all players in the small employer market -- insurance companies, medical service plans, multiple employer welfare associations, etc. All competing entities in the small employer market, including non-insured benefit plans, would have to be bound by the same rules in order to prevent any company or segment of the market from being placed at a disadvantage. The reforms included in SB 242 ensures fair access to and continuity of coverage for small employers and their employees. The issues embraced in SB 242 are:

<u>guaranteed availability</u> -- all small employer groups would be able to obtain private health insurance regardless of the health risk they present.

<u>coverage of whole groups</u> -- 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 and/or individuals in these groups would be assured that their coverage would not be cancelled because of deteriorating health.

continuity of coverage -- once a person is covered in the small employer market and satisfied a plan's preexisting condition restrictions, he or she would not have to meet those requirements again when changing jobs or when the employer changes carriers.

premium pricing limits -- insurance carriers would be required to limit how much their rates could vary for groups similar in geography, demographic composition and plan design.

To give effect to these proposals, SB 242 authorizes a private not-for-profit Small Employer Health Reinsurance Association. Without the Reinsurance Association these reforms are not achievable. The Reinsurance Association allows insurers to pay a premium in exchange for having the reinsurer bear the risk for reinsured individuals. This allows insurers to treat all individuals in a group the same way -- as SB 242 does not break up groups for the purpose of reinsurance -- all members would have the same benefits. The reinsurer stands behind the insurer and simply reimburses for claims associated with reinsured individuals. This allows insurers to spread high risks, broadly through the private market rather than concentrated in one small employer group. S.B. 242 is a carefully crafted balance between carrier disincentives to write the guaranteed issued business, adequate protections for carriers from internalizing too much

risk and ensuring that the losses of the reinsurance program do not grow too large.

Besides the small group market reforms discussed above, one of the most effective means to obtain cost control is to improve our health delivery and financing system through effective managed care programs. Managed care has proved it can control costs. A growing number of studies from the seminal Rand Study of HMOs in the mid 1970's to the recent Laventhol and Horwath study which assessed the cost savings of managed care in the CHAMPUS Reform Initiative (savings to both the Defense Department and CHAMPUS beneficiaries of $148.9 million in 1988 and 1989). For these and other reasons cost containment provisions including aspects of managed care may be incorporated into the small employer health plans developed by the Small Employer Health Reinsurance Board.

Small employers are also the affected party when various legislatures mandate their plans include specific providers or services. The cumulative effect of the various mandated benefits is to increase the overall cost of the insurance plan to the small employers who is in the most need of relief for the high cost of health care and are too small to self-insure and thus escape these mandates. A study in 1989 by a University of Illinois economist concluded that 16 percent of small employers not providing health insurance would offer benefits in the absence of state mandates. Therefore, SB 242 exempts small employer health plans from any laws that would impose restrictions on insurers negotiating with providers for services

or prices of services or requires the small employer plans to include specific benefits or services rendered by certain providers.

The following is a brief discussion of each section of SB-242:

Section 1. Findings -- describes the need for Alaska to address the issue of the uninsured and to make available to small employers, health insurance with stability and predictability of rate increases as well as guaranteed availability of insurance and coverage continuation.

Section 2. Small Employer Health Reinsurance Association. 21.55.10 -- creates a not-for-profit private legal entity whose membership consists of all insurers in the small employer insurance market -- insurance companies, hospital and medical service corporations, HMOs, and welfare arrangements.
21.55.020 -- describes the Reinsurance Association board composition which assures representation for all types of insurers doing business in the small group market including welfare arrangements and guarantees a majority of seats to insurers in the small group market. The director of insurance serves as an ex-officio member of the board.
21.55.030 -- discusses the various powers of the Association board. This includes the establishment and maintenance of a list of guaranteed issue carriers, those top ten insurers based on total premium volume in the small employer market in Alaska, who are required to accept all applicants from the small employer marketplace. An insurer other than one of the "top ten" may

inform the Association board of their desire to become a guaranteed issue carrier. In addition, the board is empowered to design an array of health coverage products by which reinsurance will be provided.

21.55.040 -- requires the reinsurance association to submit a plan of operation to the Insurance Director for approval. This plan assures fair, reasonable and equitable administration of the Association. It does permit the Director of Insurance, after notice and hearing, to adopt reasonable regulations if the Association fails to submit a suitable plan of operation within 180 days from the effective date of the bill.

21.55.050 -- establishes specific provisions for reinsurance of eligible employees of a small employer or dependents of eligible employees. By requiring guaranteed issue carriers to accept groups with greater than normal risks, insurers need assistance in spreading the greater risk, therefore, the establishment of the Reinsurance Association. To reduce the volume of reinsured claims, reinsurance is available on a three-year basis. If reinsurance were permitted annually, insurers would declare more groups or individuals high-risk and utilize reinsurance more often increasing reinsurance losses to unacceptable levels. Because reinsurance would be aimed at employer groups and employees known to be high risk, and because the premium price is capped (1.5 times the adjusted average market premium for groups and 5.0 times for individuals) to encourage carriers to participate in the small employer market, in the aggregate the cost of reinsured persons may well exceed the reinsurance

premiums. The administrating insurer will determine any losses annually. Any losses are covered through assessments from all members in the Reinsurance Association based on the member's share of total premiums net of reinsurance premiums paid for coverage under the chapter in the small employer market, including, to the extent permitted under ERISA, other benefit arrangements covering small employers. Assessments are capped at four percent of premiums charged for health benefit plans covering small employers.

To assure that insurers only cede risk to the reinsurance mechanism when necessary, the premiums charged by the reinsurer are set at 1.5 times the average adjusted market premium price for similar type groups and benefits or 5 times the average adjusted premium market price for individuals with similar type benefits. Insurers are constrained from recouping the increased reinsurance costs as they may only attempt to recoup the 1.5 times average adjusted market premium price within the constraints of the overall rating bands described below. Only the level of coverage provided up to but not exceeding the coverage provided in a small employer health benefit plan is eligible for reinsurance.

These plans are required to incorporate cost containment techniques developed by the board, including but not limited to high cost case management, hospital precertification techniques and other cost containment techniques established by the Association.

Within a specified time of the coverage commencing nonguaranteed issue insurers may reinsure eligible employees and dependents who were hired subsequent to the coverage being offered by the insurer and who are not late enrollees . This section also recognizes that federally qualified HMOs reinsurance premium may be modified to reflect the portion of the risk ceded to the Association, i.e., federally qualified benefits may be different from the benefits determined to be included in the reinsured health plans by the reinsurance board.

21.55.060-21.55.080 -- are sections exempting the Association from the Administrative Procedures Act, imposition of taxes and limits the liability of the Association board.

21.55.100 -- Small Employer Health Insurance Plans. The program applies to all health insurance plans for individuals and group health benefit plans if they provide coverage to one or more employees and the employer pays all or part of the premium and the health plan is applicable to the IRS code section 26 U.S.C. 106 or 26 U.S.C. 162.

This section also exempts all small employer health plans (25 employees or less) from any restrictions on an insurer's ability to negotiate with providers regarding reimbursement for services and eliminates the requirement that the benefit plan cover specific mandated benefits or classes of providers. These provisions will increase the affordability of small employer health plans while providing quality health care to Alaska residents.

21.55.110 -- Underwriting and Rating Requirements. This provision provides stability and predictability of rates; renewability of the insurance contract; guarantees the availability of insurance to all small employers and removes the concern of people with preexisting conditions that they would have to satisfy additional preexisting condition exclusions if they change jobs or if their employer changed insurance carriers. Once someone had satisfied a plan's 12-month preexisting condition restriction, he or she would no longer be required to satisfy those requirements again when changing jobs or when the employer changes insurers.

The premium pricing limitations included in this chapter limits an insurer's ability to vary rates for groups in similar geography, demographic composition and plan design. Specifically, an insurers premiums for similar groups could not vary by more than 35 percent for the carrier's midpoint rate. There is also a 15 percent limitation on how much a carrier could vary rates by industry. Finally, carriers would have to limit a group's year-to-year premium increases to no more than 15 percent above the carrier's trend (the year-to-year increase in the lowest new business rate). These provisions assure the small employer availability of and accessibility to predictable and renewable insurance rates.

21.55.120 Guaranteed Issue Carriers. The top 10 insurers in Alaska based on total premium volume in the small employer market are determined to be guaranteed issue carriers. Other insurers

are permitted to be guaranteed issue carriers if they notify the Reinsurance Board one year in advance of the insurer becoming a so designated. Guaranteed issue carriers are required to offer at least one small employer health plan to a small employer requesting small employer coverage. These carriers may reinsure an individual or group within the provisions of 21.55.060 and must comply with the Reinsurance Board's plan of operation requirements for guaranteed issue insurers.

21.55.130 Small Employer Benefit Plans. The Reinsurance Association board is required to design small employer health benefit plans that are eligible for reinsurance. The board also designs the benefit levels, copayments and deductibles for these plans. The small employer benefit plans designed by the reinsurance board are the only benefit plans which may be reinsured. Benefit plans with benefits exceeding the small employer benefit plan will only be reinsured to the level of benefits included in the board's approved plan. The plans are permitted to include various cost containment features to assure the services are medically appropriate, rendered in the appropriate setting at reasonable prices.

21.55.140 Conditions for Ceasing to Do Business. Insurers ceasing to do business in the small employer market are required to give notice of this decision to the insurance department, the reinsurance board, the policyholder and the employer. Coverage is required to be continued for one year after the date of notification. An insurer is also prevented from reentering the small group market for at least five years from the date the

notice was given that they decided to cease to do business in this Alaska market.

21.55.250 Definitions. This section describes all the terms used in this chapter.

Section 3

The term "insurer" was redefined for this chapter to include HMOs. Therefore, it is necessary to cross reference the definition of HMO for these purposes to the provisions of this chapter. Section 3 achieves this purpose.

Section 4

The term "insurer" was redefined for this chapter to include hospital or medical service corporations. Therefore, it is necessary to cross reference the other sections of the insurance code related to these organizations for the purpose of applicability to this chapter.

Section 5 Transition. Not all sections of the chapter become effective upon enactment. This section lists those portions of the chapter which begin at dates later than the July 1, 1991 effective date.

Section 6 Lists the effective date of the chapter as July 1, 1991.

March 11, 1991

SMALL EMPLOYER MARKET REFORMS AND REINSURANCE MECHANISM

On February 21, 1991 the HIAA Board of Directors reaffirmed its commitment to the comprehensive set of recommendations adopted a year ago that the Association believes can be achieved in the context of a viable private marketplace. The essence of our proposal is to make certain changes in the market so that it provides substantially more predictability and protection to the purchasers of coverage.

The small employer market precepts that the HIAA recommends are:

1. **Guaranteed Access to Coverage.** All small employer groups would be able to obtain private health insurance for basic coverage regardless of the health risk they present. A reinsurance mechanism would allow carriers to make this basic prototype benefit coverage available to any small employer for no more than 150 percent of the average premium for similar groups.

2. **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.

3. **Renewability of Coverage.** At renewal time, employer groups and/or individuals in these groups would be assured that their coverage would not be canceled because of deteriorating health.

4. **Continuity of Coverage.** Once a person is covered in the small employer market and satisfied a plan's preexisting condition restrictions, he or she would not have to meet those requirements again when changing jobs or when the employer changes carriers.

5. **Premium Pricing Limits.** Insurance carriers would be required to limit how much their rates could vary for groups similar in geography, demographic composition and plan design. More specifically, a carrier's premiums for similar groups could not vary by more than 35 percent from the carrier's midpoint rate (halfway between the lowest and highest rate). There would also be a 15 percent limitation on how much a carrier could vary rates by industry. Finally, carriers would have to limit a group's year-to-year premium increase to no more

than 15 percent above the carrier's "trend" (the year-to-year increase in the lowest new business rate).

GUARANTEEING AVAILABILITY

The "top ten" carriers in a states' small employer market would have to guarantee issue prototype benefit coverage to all applicant small employer groups. Other (non-top ten) carriers could choose to also act as guaranteed issue carriers, although they would not be required to do so. There would be a publicly available list of guaranteed issue companies. Insurers rejecting groups would be responsible for referring the group to this list (or telephone number).

Guaranteed issue carriers would have access to both individual and group reinsurance at issue, renewal and for new entrants. These carriers would have to make prototype benefits available to all small employers, at a rate of no more than 150 percent of adjusted average market premiums. They would face no cost-sharing for group reinsurance (priced at 150 percent of adjusted average market premium minus a ceding factor), could require an advance premium deposit (not to exceed three months) for poor credit risks, and could make special arrangements to cover employees in groups with exceptionally high employee turnover rates.

Insurers that choose not to guarantee issue would not be obligated to accept all applicant small employer groups. However, consistent with the whole group precept, they would be required to accept or reject entire employer groups. These carriers would only access to individual reinsurance and only for new entrants to existing cases. This is to provide financial relief for the new entrants that they would be required to accept under the continuity precept.

Both guaranteed issue and other carriers would have access to individual reinsurance (priced at 500 percent of adjusted average market claims experience, and including a $5,000 deductible but no coinsurance payments). Both carrier types would be included in the assessment base for tier one financing of reinsurance losses.

Non-guaranteed issue carriers that wish to become guaranteed issue carriers, or guaranteed issue wishing to become non-guaranteed issue, would be required to announce one year in advance their intentions to change. Carriers newly converting to guaranteed issue would not be allowed to apply more favorable guaranteed issue reinsurance terms to business already on their books when they make such a change.

Guaranteed issue carriers would be able to appeal to the reinsurance board in the event that they experienced an unfair share of administrative and credit risks. Where the Board finds

that a carrier has experienced such an unfair burden, a decreased reinsurance price to offset administrative expenses may be allowed, or a temporary suspension of guaranteed issue may be granted to the carrier.

A carrier would not have to guarantee issue business received from any agent or broker, but would be free to directly issue coverage to such business or to refer the business to one of its own agents.

HIAA believes this approach allays apprehension over who the designated carrier would be and what their practices are. Another major advantage of this approach is that it does not mandate that every carrier in the market guarantee issue. This will be more efficient since carriers that are only marginally operating in a number of local markets would not have to incur all of the fixed costs associated with acting as a designated carrier (e.g., offering a prototype plan). Further, it will be easier to monitor carriers' cost management of reinsured cases since there will be fewer designated carriers to oversee. Finally, it avoids the problem of one designated carrier (or a very small number of designated carriers) being treated by legislators as a quasi-governmental program and subject to extremely adverse regulatory or financial treatment (e.g., setting rates below market norms).

DEFINING SMALL EMPLOYER GROUPS

Employer-based plans issued to firms with only one or two employees should be excluded from the small employer market reforms and reinsurance. Such plans should continue to be regulated under a state's group or individual insurance laws.

High risk pools should be established in every state and would act to guarantee availability of coverage to persons without access to employer based coverage (i.e., individuals without an attachment to the workplace, as well as high risk persons employed by businesses with one or two employees). High risk pools would not be available to individuals working for firms with at least three employees offering employer-financed coverage to any or all employees.

The following small employer market reforms would <u>not</u> apply to employer-based individual policies: (a) guarantee issue -- carriers would not be required to guarantee issue individual policies to new employer-based groups of individuals (except for new adds to existing groups of individuals as described below) and (b) rating and renewability regulation -- individual rates will not be regulated if there is effective rate regulation in a particular state. In making a determination as to whether there is effective regulation of rates one should analyze the Department's practices rather than relying solely on the

statutory or regulatory authority in place in a particular state.

Individual policies would not have access to the small employer reinsurance mechanism. However, reinsurance assessments would be imposed on employer-based individual policies for employers with 3 to 25 lives to offset the relatively higher costs due to the guaranteed availability of small group coverage to all small employers.

The following small employer market reforms would apply to individual (as well as group) employer-based plans for small employers with 3 to 25 employees: (a) The HIAA precept on whole groups: the same plan must be made available to all eligible employees of the firm, including high risk employees and new adds and (b) Pre-existing conditions: if a person was covered by (or satisfied preexisting condition exclusions under) the previous employer-based plan, the new employer-based plan must waiver preexisting condition requirements for those conditions.

FINANCING SOURCES

First tier assessments should be capped at four percent of small employer market premium. For second tier financing, HIAA should be open to a range of alternative broad sources of financing that might be achievable in a given state.

Metropolitan Life Insurance Company
One Madison Avenue, New York, NY 10010-3690

Robert O. Fleckenstein
Assistant Vice-President
Government and Industry Relations

Metropolitan Life
AND AFFILIATED COMPANIES

The Honorable Virginia M. Collins
Vice Chair, Labor & Commerce Committee
State Senate
Juneau, Alaska 99811

RE: SB 242

Dear Senator Collins

Metropolitan Life supports efforts to reform the small group health insurance practices embodied in SB 242. We respectfully urge your Committee to favorably report this bill.

Sincerely,

Robert O. Fleckenstein

Assistant Vice President

April 19, 1991
ROF:wsb

cc: Ms. Jan A. Meisels
HIAA

the Principal Financial Group

Principal Mutual
Life Insurance Company

April 19, 1991

The Honorable Virginia Collins
Alaska Senate
Vice Chairperson
Senate Labor & Commerce Committee
Juneau, Alaska 99811

RE Senate Bill 242 (Small Group Health Insurance Reform)

Dear Senator Collins

I am writing on behalf of Principal Mutual Life Insurance Company to support Senate Bill 242 relating to reforms in the Alaska small group health insurance markets. Principal Mutual is currently the sixth largest life insurance company in the United States measured by premium income and has been a major group health insurance carrier for many years.

We believe that Senate Bill 242 will effectively address the problem that many small businesses face today in obtaining health insurance at a reasonable premium rate for all employees. Senate Bill 242 will guarantee access to coverage for those employees by establishing an industry supported reinsurance pool which spreads the losses associated with high risk employer groups. The National Association of Insurance Commissioners just this week took preliminary steps toward approving a model act which would be very similar to Senate Bill 242. Senate Bill 242 will refine the existing insurance mechanism without unduly disrupting the marketplace.

Senate Bill 242 is a responsible approach to dealing with the problem of employee access to small group health insurance. We strongly encourage your support of this measure. It will work for Alaskans.

Sincerely,

Merle T. Pederson
Assistant Counsel

MTP:paa
\mtp\0419vc.ltr

Mailing Address: Des Moines, IOWA 50392-0001 (515) 247-5111

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

NFIB Alaska

National Federation of Independent Business

FAX COVER SHEET

DATE: 4/7/92

NUMBER OF PAGES: 2 6
(Including this page)

TO: Melissa

COMPANY: Senator Sturgulewski's Office

FAX NO. 465-3810

FROM: Rosa

FAX NO: (907) 789-3433

If this message is not received correctly
please call (907) 789-4278

MESSAGE: I have the flu & may not be able to attend the Senate HESS hearing in the morning. Therefore, I would appreciate you including my letter in the Committee members meeting folders.

Thanks!

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

The Guardian of Small Business

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 mean 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 th 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

AlaskaBusiness

MONTHLY

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Cover photo: © 1991 Chris Arend. The Alaska Zoo's Annabelle paints with nontoxic acrylics. David Hall, elephant trainer and painting coach, holds a framed painting.

12-1991

EALTH CARE

posed Legislation

lieve the plan would saddle business with the enormous costs of fixing the nation's health care ills. Among the legislation's critics are the U.S. Chamber of Commerce, the Health Insurance Association of America and organizations representing small business.

They charge that the bill, which would impose a government mandate for employers to purchase health insurance, would promise far more than could be delivered at the predicted costs. The proposed solution has been dubbed by its detractors a "play-or-pay" system because all employers would have to provide full-time and part-time workers and their dependents with private health insurance or pay a payroll tax to fund a government program that would provide coverage.

Several provisions in the legislation are aimed at making the program acceptable to small companies – by definition, those having fewer than 100 workers. Those provisions include a phase-in period of up to five years, determined by the number of employees, before small businesses are required to provide or contribute to coverage for workers; special treatment for new small businesses and for small businesses that have not previously provided coverage; the creation of federal standards for the small-group health insurance market; and tax revisions that would allow 100 percent deductibility for health insurance premiums by the self-employed and would establish a 25-percent tax credit for certain qualifying low-profit firms.

Alaska Business Monthly sought unsuccessfully to find an Alaskan spokesperson to defend the mandated health care bill. Several Alaskans, however, criticize the legislation. The following two viewpoint articles represent pro and con arguments. Also, on the next page, you'll find a capsulization of the bill presented in the "Executive Summary" prepared for the bill's introduction.

By Judith Fuerst Griffin

NO

By Resa Jerrel

As state director of the National Federation of Independent Business, Resa Jerrel represents the interest of small-business owners before the Alaska Legislature and coordinates grass-roots lobbying activities of the organization's 5,200 members. Jerrel previously has been director of governmental relations for Associated General Contractors of Alaska and administrative assistant to the Alaska Senate Resources Committee.

Millions of Americans do not have health insurance, and many among this group are small-business owners and their employees. In Alaska, it is estimated that 90,000 people are uninsured or underinsured. For small firms, the cost of health insurance and the lack of availability of group health plans are the two major stumbling blocks to health insurance coverage.

It comes as no surprise, then, that finding a way to provide health insurance for these uninsured is on the minds of members of Congress. What is surprising is how some lawmakers want to address the problem.

One proposal now being touted on Capitol Hill is Senate Bill 1227. This plan would require businesses to provide health insurance to their workers or pay a hefty payroll tax – the "play or pay" proposal. The taxes levied on business would go into a pool to cover the costs of a federally subsidized Medicare-type health plan. Under the proposal, businesses that do not offer health insurance would be saddled with a payroll tax increase of as much as 8 percent. This tax almost certainly would have to rise to keep up with skyrocketing health costs. The cost to business owners and other taxpayers is estimated at $6 billion for the first year alone.

A "play or pay" program is in reality a tax on labor. Already 37 to 50 cents of every dollar in pay goes toward mandated programs such as workers' compensation, unemployment insurance and social security. Any government policy that mandates small-business owners to cover their employees – regardless of cost or profitability – will cause small-business failures, changes in employment policies, higher unemployment and higher product costs to consumers. The proposal allows no flexibility and it would increase the cost of health insurance. It would inhibit small firms from increasing wages, as well as from expanding other benefits, production capacity and staff.

Employees benefit much more when small firms are encouraged to provide flexible fringe benefits, rather than being forced into offering a one-size-fits-all benefit package. Competitiveness of small firms is enhanced through increased flexibility and improved ability to fashion benefit plans to meet employee needs.

Further, according to a study prepared for the NFIB Foundation, the research affiliate of the National Federation of Independent Business, this proposal will produce an effect directly opposite what supporters seek. According to the study, instead of encouraging small-business owners to offer health insurance, the "play or pay" approach will create incentives for many to pay the tax instead of paying for health insurance out of their own pockets. The result: The amount of money required to operate the program will be significantly larger than what the added payroll taxes will generate.

The incentive to pay the tax rather than purchase a health insurance plan will be especially attractive to small businesses that hire unskilled and part-time workers. For example, a business with 10 workers who earn $9 an hour and two part-time workers earning $6.50 an hour could cut the cost of health care in half by paying the tax and dropping the employees' private health insurance.

At the present time, small-business employers pay at least 20 percent more for the same health insurance coverage as larger companies. Under the

continued on page 19

YES *continued from page 16*

health insurance will be eligible to receive health benefits through AmeriCare.

AmeriCare is a dramatically new public program. Federal standards will be set for eligibility, benefits and reimbursement. The legislation also includes a number of provisions that are intended to provide financial assistance to small businesses in the form of tax credits to help them adjust to the new requirements.

In addition, this legislation includes a provision to reform the small-group insurance market. This reform is critical to small businesses that currently cannot afford insurance or whose employees are excluded from coverage because of pre-existing conditions.

The legislation also recognizes that the federal and state governments must share the burden in reforming the health care system and assuring access to care for all of our citizens. Even under the best-case scenario, not all Americans will have access to employer-based health insurance.

If this legislation is to accomplish our goal of providing quality, affordable health care for all Americans, it must have as its underlying foundation meaningful cost containment. The cost-containment provisions included in this bill will result in significant reductions in the rate of increases throughout the system. The establishment of a National Health Care Expenditure Board and state consortia are the linchpin of cost-containment provisions that are estimated to save nearly $80 billion over five years.

Reforming the health care system will be difficult. While most of us believe there is a serious problem, few can agree on the solution. A perfect solution does not exist. Some argue that the United States should adopt a Canadian model of national health insurance. Others argue that tax incentives to businesses with no requirement to provide coverage are the answer.

The legislation we are introducing today represents a compromise between those two views, keeping in mind our own traditions and values as Americans. Our nation's health care system is on the critical list. I believe the time to act is now. If we do not work together to control the soaring costs of health care and to provide care for millions of Americans now not covered or at risk of losing their coverage, we will all fall victim to the collapse of the system. ❖

NO *continued from page 17*

proposal, small-business employees could very well receive greater benefits under the federally subsidized program.

Facing the prospect of health care costs rising faster than employee wages, small-business owners may find that the "play or pay" proposal offers a more financially attractive health package. They may decide it is cheaper to pay the tax and get better health coverage.

If the "play or pay" proposal becomes law, this plan effectively will mark the beginning of a federal takeover of private health insurance. This will lead to a nationalized, Medicare-type public insurance system with uncontrolled health care costs.

Small-business owners fear a national health insurance system. They remember the efficiency of the U.S. Postal Service, the compassion of the Internal Revenue Service, the demeanor of Occupational Safety and Health Administration inspectors, and Pentagon prices. Small-business owners put their faith in the private-sector free-market system, which can and does deliver better quality and efficiency than any government agency.

Once the machinery is put in motion and the majority of smaller firms opt to pay rather than play, the advocates of a national health plan will have the excuses they have been looking for to take over the health care needs of Americans. The prospect is not a pleasant one to contemplate. Small-business owners believe a true free-market approach is a much better idea.

With more then 5,200 members, the Juneau-based National Federation of Independent Business/Alaska is the state's largest small-business advocacy organization. NFIB/Alaska draws its members from all walks of commercial life: from family farms to neighborhood retailers, from independent manufacturers to doctors and lawyers, from wholesalers to janitorial service firms.

Each year NFIB/Alaska polls its diverse membership on a variety of issues. The federation uses the poll results to form its legislative agenda, lobbying in support of positions approved by majority vote. In 1989 NFIB/Alaska asked its members: Should legislation be enacted requiring employers to provide basic health-care insurance coverage for their employees? Eighty-seven percent of the responding members were opposed to the idea. ❖

217 Second Street, Suite 201
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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

NATIONAL ACADEMY FOR STATE HEALTH POLICY

PORTLAND, MAINE

Access and the Uninsured:

A Guide for States

Patricia A. Butler, J.D.
Boulder, Colorado

Elizabeth H. Kilbreth, Associate Director
Human Services Development Institute
Edmund S. Muskie Institute of Public Affairs
University of Southern Maine

Members, Steering Committee on the Uninsured
National Academy for State Health Policy

April, 1991

With Support from the Health Resources and Services Administration, DHHS, and
The Pew Charitable Trusts, Philadelphia, Pennsylvania

The highest rated group within an insurer's small employer line of business cannot be given rates more than 20 percent above the average of all the groups within that line of business. In **New York**, insurance regulation limits rate increases for health risk factors to 50 percent above what would otherwise be charged. These limitations attempt to prevent the use of exorbitant rate quotes as a way of effectively terminating some small groups. It may also provide some cross-subsidization among sub-groups, keeping premium costs somewhat more equitable across the market.

Limiting renewal rate increases

New York precludes using claims experience as a factor in setting rates until the group life years have reached fifty. In other words, a group of ten persons could not be experience rated until after its fifth year with a carrier while a group of twenty-five could be experience-rated after two years. In addition, New York prohibits the use of claims experience in establishing renewal rates if evidence of insurability was used in determining the initial premiums (or in determining whether or not to underwrite the group). Thus insurers in New York have a choice between initial medical underwriting or using claims experience for renewal rates (with a maximum mark-up of 50 percent).

Comprehensive Small Group Market Reform Proposals

Concerned with the dysfunctions of the small group market, both HIAA and NAIC have developed or are developing comprehensive proposals designed to substantially increase availability of coverage, stabilize premium rates and distribute risk more broadly. These proposals combine guaranteed issue and renewal, continuity of coverage provisions, underwriting, and rating reforms, and reinsurance mechanisms designed to protect insurers from losses and small group pools from significant and rapid deterioration. **Connecticut** has already enacted parts of these recommendations.

Proposed Underwriting and Rating Reforms

The HIAA and NAIC proposed reforms have several features in common. Both advocate whole group coverage (an insurer cannot deny coverage for an individual within an applicant group), both guarantee renewability (an insurer cannot drop a group at the end of a contract period, due to claims experience), and both advocate guaranteed continuity of coverage (with no newly imposed waiting periods) within the group market for the individual or group that changes policies. Under the terms of these proposals, an insurer could refuse to renew coverage only in cases of non-payment of premium, fraud, where a firm's size drops below eligibility levels, or if a firm is no longer conducting the same business as at the time of coverage. As is currently the case in Connecticut, North Carolina and Maine, coverage would become a transportable benefit, from group plan to group plan.

Both proposals also place limits on discretionary rating practices, but differ somewhat in the specifics of their recommendations. Under the HIAA proposal, insurers could vary by as

much as 35 percent from a mid-point, the rates offered to demographically and geographically similar groups, based on underwriting criteria. Insurers could vary rates by industry type but not by more than 15 percent from a mid-point rate (see example, Footnote 2, page 65). NAIC recommends a 25 percent rate band for groups with similar case characteristics and a 20 percent variation between different classes of business. Class of business distinctions under the NAIC proposal are allowed for lines of business acquired from other carriers, multiple employer associations, guarantee issue groups, and products sold by distinct marketing and sales representatives or organizations. Both proposals also place limits on the increase at renewal allowed for claims experience, basically allowing 15 percent on top of general inflation and any changes due to benefit modification.

In addition to these rating restrictions, the NAIC proposal precludes a number of practices that might allow an insurer to "game" the proposed system. Under this proposal, the insurer could not transfer a group involuntarily from one class of business to another. Similarly, the insurer could not offer a transfer to some groups within a class unless a similar offer was made to all groups, without regard to claims experience, health status or demographics. If an insurer drops a line of business, it cannot establish a new line for five years without prior approval from the insurance commissioner; and it cannot transfer some groups from the defunct line without offering similar coverage to all groups within that line. This proposal, in other words, precludes practices that allow insurers to weed out or differentially rate the groups with the worst experience, except within the range established by law.

Risk Distribution Proposals

To offset the potential risk associated with these reforms, HIAA has proposed a reinsurance arrangement that would protect individual insurers and spread the risk associated with the voluntary small group market broadly across the industry. A reinsurance organization would be established in which memberships would be mandatory for all insurers doing business in a state. Through this mechanism, insurers (not employers or individuals) would purchase reinsurance either for entire groups deemed to be high risk, or for individuals within groups. Premiums for groups would be capped at 150 percent of average market premiums and at 500 percent for individuals. Like state high risk pools, the premiums would not be expected to cover the claims experience of the reinsurance program, and additional funding would be secured through a proportional assessment (of four percent of premiums collected) on all carriers in the small group market, and if necessary to meet the pool's fiscal requirements, a one percent assessment on other health insurance plans.

The purchase of reinsurance would be negotiated between the primary insurer and the reinsurance organization. The high risk individual would maintain the same benefits through the same policy as the rest of his/her employment group (and not be required to purchase a separate policy through the High Risk Organization as is the case with current state High Risk Pools). Further, insurers could not pass through the entire cost of the reinsurance in

the form of premium increases to the affected individual or group, but rather would be limited to the 35 percent or 25 percent rating band ceiling described above.

NAIC is currently studying five different risk distribution strategies. Two of these strategies would be coupled with guaranteed issue requirements (i.e. insurers would be required to write policies for all applicants within eligible categories, without regard to health status). The proposals under study include: prospective reinsurance where, like the HIAA proposal, high risk groups are initially identified through medical underwriting and reinsurance is purchased through the pool; retrospective reinsurance where the pool provides stop-loss coverage of claims above a certain amount; an allocation model where high risk groups would be equitably distributed among carriers; a pooled employee option where small groups would be aggregated into benefits programs and treated as a single group for insurance purposes (like a multiple employer trust); and a designated carrier option where, like current state high risk programs, a designated insurer would administer a coverage program for high risk groups under contract to the reinsurance program.

No state has adopted either of these reform packages wholesale. However, **Connecticut** included many features from these proposals in its comprehensive health care access legislative package enacted in 1990. Encompassed in Connecticut's law are guaranteed issue provisions, guaranteed renewability, limitations on pre-existing conditions with continuity of coverage in successor plans, and required whole group coverage. Connecticut has also limited rating bands based on medical underwriting and claims experience with limits similar to the HIAA proposal. A phase-in period is allowed for existing coverage policies. In keeping with the recommendations from the HIAA, Connecticut has created a reinsurance program with mandatory participation by all insurers in the state. Insurers contribute to pool losses through a five percent assessment on their small group premiums. This assessment, if insufficient, can be supplemented by an assessment on all health benefit premiums generated in the state.

Connecticut has supplemented this small group market reform with special coverage programs for currently uninsured and low-wage small firms. Each insurer participating in the small group market is required to offer "special health care plans", designed to make transitional affordable coverage available to currently uninsured small businesses (see description, Chapter VII). Connecticut is also using the reinsurance organization to administer an even lower cost coverage plan to small businesses with ten or fewer employees, the majority of whom have wages below 200 percent of the poverty level.

Mandatory Community Rating

The rating reforms proposed by the Associations and adopted in Connecticut may broaden availability, stabilize premiums and slightly narrow the variation in price in the small group market. These proposals, however, continue to allow substantial variation in premium rates.

None does away with age/sex rating bands.[1] And even for persons with similar age/sex characteristics, the range between lowest and highest allowable rates (taking into account allowable variation for industry classification and risk characteristics) is substantial.[2] The combination of these factors can result in maintaining prohibitive differences in rates for older men or women, particularly those with prior health problems or employed in "hazardous" industries.

An alternative model for comprehensively restructuring the small group market is under consideration in at least three states (**New York, Maine** and **Vermont**). These proposals suggest that differential rating based on any factors other than geographic location be eliminated altogether and that denial of coverage based on health status be banned in the small group and individual market. Under these proposals, all insurers in the market would face similar risks because no one carrier would be in a position to screen out bad risks. The claims experience of all individuals and groups would be pooled and all would receive similar rate increases.

This guaranteed issue, community-rating model is currently found only among some Blue Cross/Blue Shield plans and some federally qualified HMOs, where it is fast disappearing. Those plans that have guaranteed issue or community-rated in the past had pools that deteriorated and required substantial increases in premiums when faced with the competition of screened, low-risk groups that could offer advantageous rates.

The argument put forward with these new proposals is that with "a level playing field", no one insurer should experience pool deterioration, and equity in cost of coverage would be maintained in the small group market.

Community rating is attractively uncomplicated. It eliminates the need for costly and administratively cumbersome medical underwriting and complex actuarial rate adjustments among different lines of business. Some argue that it also accomplishes a socially desirable goal of broadly distributing health care costs across a large population base without penalizing individuals for their health status, age or sex.

The major concern regarding community rating is that the premium necessary to cover the claims experience of the community pool, including all those with expensive health

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[1]Typically, a healthy fifty year old man may be charged double the premium of a healthy twenty-five year old man in manually rated policies, and a woman will have premiums 40 percent higher than a man of the same age - in a plan without maternity coverage.

[2]An example of possible premium spread among individuals with similar case characteristics under HIAA's proposal is as follows: Allowable variation in monthly premium based on industry classification (15 percent variation) - low, $127.50; midpoint, $150.00; high, $172.50. Highest possible premium (35 percent above high risk business group midpoint) - $232.87. Lowest possible premium (35 percent below low risk business group midpoint) - $82.87. Spread between lowest premium and highest premium among individuals with similar case characteristics - 280 percent.

conditions, would be very high, encouraging the young and healthy to go without coverage. In other words, the community pool might suffer the same deterioration experienced by individual insurers who have not aggressively applied medical underwriting criteria. In a voluntary market, where individuals and employer groups can choose whether or not to purchase coverage or to self-insure, it is difficult to assure broad participation with a costly product.

These concerns are real, although it is difficult to predict with any accuracy the likely impact of either the rating reforms proposed by the Associations or the community-rating proposals. Since all these proposals remove barriers to potentially high cost users, the median coverage cost under each plan is likely to rise, driving some from the market. It is unclear how many currently insured will drop out of the system when faced with price increases, especially if lower cost coverage is not available elsewhere.

HIAA and some of the other state-specific proposals suggest counter-balancing these potential increases in cost with reductions in the scope of benefits as a means of lowering premiums. The pros and cons of benefit reductions are discussed in Chapter VII. Some of the proposals are also coupled with mechanisms that shift some of the costs of the small group market more broadly across the insured population, such as the HIAA model's proposed assessment of all insurance carriers to fund the reinsurance program. One proposal in Maine contains a feature that would entitle any carrier offering a guaranteed issue, community-rated product in the small group market to a substantial hospital discount on all claims generated by their small group line of business. Since the hospital losses for these discounted services would be passed on to other hospital payors, this feature would constitute an indirect assessment on all other insurers and payors.

Whatever the mechanism - reduced benefits, a reinsurance program, a hospital discount, employer tax credits or direct subsidies - states may want to consider ways of linking reforms of the small group market to strategies designed to bring down insurance prices. The "no-cost" options available to states may not be no cost after all.

Chapter VII Private Sector Initiatives

Introduction

Private health care providers have traditionally responded to the needs of uninsured and low income people throughout the country. Hospitals, physicians, and other practitioners render millions of dollars of charity care to individual patients (Fraser, 1988). In some communities medical societies or non-profit clinics have organized formal private sector referral networks. These programs often coordinate with local government and public health activities. In the last few years some insurance carriers have developed innovative programs in several states that either directly fund children's health care or make lower-priced health insurance available to small firms. In most cases these programs developed independent of any public involvement but some were fostered or enhanced by public funding or regulation. As discussed in Chapter IV, Blue Cross plans with "open enrollment" (i.e. guaranteed issue without medical underwriting) and the high risk pools financed by assessments on insurers and HMOs without a tax credit also represent ways the private sector finances health care for people who would otherwise be uninsured. For example, Blue Cross of California recently began voluntarily accepting one small group previously rejected due an to employee medical condition for every five standard groups, at rates 30 percent higher than standard groups.

The private sector is also responding, independent of public initiatives, to the need for lower cost insurance products. These efforts are for the most part directed toward alternative benefit configurations, increasing cost sharing and eliminating some "non-basic" services, such as mental health.

States have responded to these initiatives in a variety of ways, ranging from regulatory changes to encourage such developments, to the initiation of public/private partnerships (eg. **Michigan**'s Medicaid/Blue Cross children's plan, Chapter II), to some instances of resistance to relaxing mandated benefits.

Blue Cross "Caring Foundation" Plans

Following the 1985 example of Blue Cross of Western **Pennsylvania**, Blue Cross Associations in ten other states have developed private sector programs to subsidize outpatient health services for low income children (Appendix, Table A). These programs, which look like "insurance" to enrollees, but which are generally treated by regulatory agencies as charity care programs, vary slightly but generally serve children under age 19 in families ineligible for Medicaid but with incomes under the federal poverty level. Most programs cover only completely uninsured children, not children whose insurance has high deductibles or does not cover well child care (although as noted in Chapter II, about 30 percent of the children enrolled in **Minnesota**'s Child Health Plan have group insurance but need supplemental coverage for ambulatory care). As Medicaid eligibility has recently increased, some of the Caring Foundation programs have raised eligibility standards to 133

percent of poverty. Families pay no enrollment fee, though in some of the programs that offer drug benefits they pay a $1 to $3 copayment per prescription. To spread risk, some programs require that all eligible children in a family enroll.

The programs cover outpatient care, preventive services (well-child visits, immunizations), acute care (visits for illness, accidents) emergency services, diagnostic (lab and x-ray) services, and outpatient surgery. A few of the programs offer prescription drugs. Inpatient services are not covered. Providers are primarily physicians in the Blue Cross/Blue Shield network and hospitals for outpatient and emergency care. Physicians are generally paid their normal Blue Cross rates (often a discount off usual and customary charges).

Caring Foundations are private non-profit corporations funded through philanthropic donations. Civic groups, churches, and other organizations are encouraged to "sponsor" a child or family. All Blue Cross Associations donate administrative costs for staff and claims processing. Some also match private donations to fund the health care services, whose costs range from about $200 to $300 per child per year. The state of Iowa appropriated $300,000 in start-up funds in 1989 to match private contributions for the Caring Foundation program in that state. Blue Cross of Western Pennsylvania has the largest enrollment among Caring Foundation plans - 6,000 children (15 percent of the estimated eligible population) who remain on the program an average of about 19 months.

Because they are designed to supplement Medicaid, Caring Foundation programs require potentially eligible children to apply for Medicaid before applying to the Foundation. Through their outreach and public relations efforts, some plans have identified a large number of Medicaid-eligible children. Thus they can be an important Medicaid screening agency with which state Medicaid programs could coordinate.

Several Caring Foundation plans have begun in the last year, and it is possible that this model will spread to other states. State agencies can play a role in encouraging such programs to develop. Even if they cannot offer matching funds, they can arrange to share publicity and outreach activities. A close relationship between the Medicaid eligibility staff and the Caring Foundation staff that processes applications is important to assure that each program plays its appropriate role and that maximum federal matching is achieved in order to serve as many low income children as possible.

Modified Health Insurance Products

In its earliest form, health insurance was designed to indemnify subscribers against the costs of catastrophic illness by covering hospital, surgical, and accident benefits with a large deductible. Such catastrophic coverage plans are still available from some health insurers. For instance, Blue Cross plans in several states market a "Basic" plan of hospital, surgical, sickness and accident benefits (often with obstetrical care) with high cost sharing and lower than normal annual and lifetime limits. However, catastrophic coverage is not the norm and appears to have limited appeal, especially to employer groups, whose policies generally have

low cost sharing features, increasingly broader benefits, and generous life-time maximum and stop loss provisions. Concern about the uninsured has generated a search for lower cost insurance plans that might be more attractive to small, uninsured employers than such traditional catastrophic coverage.

Benefits Under Existing Legal Authority

A few of the Johnson Foundation demonstrations lowered insurance premiums without public subsidies by such strategies as managed care, provider discounts, or high cost sharing on inpatient services but little or no cost sharing on preventive care (See Appendix II). For instance, an HMO in **Utah** reduced premiums through managed care strategies and high copayments for acute care, while one in **Tennessee** lowered costs by deep hospital discounts. The SCOPE project in Denver offers a plan through United States Life, a large indemnity carrier, that includes both a limited provider network and cost sharing for inpatient and acute care with no copayment for preventive services. These plans cover catastrophic costs (e.g., full coverage after $2,500 in out-of-pocket expenditures on acute care) while providing first dollar coverage for preventive services that young families may need (eg. full coverage for all recommended well-child visits in the first five years of life and immunizations). Such a plan design is attractive because subscribers feel that they can use the plan[1] and are willing to pay the small additional premium for preventive benefits.

Developed specifically for currently uninsured small groups, these limited benefit products are not attractive to most currently insured firms (other than those contemplating dropping their insurance due to cost). But they fill a void in the market. They are popular and, although enrollment rates may seem modest from the viewpoint of covering the uninsured population, the insurance industry finds enrollment very encouraging. The demonstration project experience also seems to be inspiring imitation. About a year after SCOPE began marketing in the Denver area, a competitor has started marketing a similar product. Some Blue Cross plans are also developing products with coverage of specified preventive services and high deductibles. Because of high cost sharing in some of these plans, however, it could be argued that enrollees with low incomes have merely moved from the status of uninsured to underinsured.[2]

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[1]The original concept of health insurance as spreading the risk of an unexpected and potentially very costly event has changed to a mechanism for partially prepaying the costs of health care. Thus, people often express a preference for a plan that they can expect to use, even for an extra cost, rather than one that protects them against an unpredictable and costly risk.

[2]Low income SCOPE enrollees are eligible for subsidies for hospital cost sharing through Colorado's Medically Indigent program.

Insurance Regulation to Expand Coverage

Required Small Group Policies

While the limited benefit products described above are emerging in states with few mandated insurance benefits, other states are attempting to encourage non-traditional plans by explicit regulation. For instance, as part of its 1990 omnibus health care financing and insurance regulation reform bill, **Connecticut** requires all insurers writing small group products to offer "special health care plans" to any firm with under 25 employees (except firms under eleven employees, a majority of whom are low income[3]) that has been uninsured for at least two years. Payment is limited to 75 percent of Medicare's rates, and the statute requires providers to accept these rates. Insurers must pay out at least 75 percent of the premium in benefits, and premiums for these plans are not subject to the state's 2 percent premium tax.

Insurance Mandate Waivers

Over 700 different types of services (e.g., mental health, mammography), providers (e.g., chiropractors, optometrists, psychologists), or prospective enrollees (e.g., newborns, adoptive children, disabled children) are covered through insurance mandates throughout the U.S. (Gabel et al., 1989). Some of these laws merely require that the benefit be offered ("mandated offering"), but most require that the benefit be covered ("mandated coverage"). In 1990 eight states enacted laws permitting insurers to offer special products to small groups (generally 25 or fewer employees) that eliminate some of the state group insurance mandates (See Appendix I, Table C). The insurance pools in **Oregon** and **Oklahoma** (participation in which entitles employers to income tax credits discussed in Chapter V) will also develop or authorize purchase of insurance that may not include state mandates.

These laws approach the issue of alternative product design in two ways:

- Some statutes, such as that in **Missouri**, permit a carrier writing small group coverage to develop policies that eliminate such services as substance abuse, mammograms, newborn coverage, home health, or hospice care.

- Other laws (e.g., in **Rhode Island** or **Virginia**) both waive specific mandates and define the minimum benefits that must be covered, such as a given number of hospital days, physician visits, and other services. Some of these laws actually add new benefits, such as prenatal and maternity care, in order to assure that they meet the needs of the younger families likely to use them.

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[3] A newly created public reinsurance pool will offer a special health care plan to firms under ten with a majority of low wage employees; this plan is required to pay out at least 80 percent of premiums in benefits and operate on a "no gain/no loss" basis.

So far, insurers in **Washington** and **Virginia** have developed products under these laws. Premiums are estimated to be 60 percent to 70 percent of the cost of full-benefits policies. Some plans include prenatal and well child care not required by state law. The products are thus far well received (New York Times, 1990). Once again, the issue of whether these limited products are adequate depends on the design of each plan and the needs of enrollees.

As most policy makers have learned, the debate over mandated insurance benefits is highly charged. Insurers and employers resist the idea of any government mandates, contending that eliminating mandates would lower insurance prices to affordable levels. Certainly many larger firms have become self-insured to avoid the requirements of premium taxes and benefit mandates (Gabel et al., 1989).[4] Providers and constituent groups argue for maintaining and expanding insurance benefits in order to assure that needed services are affordable and to spread their costs over the largest possible population.

There is no consensus on the critical issue of the cost of these mandates or even the best method to measure their costs. While some services, such as inpatient substance abuse treatment, seem likely to add to the cost of health insurance, others, such as home care or hospice care can substitute for more expensive hospital or nursing home services (Gabel et al., 1989). Still others, such as prenatal care and mammography save longer-term health care costs (Institute of Medicine, 1985; State of Hawaii, 1990). Some benefits are also thought to add to costs because they uncover other problems that need medical attention. Laws requiring that all providers legally entitled to render a service must be reimbursed if the service is offered (e.g., requiring psychologists to be paid if mental health care is covered) probably result in covering lower cost providers but appear also to increase overall use of the service among people preferring to use non-physician practitioners (Gabel et al., 1989). Still other services, such as obstetrical or newborn care, are costly but may serve an important public policy purpose and can be much less expensive if their costs are spread over a large group of enrollees rather than just people selecting the benefit or needing the service.

Consideration of "bare-bones" policies exempt from mandated benefits provides policy-makers an opportunity to consider what services ought to be available to all citizens as well as which services to cut. Several states, including **Rhode Island, Virginia,** and **Illinois,** have taken this approach and maintained mandates for such services as coverage of newborns, adopted and disabled children; well child care; and prenatal care. Other states, however, have allowed the ax to fall on such preventive services as mammography and well-child care where there are inarguable public health benefits and at least arguable potential long-term cost savings.

Policy makers should seek objective information about the costs and benefits of these requirements. States such as **Maryland** and **Maine** have enacted laws requiring a cost-benefit analysis of any proposed additional mandates--a challenging task. The arguments about

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[4] This is true despite the fact that surveys of benefits offered by self-insured firms reveal that they provide the most common mandated services, such as mental health and substance abuse (Bartlett, 1990).

mandates will be better served if an objective evaluation can be undertaken of the need for each service in question, its costs, its substitution and augmentation effects, and the opportunities for managing each type of care. Most of the research on the costs of mandated benefits has been funded by the insurance industry and has tended to examine the proportion of all claims represented by mandates, which ranges from 6 percent to 21 percent, rather than the substitution and additive effects of mandates. (Ralston et al., 1988; Gabel et al., 1989; Wisconsin Insurance Commissioner, 1990)

Fortunately, it is not necessary for policy makers to delve into the entire mandated benefits controversy to encourage more variety in the health insurance market. As discussed in Chapter IV, public agencies could fund or merely foster new insurance plan development efforts. If there is sound evidence that lower cost products cannot be developed within the state's current insurance law, consideration of mandated benefit waivers may be appropriate. Such a proposal should be based on market information about what employers and employees are interested in buying, detailed actuarial data on costs of different benefits to the target population, and public policy goals of encouraging coverage of selected services regardless of their cost impact. To facilitate employers' choices among plans and evaluate the price impact of foregone benefits, a waiver law should require, as do those in Illinois and Virginia, that insurers disclose to prospective purchasers the state's mandated benefits not covered in the limited plan and the premium savings associated with them.

LETTERS

Asian American Perspectives

As an Asian American elected official, I appreciated the perspectives presented in Rob Gurwitt's November article, "Have Asian Americans Arrived Politically? Not Quite" [page 32].

Almost all Asian American politicians, except for those in Hawaii, are elected in districts where less than 10 percent of the population is Asian American. The candidates, therefore, feel they must be better qualified and appealing to a broad cross section of voters.

Each year, Asian American communities become more established economically, better organized and in agreement on some common Asian American issues. With this process, a framework is being formed for the Asian American community to influence the political process.

Lloyd F. Hara
City Treasurer
Seattle

I take exception to your statement that the Los Angeles suburb of Monterey Park is the nation's only city with an Asian-origin majority.

I am a longtime resident of Hawaii who just moved to Washington state. I believe the statistics will clearly show that Hawaii has an overall Asian population of about 80 percent.

Why is it that our lovely state of Hawaii is so often overlooked when comparing community statistics?

Edwyna Carole Fong
Assistant Planner
Skagit County Department of Planning and Community Development
Mount Vernon, Washington

The reference should have been to mainland cities. Hawaii state government statistics indicate that, as of 1987, 60.5 percent of Hawaiians were Asians or Pacific Islanders. Those figures, however, do not include substantial numbers of people of mixed background.

Health Insurance in Connecticut

I was disappointed in reading your November article "Health Insurance for All: A Possible Dream?" [page 56] that no mention was made of landmark legislation passed last year in Connecticut to address the problem of access to health care for the poor and employees of small businesses.

The law imposes significant reforms on the health insurance market in the state. Among other provisions, it mandates that any employer with 25 or fewer employees can obtain health insurance from any carrier in the market and that no individual employee can be excluded from coverage.

We believe the new law, which should be fully operational early this year, is the most comprehensive piece of health access legislation adopted in 1990. My company, one of the largest small-business health insurers, is pursuing similar legislation in many other states in conjunction with our national trade association, the Health Insurance Association of America.

F. Peter Libassi
Senior Vice President
The Travelers Companies
Hartford, Connecticut

Reinventing Small-Town America

The good people of Baker, Montana, are not alone as they seek to reinvent their community to compete in the world market ["A Small Town's Choice: Change, Or Fade Away," September, page 32]. Communities across the country are slowly coming to realize that they must undertake the same painful process.

It is important that communities take a long-term, comprehensive approach to community revitalization, and one that builds on local assets. Over the past 10 years, the National Main Street Center, a program of the National Trust for Historic Preservation, has helped organize local revitalization programs in more than 660 communities (average population: 23,000) in 31 states.

We've seen more than 51,000 new jobs created in these communities, along with 15,000 new businesses and 21,000 building rehabilitation projects. We have recently begun to work in communities with populations under 5,000—at 468 people, Bonaparte, Iowa, is our smallest Main Street town. At present, 51 small communities in seven states are successfully applying the Main Street approach to revitalization.

Kennedy Smith
Acting Director
National Main Street Center
Washington, D.C.

Write to the National Main Street Center in care of the National Trust for Historic Preservation, 1785 Massachusetts Ave. N.W., Washington, D.C. 20036. Phone (202) 673-4000.

I was struck by Rob Gurwitt's cover story in your September issue on efforts by community leaders in Baker, Montana, to invent a new economic future for the town. He managed to convey the poignance of Baker's predicament while also conveying the grit and hopefulness of its leaders. A program administered here at the University of Minnesota also deals on a daily basis with that same grit and hopefulness, focusing on Minnesota, Montana and North and South Dakota.

The aim of the W.K. Kellogg Public Policy Program, which is funded by the W.K. Kellogg Foundation, is to reach out to the kind of local leaders you identified in Baker and to bring them up-to-the-minute information on a wide variety of rural development issues so that they are better equipped to make policy decisions.

In the 18 months we've been in operation, we have sponsored seminars and conferences on such topics as rural education, rural economic development, the Canada-U.S. Free Trade Agreement, agricultural policy and rural health care policy.

The sparse population of the four states our program covers means that local governments have little (and decreasing) resources, and participants in our conferences often have to travel vast distances to attend. What keeps

Employee Retirement Income ... 1974

§ 1002. Definitions

For purposes of this title:

(1) The terms "employee welfare benefit plan" and "welfare plan" mean any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or (B) any benefit described in section 302(c) of the Labor Management Relations Act, 1947 [29 USCS § 186(c)] (other than pensions on retirement or death, and insurance to provide such pensions).

(2)(A) Except as provided in subparagraph (B), the terms "employee pension benefit plan" and "pension plan" mean any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that by its express terms or as a result of surrounding circumstances such plan, fund, or program—

(i) provides retirement income to employees, or

(ii) results in a deferral of income by employees for periods extending to the termination of covered employment or beyond,

regardless of the method of calculating the contributions made to the plan, the method of calculating the benefits under the plan or the method of distributing benefits from the plan.

(B) The Secretary may by regulation prescribe rules consistent with the standards and purposes of this Act providing one or more exempt categories under which—

(i) severance pay arrangements, and

(ii) supplemental retirement income payments, under which the pension benefits of retirees or their beneficiaries are supplemented to take into account some portion or all of the increases in the cost of living (as determined by the Secretary of Labor) since retirement,

shall, for purposes of this title, be treated as welfare plans rather than pension plans. In the case of any arrangement or payment a principal effect of which is the evasion of the standards or purposes of this Act applicable to pension plans, such arrangement or payment shall be treated as a pension plan.

(3) The term "employee benefit plan" or "plan" means an employee welfare benefit plan or an employee pension benefit plan or a plan which is both an employee welfare benefit plan and an employee pension benefit plan.

(4) The term "employee organization" means any labor union or any organization of any kind, or any agency or employee representation committee, association, group, or plan, in which employees participate and which exists for the purpose, in whole or in part, of dealing with employers concerning an employee benefit plan, or other matters incidental to employment relationships; or any employees' beneficiary association organized for the purpose in whole or in part, of establishing such a plan.

(5) The term "employer" means any person acting directly as an employer, or indirectly in the interest of an employer, in relation to an employee benefit plan; and includes a group or association of employers acting for an employer in such capacity.

(6) The term "employee" means any individual employed by an employer.

(7) The term "participant" means any employee or former employee of an employer, or any member or former member of an employee organization, who is or may become eligible to receive a benefit of any type from an employee benefit plan which covers employees of such employer or members of such organization, or whose beneficiaries may be eligible to receive any such benefit.

(8) The term "beneficiary" means a person designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit thereunder.

(9) The term "person" means an individual, partnership, joint venture, corporation, mutual company, joint-stock company, trust, estate, unincorporated organization, association, or employee organization.

(10) The term "State" includes any State of the United States, the District of Columbia, Puerto Rico, the Virgin Islands, American Samoa, Guam, Wake Island, and the Canal Zone. The term "United States" when used in the geographic sense means the States and the Outer Continental Shelf lands defined in the Outer Continental Shelf Lands Act (43 U.S.C. 1331–1343).

(11) The term "commerce" means trade, traffic, commerce, transportation, or communication between any State and any place outside thereof.

(12) The term "industry or activity affecting commerce" means any activity, business, or industry in commerce or in which a labor dispute would hinder or obstruct commerce or the free flow of commerce, and includes any activity or industry "affecting commerce" within the meaning of the Labor Management Relations Act, 1947, or the Railway Labor Act.

(13) The term "Secretary" means the Secretary of Labor.

(14) The term "party in interest" means, as to an employee benefit plan—

(A) any fiduciary (including, but not limited to, any administrator, officer, trustee, or custodian), counsel, or employee of such employee benefit plan;

(B) a person providing services to such plan;
(C) an employer any of whose employees are covered by such plan;
(D) an employee organization any of whose members are covered by such plan;
(E) an owner, direct or indirect, of 50 percent or more of—
(i) the combined voting power of all classes of stock entitled to vote or the total value of shares of all classes of stock of a corporation.
(ii) the capital interest or the profits interest of a partnership, or
(iii) the beneficial interest of a trust or unincorporated enterprise,
which is an employer or an employee organization described in subparagraph (C) or (D);
(F) a relative (as defined in paragraph (15)) of any individual described in subparagraph (A), (B), (C), or (E);
(G) a corporation, partnership, or trust or estate of which (or in which) 50 percent or more of—
(i) the combined voting power of all classes of stock entitled to vote or the total value of shares of all classes of stock of such corporation,
(ii) the capital interest or profits interest of such partnership, or
(iii) the beneficial interest of such trust or estate,
is owned directly or indirectly, or held by persons described in subparagraph (A), (B), (C), (D), or (E);
(H) an employee, officer, director (or an individual having powers or responsibilities similar to those of officers or directors), or a 10 percent or more shareholder directly or indirectly, of a person described in subparagraph (B), (C), (D), (E), or (G), or of the employee benefit plan; or
(I) a 10 percent or more (directly or indirectly in capital or profits) partner or joint venturer of a person described in subparagraph (B), (C), (D), (E), or (G).

The Secretary, after consultation and coordination with the Secretary of the Treasury, may by regulation prescribe a percentage lower than 50 percent for subparagraph (E) and (G) and lower than 10 percent for subparagraph (H) or (I). The Secretary may prescribe regulations for determining the ownership (direct or indirect) of profits and beneficial interests, and the manner in which indirect stockholdings are taken into account. Any person who is a party in interest with respect to a plan to which a trust described in section 501(c)(22) of the Internal Revenue Code of 1986 [26 USCS § 501(c)(22)] is permitted to make payments under section 4223 [29 USCS § 1403] shall be treated as a party in interest with respect to such trust.

(15) The term "relative" means a spouse, ancestor, lineal descendant, or spouse of a lineal descendant.

(16)(A) The term "administrator" means—
(i) the person specifically so designated by the terms of the instrument under which the plan is operated;

(ii) if an administrator is not so designated, the plan sponsor; or

(iii) in the case of a plan for which an administrator is not designated and a plan sponsor cannot be identified, such other person as the Secretary may by regulation prescribe.

(B) The term "plan sponsor" means (i) the employer in the case of an employee benefit plan established or maintained by a single employer, (ii) the employee organization in the case of a plan established or maintained by an employee organization, or (iii) in the case of a plan established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the plan.

(17) The term "separate account" means an account established or maintained by an insurance company under which income, gains, and losses, whether or not realized, from assets allocated to such account, are, in accordance with the applicable contract, credited to or charged against such account without regard to other income, gains, or losses of the insurance company.

(18) The term "adequate consideration" when used in part 4 of subtitle B [29 USCS §§ 1101 et seq.] means (A) in the case of a security for which there is a generally recognized market, either (i) the price of the security prevailing on a national securities exchange which is registered under section 6 of the Securities Exchange Act of 1934 [15 USCS § 78f], or (ii) if the security is not traded on such a national securities exchange, a price not less favorable to the plan than the offering price for the security as established by the current bid and asked prices quoted by persons independent of the issuer and of any party in interest; and (B) in the case of an asset other than a security for which there is a generally recognized market, the fair market value of the asset as determined in good faith by the trustee or named fiduciary pursuant to the terms of the plan and in accordance with regulations promulgated by the Secretary.

(19) The term "nonforfeitable" when used with respect to a pension benefit or right means a claim obtained by a participant or his beneficiary to that part of an immediate or deferred benefit under a pension plan which arises from the participant's service, which is unconditional, and which is legally enforceable against the plan. For purposes of this paragraph, a right to an accrued benefit derived from employer contributions shall not be treated as forfeitable merely because the plan contains a provision described in section 203(a)(3) [29 USCS § 1053(a)(3)].

(20) The term "security" has the same meaning as such term has under section 2(1) of the Securities Act of 1933 (15 U.S.C. 77b(1)).

(21)(A) Except as otherwise provided in subparagraph (B), a person is a fiduciary with respect to a plan to the extent (i) he exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting

management or disposition of its assets, (ii) he renders investment advice for a fee or other compensation, direct or indirect, with respect to any moneys or other property of such plan, or has any authority or responsibility to do so, or (iii) he has any discretionary authority or discretionary responsibility in the administration of such plan. Such term includes any person designated under section 405(c)(1)(B) [29 USCS § 1105(c)(1)(B)].

(B) If any money or other property of an employee benefit plan is invested in securities issued by an investment company registered under the Investment Company Act of 1940, such investment shall not by itself cause such investment company or such investment company's investment adviser or principal underwriter to be deemed to be a fiduciary or a party in interest as those terms are defined in this title, except insofar as such investment company or its investment adviser or principal underwriter acts in connection with an employee benefit plan covering employees of the investment company, the investment adviser, or its principal underwriter. Nothing contained in this subparagraph shall limit the duties imposed on such investment company, investment adviser, or principal underwriter by any other law.

(22) The term "normal retirement benefit" means the greater of the early retirement benefit under the plan, or the benefit under the plan commencing at normal retirement age. The normal retirement benefit shall be determined without regard to—

(A) medical benefits, and

(B) disability benefits not in excess of the qualified disability benefit.

For purposes of this paragraph, a qualified disability benefit is a disability benefit provided by a plan which does not exceed the benefit which would be provided for the participant if he separated from the service at normal retirement age. For purposes of this paragraph, the early retirement benefit under a plan shall be determined without regard to any benefit under the plan which the Secretary of the Treasury finds to be a benefit described in section 204(b)(1)(G) [29 USCS § 1054(b)(1)(G)].

(23) The term "accrued benefit" means—

(A) in the case of a defined benefit plan, the individual's accrued benefit determined under the plan and, except as provided in section 204(c)(3) [29 USCS § 1054(c)(3)], expressed in the form of an annual benefit commencing at normal retirement age, or

(B) in the case of a plan which is an individual account plan, the balance of the individual's account.

The accrued benefit of an employee shall not be less than the amount determined under section 204(c)(2)(B) [29 USCS § 1054(c)(2)(B)] with respect to the employee's accumulated contribution.

(24) The term "normal retirement age" means the earlier of—

(A) the time a plan participant attains normal retirement age under the plan, or

(B) the later of—

(i) the time a plan participant attains age 65, or

(ii) the 5th anniversary of the time a plan participant commenced participation in the plan.

(25) The term "vested liabilities" means the present value of the immediate or deferred benefits available at normal retirement age for participants and their beneficiaries which are nonforfeitable.

(26) The term "current value" means fair market value where available and otherwise the fair value as determined in good faith by a trustee or a named fiduciary (as defined in section 402(a)(2) [29 USCS § 1102(a)(2)]) pursuant to the terms of the plan and in accordance with regulations of the Secretary, assuming an orderly liquidation at the time of such determination.

(27) The term "present value", with respect to a liability, means the value adjusted to reflect anticipated events. Such adjustments shall conform to such regulations as the Secretary of the Treasury may prescribe.

(28) The term "normal service cost" or "normal cost" means the annual cost of future pension benefits and administrative expenses assigned, under an actuarial cost method, to years subsequent to a particular valuation date of a pension plan. The Secretary of the Treasury may prescribe regulations to carry out this paragraph.

(29) The term "accrued liability" means the excess of the present value, as of a particular valuation date of a pension plan, of the projected future benefit costs and administrative expenses for all plan participants and beneficiaries over the present value of future contributions for the normal cost of all applicable plan participants and beneficiaries. The Secretary of the Treasury may prescribe regulations to carry out this paragraph.

(30) The term "unfunded accrued liability" means the excess of the accrued liability, under an actuarial cost method which so provides, over the present value of the assets of a pension plan. The Secretary of the Treasury may prescribe regulations to carry out this paragraph.

(31) The term "advance funding actuarial cost method" or "actuarial cost method" means a recognized actuarial technique utilized for establishing the amount and incidence of the annual actuarial cost of pension plan benefits and expenses. Acceptable actuarial cost methods shall include the accrued benefit cost method (unit credit method), the entry age normal cost method, the individual level premium cost method, the aggregate cost method, the attained age normal cost method, and the frozen initial liability cost method. The terminal funding cost method and the current funding (pay-as-you-go) cost method are not acceptable actuarial cost methods. The Secretary of the Treasury shall issue regulations to further define acceptable actuarial cost methods.

(32) The term "governmental plan" means a plan established or maintained for its employees by the Government of the United States, by the

government of any State or political subdivision thereof, or by any agency or instrumentality of any of the foregoing. The term "governmental plan" also includes any plan to which the Railroad Retirement Act of 1935 or 1937 applies, and which is financed by contributions required under that Act and any plan of an international organization which is exempt from taxation under the provisions of the International Organizations Immunities Act (59 Stat. 669).

(33)(A) The term "church plan" means a plan established and maintained (to the extent required in clause (ii) of subparagraph (B)) for its employees (or their beneficiaries) by a church or by a convention or association of churches which is exempt from tax under section 501 of the Internal Revenue Code of 1986 [26 USCS § 501].

(B) The term "church plan" does not include a plan--

(i) which is established and maintained primarily for the benefit of employees (or their beneficiaries) of such church or convention or association of churches who are employed in connection with one or more unrelated trades or businesses (within the meaning of section 513 of the Internal Revenue Code of 1986 [26 USCS § 513]), or

(ii) if less than substantially all of the individuals included in the plan are individuals described in subparagraph (A) or in clause (ii) of subparagraph (C) (or their beneficiaries).

(C) For purposes of this paragraph—

(i) A plan established and maintained for its employees (or their beneficiaries) by a church or by a convention or association of churches includes a plan maintained by an organization, whether a civil law corporation or otherwise, the principal purpose or function of which is the administration or funding of a plan or program for the provision of retirement benefits or welfare benefits, or both, for the employees of a church or a convention or association of churches, if such organization is controlled by or associated with a church or a convention or association of churches.

(ii) The term employee of a church or a convention or association of churches includes—

(I) a duly ordained, commissioned, or licensed minister of a church in the exercise of his ministry, regardless of the source of his compensation;

(II) an employee of an organization, whether a civil law corporation or otherwise, which is exempt from tax under section 501 of the Internal Revenue Code of 1986 [26 USCS § 501] and which is controlled by or associated with a church or a convention or association of churches; and

(III) an individual described in clause (v).

(iii) A church or a convention or association of churches which is exempt from tax under section 501 of the Internal Revenue Code

of 1986 [26 USCS § 501] shall be deemed the employer of any individual included as an employee under clause (ii).

(iv) An organization, whether a civil law corporation or otherwise, is associated with a church or a convention or association of churches if it shares common religious bonds and convictions with that church or convention or association of churches.

(v) If an employee who is included in a church plan separates from the service of a church or a convention or association of churches or an organization, whether a civil law corporation or otherwise, which is exempt from tax under section 501 of the Internal Revenue Code of 1986 [26 USCS § 501] and which is controlled by or associated with a church or a convention or association of churches, the church plan shall not fail to meet the requirements of this paragraph merely because the plan—

(I) retains the employee's accrued benefit or account for the payment of benefits to the employee or his beneficiaries pursuant to the terms of the plan; or

(II) receives contributions on the employee's behalf after the employee's separation from such service, but only for a period of 5 years after such separation, unless the employee is disabled (within the meaning of the disability provisions of the church plan or, if there are no such provisions in the church plan, within the meaning of section 72(m)(7) of the Internal Revenue Code of 1986 [26 USCS § 72(m)(7)] at the time of such separation from service.

(D)(i) If a plan established and maintained for its employees (or their beneficiaries) by a church or by a convention or association of churches which is exempt from tax under section 501 of the Internal Revenue Code of 1986 [26 USCS § 501] fails to meet one or more of the requirements of this paragraph and corrects its failure to meet such requirements within the correction period, the plan shall be deemed to meet the requirements of this paragraph for the year in which the correction was made and for all prior years.

(ii) If a correction is not made within the correction period, the plan shall be deemed not to meet the requirements of this paragraph beginning with the date on which the earliest failure to meet one or more of such requirements occurred.

(iii) For purposes of this subparagraph, the term "correction period" means—

(I) the period ending 270 days after the date of mailing by the Secretary of the Treasury of a notice of default with respect to the plan's failure to meet one or more of the requirements of this paragraph; or

(II) any period set by a court of competent jurisdiction after a final determination that the plan fails to meet such requirements,

or, if the court does not specify such period, any reasonable period determined by the Secretary of the Treasury on the basis of all the facts and circumstances, but in any event not less than 270 days after the determination has become final; or

(III) any additional period which the Secretary of the Treasury determines is reasonable or necessary for the correction of the default,

whichever has the latest ending date.

(34) The term "individual account plan" or "defined contribution plan" means a pension plan which provides for an individual account for each participant and for benefits based solely upon the amount contributed to the participant's account, and any income, expenses, gains and losses, and any forfeitures of accounts of other participants which may be allocated to such participant's account.

(35) The term "defined benefit plan" means a pension plan other than an individual account plan; except that a pension plan which is not an individual account plan and which provides a benefit derived from employer contributions which is based partly on the balance of the separate account of a participant—

(A) for the purposes of section 202 [29 USCS § 1052], shall be treated as an individual account plan, and

(B) for the purposes of paragraph (23) of this section and section 204 [29 USCS § 1054], shall be treated as an individual account plan to the extent benefits are based upon the separate account of a participant and as a defined benefit plan with respect to the remaining portion of benefits under the plan.

(36) The term "excess benefit plan" means a plan maintained by an employer solely for the purpose of providing benefits for certain employees in excess of the limitations on contributions and benefits imposed by section 415 of the Internal Revenue Code of 1986 [26 USCS § 415] on plans to which that section applies, without regard to whether the plan is funded. To the extent that a separable part of a plan (as determined by the Secretary of Labor) maintained by an employer is maintained for such purpose, that part shall be treated as a separate plan which is an excess benefit plan.

(37)(A) The term "multiemployer plan" means a plan—

(i) to which more than one employer is required to contribute,

(ii) which is maintained pursuant to one or more collective bargaining agreements between one or more employee organizations and more than one employer, and

(iii) which satisfies such other requirements as the Secretary may prescribe by regulation.

(B) For purposes of this paragraph, all trades or businesses (whether or not incorporated) which are under common control within the meaning of section 4001(b)(1) [29 USCS § 1301(b)(1)] are considered a single employer.

(C) Notwithstanding subparagraph (A), a plan is a multiemployer plan on and after its termination date if the plan was a multiemployer plan under this paragraph for the plan year preceding its termination date.

(D) For purposes of this title, notwithstanding the preceding provisions of this paragraph, for any plan year which began before the date of the enactment of the Multiemployer Pension Plan Amendments Act of 1980 [enacted Sept. 26, 1980], the term "multiemployer plan" means a plan described in section 3(37) of this Act [para. (37) of this section] as in effect immediately before such date.

(E) Within one year after the date of the enactment of the Multiemployer Pension Plan Amendments Act of 1980 [enacted Sept. 26, 1980], a multiemployer plan may irrevocably elect, pursuant to procedures established by the corporation and subject to the provisions of sections 4403 [4303](b) and (c) [29 USCS § 1453(b) and (c)], that the plan shall not be treated as a multiemployer plan for all purposes under this Act or the Internal Revenue Code of 1954 [26 USCS §§ 1 et seq.] if for each of the last 3 plan years ending prior to the effective date of the Multiemployer Pension Plan Amendments Act of 1980—

(i) the plan was not a multiemployer plan because the plan was not a plan described in section 3(37)(A)(iii) of this Act [para. (37)(A)(iii) of this section] and section 414(f)(1)(C) of the Internal Revenue Code of 1954 [26 USCS § 414(f)(1)(C)] (as such provisions were in effect on the day before the date of the enactment of the Multiemployer Pension Plan Amendments Act of 1980 [enacted Sept. 26, 1980]); and

(ii) the plan had been identified as a plan that was not a multiemployer plan in substantially all its filings with the corporation, the Secretary of Labor and the Secretary of the Treasury.

(F)(i) For purposes of this title a qualified football coaches plan—

(I) shall be treated as a multiemployer plan to the extent not inconsistent with the purposes of this subparagraph; and

(II) notwithstanding section 401(k)(4)(B) of the Internal Revenue Code of 1986 [26 USCS § 401(k)(4)(B)], may include a qualified cash and deferred arrangement.

(ii) For purposes of this subparagraph, the term "qualified football coaches plan" means any defined contribution plan which is established and maintained by an organization—

(I) which is described in section 501(c) of such Code [26 USCS § 501(c)];

(II) the membership of which consists entirely of individuals who primarily coach football as full-time employees of 4-year colleges or universities described in section 170(b)(1)(A)(ii) of such Code [26 USCS § 170(b)(1)(A)(ii)]; and

(III) which was in existence on September 18, 1986.

(38) The term "investment manager" means any fiduciary (other than a trustee or named fiduciary, as defined in section 402(a)(2) [29 USCS § 1102(a)(2)])—

(A) who has the power to manage, acquire, or dispose of any asset of a plan;

(B) who is (i) registered as an investment adviser under the Investment Advisers Act of 1940 [15 USCS §§ 80b-1 et seq.]; (ii) is a bank, as defined in that Act [15 USCS §§ 80b-1 et seq.]; or (iii) is an insurance company qualified to perform services described in subparagraph (A) under the laws of more than one State; and

(C) has acknowledged in writing that he is a fiduciary with respect to the plan.

(39) The terms "plan year" and "fiscal year of the plan" mean, with respect to a plan, the calendar, policy, or fiscal year on which the records of the plan are kept.

(40)(A) The term "multiple employer welfare arrangement" means an employee welfare benefit plan, or any other arrangement (other than an employee welfare benefit plan), which is established or maintained for the purpose of offering or providing any benefit described in paragraph (1) to the employees of two or more employers (including one or more self-employed individuals), or to their beneficiaries, except that such term does not include any such plan or other arrangement which is established or maintained—

(i) under or pursuant to one or more agreements which the Secretary finds to be collective bargaining agreements, or

(ii) by a rural electric cooperative.

(B) For purposes of this paragraph—

(i) two or more trades or businesses, whether or not incorporated, shall be deemed a single employer if such trades or businesses are within the same control group,

(ii) the term "control group" means a group of trades or businesses under common control,

(iii) the determination of whether a trade or business is under "common control" with another trade or business shall be determined under regulations of the Secretary applying principles similar to the principles applied in determining whether employees of two or more trades or businesses are treated as employed by a single employer under section 4001(b) [29 USCS § 1301(b)], except that, for purposes of this paragraph, common control shall not be based on an interest of less than 25 percent, and

(iv) the term "rural electric cooperative" means—

(I) any organization which is exempt from tax under section 501(a) of the Internal Revenue Code of 1986 [26 USCS § 501(a)] and which is engaged primarily in providing electric service on a mutual or cooperative basis, and

(II) any organization described in paragraph (4) or (6) of section 501(c) of the Internal Revenue Code of 1986 [26 USCS § 501(c)(4) or (6)] which is exempt from tax under section 501(a) of such Code [26 USCS § 501(a)] and at least 80 percent of the members of which are organizations described in subclause (I).

(41) Single-employer plan. The term "single-employer plan" means an employee benefit plan other than a multiemployer plan.

(Sept. 2, 1974, P. L. 93-406, Title I, Subtitle A, § 3, 88 Stat. 832; Sept. 26, 1980, P. L. 96-364, Title III, §§ 302, 305, Title IV, §§ 407(a), 409, 94 Stat. 1291, 1294, 1303, 1307; Jan. 14, 1983, P. L. 97-473, Title III, § 302(a), 96 Stat. 2612; Apr. 7, 1986, P. L. 99-272, Title XI, § 11016(c)(1), 100 Stat. 273; Oct. 21, 1986, P. L. 99-509, Title IX, Subtitle C, § 9203(b)(1), 100 Stat. 1979; Oct. 22, 1986, P. L. 99-514, Title XVIII, Subtitle A, Ch 7, § 1879(u)(3), 100 Stat. 2913; Dec. 22, 1987, P. L. 100-202, § 136(a), 101 Stat. 1329-441; Dec. 19, 1989, P. L. 101-239, Title VII, Subtitle G, Part V, Subpart B, § 7871(b)(2), Subpart C, § 7881(m)(2)(D), Subpart D, §§ 7891(a)(1), 7893(a), 7894(a)(1)(A), (2)(A), (3), (4), 103 Stat. 2435, 2444, 2445, 2447, 2448.)

HISTORY; ANCILLARY LAWS AND DIRECTIVES

References in text:

"This title", referred to in this section, is Title I of Act Sept. 2, 1974, P. L. 93-406, 88 Stat. 832, popularly known as the Employee Retirement Income Security Act of 1974, which appears generally as 29 USCS § 1001-§ 1168. For full classification of this Title, consult USCS Tables volumes.

"This Act", referred to in this section, is the Employee Retirement Income Security Act of 1974, Act Sept. 2, 1974, P. L. 93-406, 88 Stat. 829, which appears generally as 29 USCS §§ 1001 et seq. For full classification of this Act, consult USCS Tables volumes.

"The Outer Continental Shelf Lands Act", referred to in this section, is Act Aug. 7, 1953, ch 345, 67 Stat. 462, which is generally classified to 43 USCS §§ 1331 et seq. For full classification of this Act, consult USCS Tables volumes.

"The Labor Management Relations Act, 1947", referred to in this section, is Act June 23, 1947, ch 120, 61 Stat. 136, and appears generally as 29 USCS §§ 141 et seq. For full classification of such Act, consult USCS Tables volumes.

"The Railway Labor Act", referred to in this section, is Act May 20, 1926, ch 347, 44 Stat. 577, and appears generally as 45 USCS §§ 151 et seq. For full classification of such Act, consult USCS Tables volumes.

"The Investment Company Act of 1940", referred to in this section, is Act Aug. 22, 1940, ch 686, Title I, 54 Stat. 789, and appears generally as 15 USCS §§ 80a-1 et seq. For full classification of such Act, consult USCS Tables volumes.

"The Railroad Retirement Act of 1935 or 1937" or "that Act", referred to in this section, is Act Aug. 29, 1935, ch 812, 49 Stat. 867, as amended generally by Act June 24, 1937, ch 382, Part 1, 50 Stat.

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Mary Van Nimwegen

4-19-91 Senate Labor & Commerce 8:12 a.m.