

SB

173

SFIN

FILE

SENATE FINANCE COMMITTEE REPORT

DATE: 4/1/93

FURTHER:

DATE TURNED INTO OFFICE: 4-8-93

The Finance Committee considered **SENATE BILL NO. 173**

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

and recommends:

- replace with _____ CS SB 173 (FINANCE)
- or adopt previous _____ CS _____ (_____)
- attaches amendment(s)

- same title
- new title
- technical title change (HB only)

adopts _____ Letter of Intent

further referral to the _____

do pass

do not pass

no recommendation

individual recommendations

*CS (Fin)
coming*

NEW FISCAL NOTES

Department	Date	Zero	Fiscal

PREVIOUS FISCAL NOTES

Department	Date	Zero	Fiscal
<i>DCVED</i>	<i>3-26-93</i>	<i>0</i>	

Appropriation No Fiscal Note

DO PASS.

Tim Kelly
Steve Ruffin
George Schell
Bob Thayer

OTHER RECOMMENDATIONS:

1. *Tim Kelly*
 Co-Chair: Signature/Recommendation

2. _____
 Co-Chair: Signature/Recommendation

FISCAL NOTE

No. 1

Bill Version: SB 173

(S) Publish Date: 3-31-93

STATE OF ALASKA
1993 LEGISLATIVE SESSION

Revision Date: _____

Department Affected: Commerce and Economic Development

Title: Group Health Ins. for Small Employers

BRU: Insurance

Component: Operations

Sponsor: Senators Rieger, Pearce, Salo, Kelly, Phillips

COMPONENT SERIAL NO. 354

Requestor: _____

EXPENDITURES/REVENUES:

OPERATING	FY 94	FY 95	FY 96	FY 97	FY 98	FY 99
PERSONAL SERVICES	0	0	0	0	0	0
TRAVEL	0	0	0	0	0	0
CONTRACTUAL	0	0	0	0	0	0
SUPPLIES	0	0	0	0	0	0
EQUIPMENT	0	0	0	0	0	0
LAND & STRUCTURES	0	0	0	0	0	0
GRANTS, CLAIMS	0	0	0	0	0	0
MISCELLANEOUS	0	0	0	0	0	0
TOTAL OPERATING	0	0	0	0	0	0

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

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

FUNDING:

1002 Federal Receipts	0	0	0	0	0	0
1003 GF Match	0	0	0	0	0	0
1004 GF	0	0	0	0	0	0
1005 GF/Program Receipts	0	0	0	0	0	0
1006 GF/MHTIA	0	0	0	0	0	0
OTHER	0	0	0	0	0	0
TOTAL	0	0	0	0	0	0

POSITIONS:

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

Estimate of current year (FY 93) impact: 0

ANALYSIS: (Attach a separate page if necessary.)

No fiscal impact.

Prepared by: Joan Brown, Administrative Officer

Phone: 465-2597

Division: Insurance

Date: 3/26/93

Approved by Commissioner: Paul Fuhs

Agency: Commerce and Economic Development

Date: _____

PREPARER TO PROVIDE ALL DISTRIBUTION COPIES TO GOVERNOR'S LEGISLATIVE OFFICE

For further distribution information call the Governor's Legislative Office

4-8-93
Adapted
SKC
8-LS0907NE.1 - SR
Ford
4/7/93 moved

AMENDMENT

OFFERED IN THE SENATE
TO: SB 173

BY SENATOR RIEGER

Page 9, line 11, after "director.":

Insert "In this subsection, "gross premiums" means the premium charged for insurance before reducing the premium for a dividend or rate credit."

SENATE FINANCE
COMMITTEE (1)
Amendment Number: _____
Bill Number: SB 173
Sponsor: Rieger Date: 4/7/93
Logged In By: RW

4-8-93
Adopted
SFC

8-LS0907E.2 - SE
Ford moved
4/7/93

AMENDMENT

OFFERED IN THE SENATE
TO: SB 173

BY SENATOR RIEGER

Page 28, line 25:

Delete "1997"

Insert "1998"

SENATE FINANCE
COMMITTEE

Amendment Number: 2
Bill Number: SB 173
Sponsor: Rieger Date: 4/7/93
Logged In By: (Pm)

CS SENATE BILL NO. 173 **(Fix)**

IN THE LEGISLATURE OF THE STATE OF ALASKA

EIGHTEENTH LEGISLATURE - FIRST SESSION

BY SENATORS RIEGER, Pearce, Salo, Kelly, Phillips

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

A BILL

FOR AN ACT ENTITLED

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

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

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

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

7 (2) prevent abusive rating practices;

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

9 (4) establish rules regarding renewability of coverage;

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

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

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

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

1 insurance market.

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

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

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

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

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

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

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

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

28 CHAPTER 56. SMALL EMPLOYER HEALTH INSURANCE.

29 ARTICLE 1. SMALL EMPLOYER HEALTH REINSURANCE ASSOCIATION.

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

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

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

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

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

27 Sec. 21.56.030. GENERAL POWERS. The association may

- 28 (1) exercise the powers granted to insurers under the laws of the state,
29 except that the association may not issue insurance;
- 30 (2) sue or be sued;
- 31 (3) enter into contracts with insurers, similar associations in other

1 states, or with other persons for the performance of administrative functions;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

9 (5) effectuating a methodology for applying the dollar thresholds
10 contained in this section for insurers that pay or reimburse health care providers by
11 capitation or salary; and

12 (6) provisions necessary or proper for the execution of the powers and
13 duties of the association.

14 Sec. 21.56.050. HEALTH CARE REINSURANCE. (a) A member may
15 reinsure health care coverage of an eligible employee of a small employer or a
16 dependent of an eligible employee of a small employer with the association only under
17 the following provisions:

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

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

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

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

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

1 claims of a reinsured employee or dependent until the insurer has paid an initial level
2 of claims for the employee or dependent of \$5,000 in a calendar year for benefits
3 covered by the association;

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

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

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

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

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

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

1 (1) the formula established under this subsection may not result in a
2 reinsuring insurer having an assessment share that is less than 50 percent or more than
3 50 percent of an amount that is based on the proportion of the reinsuring insurer's
4 total premiums earned in the preceding calendar year from health benefit plans
5 delivered or issued for delivery to small employers in this state by reinsuring insurers
6 to total premiums earned in the preceding calendar year from health benefit plans
7 delivered or issued for delivery to small employers in this state by all reinsuring
8 carriers;

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

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

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

22 (5) if the board determines that the assessments needed to fund the
23 losses incurred by the association in the previous calendar year will exceed five
24 percent of total premiums earned in the previous year from health benefit plans
25 delivered or issued for delivery to small employers in this state by reinsuring insurers,
26 the board shall evaluate the operation of the program and report its findings, including
27 any recommendations for changes to the plan of operation, to the director within 90
28 days following the end of the calendar year in which the losses were incurred; the
29 evaluation must include an estimate of future assessments, the administrative costs of
30 the program, the appropriateness of the premiums charged, and the level of insurer
31 retention under the program and the costs of coverage for small employers; if the

1 board fails to file a report with the director within 90 days following the end of the
2 applicable calendar year, the director may evaluate the operations of the program and
3 implement amendments to the plan of operation the director determines necessary to
4 reduce future losses and assessments;

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

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

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

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

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

28 (c) The board, as part of the plan of operation, shall establish a methodology
29 for determining premium rates to be charged by the program for reinsuring small
30 employers and individuals under this section. The methodology must include a system
31 for classification of small employers that reflects the types of case characteristics

1 commonly used by small employer insurers in the state. The methodology must
2 provide for the development of base reinsurance premium rates that shall be multiplied
3 by the factors set out in (b) of this section to determine the premium rates for the
4 association. The base reinsurance premium rates shall be established by the board,
5 subject to the approval of the director, and shall be set at levels that reasonably
6 approximate gross premiums charged to small employers by small employer insurers
7 for health benefit plans with benefits similar to the standard health benefit plan. The
8 board shall review the methodology established under this subsection to ensure that the
9 methodology reasonably reflects the claims experience of the program. Changes to the
10 methodology may be proposed by the board, and are subject to approval by the
11 director.

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

- 15 (1) three members who are representatives of participating insurers;
- 16 (2) one member who represents small employers;
- 17 (3) one member who represents employees of small employers; and
- 18 (4) one member who represents health care providers; and
- 19 (5) one member who represents agents or brokers.

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

- 27 (1) utilization review of health care services, including review of the
28 medical necessity of hospital and physician services;
- 29 (2) case management;
- 30 (3) selective contracting with hospitals, physicians, and other health
31 care providers;

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

4 (5) other managed care provisions.

5 Sec. 21.56.070. REQUIRED REPORT. The board shall study and report at
6 least once every two years to the director and to the legislature on the effectiveness
7 of this chapter. The report must analyze the effectiveness of the chapter in promoting
8 rate stability, product availability, and coverage affordability. The report may contain
9 recommendations for actions to improve the overall effectiveness, efficiency, and
10 fairness of the small group health insurance marketplace. The report must address
11 whether insurers, agents, brokers, managing general agents, and third-party
12 administrators are fairly and actively marketing or issuing health benefit plans to small
13 employers in fulfillment of the purposes of the chapter. The report may contain
14 recommendations for market conduct or other regulatory standards or action.

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

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

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

24 ARTICLE 2. SMALL EMPLOYER HEALTH INSURANCE PLANS.

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

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

1 the premium; or

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

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

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

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

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

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

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

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

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

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

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

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

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

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31

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 21.56.050(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 contains a restricted provider network may not be considered similar coverage to a health benefit plan that does not utilize a restricted provider network if the restriction of benefits to network providers results in substantial differences in claim costs;

(9) a small employer insurer may not use case characteristics, other than age, sex, 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 (1) the extent that premium rates for a specified small employer are
2 established or adjusted based upon the actual or expected variation in claims costs or
3 actual or expected variation in health status of the employees of the small employer
4 and their dependents; and

5 (2) the provisions of the health benefit plan

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

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

10 (C) relating to any preexisting condition provision.

11 (c) A small employer insurer shall

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

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

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

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

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

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

30 (d) The director may adopt regulations to implement the provisions of this
31 section and to ensure that rating practices used by small employer insurers are

1 consistent with the purposes of this act, including ensuring that differences in rates
2 charged for health benefit plans by small employer insurers are reasonable and reflect
3 objective differences in plan design, not including differences due to the nature of the
4 groups assumed to select particular health benefit plans.

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

8 (1) nonpayment of the required premiums;

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

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

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

14 (5) a small employer insurer who elects not to renew all of its health
15 benefit plans delivered or issued for delivery to small employers in this state; an
16 insurer who elects not to renew as described in this paragraph shall

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5 (2) a small employer insurer must waive any time period applicable to
6 a preexisting condition exclusion or limitation period with respect to particular services
7 in a health benefit plan for the period of time an individual was previously covered by
8 qualifying previous coverage that provided benefits with respect to the services,
9 provided that the qualifying previous coverage was continuous to a date not more than
10 90 days before the effective date of the new coverage; the period of continuous
11 coverage may not include a waiting period for the effective date of coverage applied
12 by the employer or insurer; this paragraph does not preclude application of a waiting
13 period applicable to all new enrollees under the health benefit plan;

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

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

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

29 (6) if a small employer insurer offers coverage to a small employer, the
30 small employer insurer shall offer coverage to all of the eligible employees of a small
31 employer and their dependents; a small employer insurer may not offer coverage to

1 only certain individuals in a small employer group or to only part of the group, except
2 in the case of late enrollees as provided in (3) of this section;

3 (7) except as provided in (1) and (3) of this section, a small employer
4 insurer may not, by a rider or amendment applicable to a specific individual, restrict
5 or exclude coverage or benefits by type of illness, treatment, medical condition, or
6 service otherwise covered by the plan.

7 Sec. 21.56.160. EXEMPTION FROM REQUIRED OFFER OF COVERAGE.

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

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

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

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

18 (4) if the small employer insurer is only maintaining in-force business
19 and has ceased enrolling new employer groups on or before January 1, 1993; this
20 paragraph does not exempt a small employer insurer from the other provisions of this
21 chapter; or

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

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

1 groups.

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

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

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

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

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

11 (d) A small employer insurer

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

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

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

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

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

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

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

1 may adopt regulations to require small employer insurers, as a condition of transacting
2 business with small employers in this state after July 1, 1993, to reissue a health
3 benefit plan to a small employer who has had its health benefit plan terminated or not
4 renewed by the insurer after January 1, 1993. The director may prescribe the terms
5 for the reissue of coverage that the director determines are reasonable and necessary
6 to provide continuity of coverage to small employers.

7 Sec. 21.56.250. DEFINITIONS. In this chapter.

8 (1) "actuarial certification" means a written statement by a member of
9 the American Academy of Actuaries or another individual acceptable to the director
10 indicating that based on the person's examination, including a review of the
11 appropriate records, actuarial assumptions, and methods used by the insurer in
12 establishing premium rates for applicable health insurance plans that a small employer
13 insurer is in compliance with the provisions of AS 21.56.120;

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

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

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

23 (5) "basic health benefit plan" means a lower cost plan offered under
24 AS 21.56.140;

25 (6) "board" means the board of directors of the association;

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

31 (8) "committee" means the health benefit plan committee established

1 in AS 21.56.060;

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

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

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

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

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

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

1 hospital service corporation, and a medical service corporation;

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

7 (A) the individual

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

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

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

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

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

22 (16) "member" means all insurers issuing health benefit plans, welfare
23 arrangements and, to the extent permitted under 29 U.S.C. 1001 - 1461 (Employee
24 Retirement Income Security Act), other benefit arrangements providing health benefit
25 plans in this state;

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

30 (18) "plan of operation" means the plan of operation of the association
31 adopted by the board under AS 21.56.040;

1 (19) "qualifying previous coverage" and "qualifying existing coverage"
2 mean benefits or coverage provided under

3 (A) Medicare or Medicaid;

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

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

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

13 (21) "reinsuring insurer" means a small employer insurer participating
14 in the reinsurance association under AS 21.56.010;

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

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

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

31 (25) "standard health benefit plan" means a health benefit plan offered

1 under AS 21.56.140 that includes benefits not offered under a basic benefit plan;

2 (26) "Taft-Hartley trust" means a jointly managed trust, as allowed by
3 29 U.S.C. 141 - 187, containing a plan of benefits for employees that is negotiated in
4 a collective bargaining agreement governing wages, hours, and working conditions of
5 employees as allowed by 29 U.S.C. 157;

6 (27) "welfare arrangement" means a multiple employer welfare
7 arrangement as defined in 29 U.S.C. 1002, but does not include a multiple employer
8 welfare arrangement that is fully insured as provided in 29 U.S.C. 1060.

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

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

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

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

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

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

29 (1) AS 21.03

30 (2) AS 21.06

31 (3) AS 21.09, except AS 21.09.090

- 1 (4) AS 21.18.010
- 2 (5) AS 21.18.030
- 3 (6) AS 21.18.040
- 4 (7) AS 21.18.120
- 5 (8) AS 21.21.321
- 6 (9) AS 21.36
- 7 (10) AS 21.42.345 - 21.42.365, 21.42.375, 21.42.380, and 21.42.385
- 8 (11) AS 21.51.120
- 9 (12) AS 21.53
- 10 (13) AS 21.54.020
- 11 (14) AS 21.56
- 12 ~~(15)~~ AS 21.69.400
- 13 ~~(16)~~ [(15)] AS 21.69.520
- 14 ~~(17)~~ [(16)] AS 21.69.600, 21.69.620, and 21.69.630
- 15 ~~(18)~~ [(17)] AS 21.78
- 16 ~~(19)~~ [(18)] AS 21.89.040
- 17 ~~(20)~~ [(19)] AS 21.89.060
- 18 ~~(21)~~ [(20)] AS 21.90.

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

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

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

- 1 (7) AS 21.18.120
- 2 (8) AS 21.21.321
- 3 (9) AS 21.36
- 4 (10) AS 21.42.345 - 21.42.365, 21.42.375, 21.42.380, and 21.42.385
- 5 (11) AS 21.51.120
- 6 (12) AS 21.53
- 7 (13) AS 21.54.020
- 8 (14) AS 21.69.400
- 9 (15) AS 21.69.520
- 10 (16) AS 21.69.600, 21.69.620, and 21.69.630
- 11 (17) AS 21.78
- 12 (18) AS 21.89.040
- 13 (19) AS 21.89.060
- 14 (20) AS 21.90.

15 * **Sec. 10. PREMIUM RATE RESTRICTION.** Regarding a health benefit plan subject to
16 AS 21.56.110, enacted in sec. 5 of this Act, that is delivered or issued for delivery before
17 July 1, 1993, a premium rate for a rating period may exceed the ranges set out in
18 AS 21.56.120(a)(1) and (2), enacted in sec. 5 of this Act, through June 30, 1996; on or after
19 July 1, 1996, the premium rate may not exceed the ranges set out in AS 21.56.120(a)(1) and
20 (2). However, through June 30, 1996, the percentage increase in the premium rate charged
21 to a small employer for a new rating period may not exceed the sum of

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

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

31 * **Sec. 11. TRANSITION.** (a) Within 180 days after the board is appointed under

1 AS 21.56.020, enacted in sec. 5 of this Act, the board of directors of the Small Employer
2 Health Reinsurance Association shall submit a small employer health benefit plan to the
3 director of the division of insurance for approval. If the association fails to submit a suitable
4 plan of operation, the director may, after notice and hearing, adopt reasonable regulations
5 necessary or advisable to effectuate the provisions of this chapter. These regulations continue
6 in force until modified by the director or superseded by a plan submitted by the association
7 and approved by the director.

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

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

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

21 (e) Notwithstanding AS 21.56.070, enacted in sec. 5 of this Act, the board of directors
22 of the Small Employer Health Reinsurance Association shall provide the report required under
23 AS 21.56.070 to the director of the division of insurance annually until December 31, 1997.

24 * **Sec. 12.** AS 21.36.025 and AS 21.56 are repealed.

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

26 * **Sec. 14.** Except as provided in sec. 13 of this Act, this Act takes effect July 1, 1993.

DIVISION OF LEGAL SERVICES


**LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA**

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

130 Seward Street, Suite 409
Juneau, Alaska 99801-2105

MEMORANDUM

March 29, 1993

SUBJECT: Small employer health insurance (SB 173)
TO: Senator Steve Rieger
FROM: Michael F. Ford
Legislative Counsel 

The following is a section by section analysis of SB 173: 

Section 1 - Purpose.

Section 2 - Makes a violation of insurance marketing practices under AS 21.56.180 an unfair trade practice.

Section 3 - Establishes the provisions of AS 21.56 as an exception to the requirement that an insurer may not discriminate between health care providers.

Section 4 - Sunset section that repeals changes in sec. 3.

Section 5 -

Sec. 21.56.010 - Establishes the Small Employer Health Reinsurance Association and requires certain insurers to be members.

Sec. 21.56.020 - Establishes the board of directors of the association and provides for specific board representation and organization.

Sec. 21.56.030 - Establishes the general powers of the association.

Sec. 21.56.040 - 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 establishes specific components of the plan.

Sec. 21.56.050 - Establishes specific provisions that apply to reinsurance provided by a member to employees or dependents of employees of a small employer. Imposes

Senator Steve Rieger

March 29, 1993

Page 2

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. 21.56.060 - Establishes the health benefit plan committee. Requires the committee to design a basic and a standard health benefit plan.

Sec. 21.56.070 - Requires the board to report on the effectiveness of the chapter.

Sec. 21.56.080 - Exempts the association from the Administrative Procedure Act.

Sec. 21.56.090 - Exempts the association from payment of taxes, except for real or personal property taxes.

Sec. 21.56.100 - Provides immunity from civil actions filed against a member of the association for a negligent act on behalf of the association.

Sec. 21.56.110 - Establishes when an individual or group health benefit plan is subject to AS 21.56 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. 21.56.120 - Establishes underwriting and rating requirements applicable to health benefits plans covering small employers.

Sec. 21.56.130 - Establishes when a health benefit plan is required to be renewed.

Sec. 21.56.140 - Requires a guaranteed issue insurer to offer at least two small employer health benefit plans and that the plans provide certain coverage. Allows a guaranteed issue insurer to reinsure, make special premium arrangements, or appeal unfair administrative or credit risk.

Sec. 21.56.150 - Establishes certain provisions that must be included in a health benefit plan.

Sec. 21.56.160 - Exempts certain small employer insurers from being required to offer health insurance coverage.

Sec. 21.56.170 - Establishes certain conditions that must be met before an insurer or welfare arrangement may cease doing business in the small employer market.

Sec. 21.56.180 - Establishes fair marketing requirements for health benefit plans.

Senator Steve Rieger

March 29, 1993

Page 3

Sec. 21.56.190 - Allows the director of the Division of Insurance to require small employer insurers to reissue a health benefit plan to certain small employers.

Sec. 21.56.250 - Definitions.

Section 6 - Provides that a health maintenance organization is subject to the small employer health insurance provisions contained in AS 21.56.

Section 7 - Sunset provision that repeals changes in sec. 6.

Section 8 - Provides that a hospital or medical service corporation is subject to the small employer health insurance provisions contained in AS 21.56.

Section 9 - Sunset provision that repeals changes in sec. 8.

Section 10 - Provision that allows premium rates to exceed the limits under 21.56.120(a) for a period of three years. Establishes limits on the percentage increase in premium rates.

Section 11 - Transition section. Requires the small employer Health Reinsurance Association to submit a health insurance plan to the Director of the Division of Insurance.

Section 12 - Sunset repeal provisions.

Sections 13 & 14 - Effective dates.

MFF:pl

93-244.plm

Alaska State Senate

SENATOR STEVE RIEGER
District 1

State Capitol
Room 516
Juneau, Alaska 99801
(907) 465-3879

Senate Finance Committee
Chair, Senate Health, Education
and Social Services Committee
Vice Chair, Senate Rules Committee
Vice Chair, Senate Labor and
Commerce Committee

SENATE BILL 173 SMALL EMPLOYER HEALTH INSURANCE REFORM

Senate Bill 173 is pro-business legislation. Based on a model drafted by the National Association of Insurance Commissioners (NAIC), it reforms the small business health insurance market in the State of Alaska and guarantees the availability of private health insurance, regardless of any "high risk" factors of clients.

Coverage must be granted to whole groups, rather than excluding those considered "high risk" by insurance companies and coverage is renewable, regardless of the "risk" associated with each person in the group being covered. The insurance is "portable" as well.

According to the Alaska Department of Labor, more than 90% of all businesses in the State of Alaska employ up to 25 employees. These are the groups that are being addressed in this legislation.

Currently, there are approximately 15 companies in the State who issue small business health insurance. Insurance companies who wish to continue to do business in the state must participate in the Small Employer Health Reinsurance Association, a reinsurance pool. If more small businesses are able to secure health insurance for all of their employees, the insurance companies will cover more low risk clients, thereby decreasing the effects of taking on any high risk individuals. As the number of insured individuals grows, the insurance pool takes on more of a group risk profile.

This legislation does not require additional state expenditures.

The Health Care Task Force, established to review and recommend changes in the Alaska health care insurance industry, recommends the enactment of legislation establishing regulatory reform measures in the small group health insurance market "by enacting the NAIC model statute" as part of an overall plan. To date, this legislation has been adopted by 24 states.

This legislation is supported by the Health Insurance Association of America, (HIAA), the National Federation of Independent Businesses, (NFIB), the Alaska State Chamber of Commerce, the Alaska State Hospital and Nursing Home Association, and other organizations.

POSITION PAPER

Department of Commerce
& Economic Development


SB 173: "An Act relating to health insurance for small employers and providing for an effective date."

The department is neutral on this legislation.

One of the more challenging issues facing this country and Alaska is the ever-increasing number of small employers unable to afford health care insurance. This bill would address small employers who have been unable to purchase health care.

The bill sets up a reinsurance pool for insurers writing small employers health insurance in the state. In order for the bill to be effective, certain provisions have to be met. The authority of the director should be for approval of members only. The pool and coverages they provide should be exempt from the mandatory coverages in Title 21. The pool shall be subject to the marketing and financial sections of Title 21. The pool should not be subject to a subsidy from the legislature or exempt from taxation. The bill adequately addresses these items as written.

Health is not a term defined in Title 21; the appropriate term is disability. Additionally, 21.56.010 should clarify if hospital and medical service corporations and health maintenance organizations, as defined in 21.87 and 21.86, respectively, are included in membership. They are included on the board.



Paul Fuhs, Commissioner

3-29-93

Date

dgl175pp.ins

BILL ANALYSIS - SB 173

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

Sec. 1. PURPOSE.

The bill provides health insurance to small employers without cost shifting, adverse selection and limits the use of preexisting condition exclusions.

AS 21.36.025 UNFAIR MARKETING PRACTICES PROHIBITED.

It is a violation to violate AS 21.56.180.

AS 21.36.090(d).

This section adds 21.56 to the list of titles that may not permit unfair discrimination against a person who provides a service covered under a group disability policy.

AS 21.36.090(d).

This is a repeat of Sec. 3.

Sec. 21.56.010. CREATION MEMBERSHIP.

This section creates a nonprofit legal entity known as Small Employer Health Reinsurance Association (SEHRA) and consists of all insurers licensed to transact health insurance in the state. Participation is mandatory as a condition for transacting health insurance in the state.

Sec. 21.56.020. BOARD OF DIRECTORS; ORGANIZATION.

(a) The board of directors of the association consists of nine individuals subject to approval by the director. The director shall endeavor to appoint at least six board members who are also small employer insurers.

(b) One board member shall represent a health maintenance organization, one board member shall represent a hospital or medical service corporation, one board member's 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.

(c) A member of the board serves for a term of three years and may be reappointed to an unlimited number of terms.

Sec. 21.56.030. GENERAL POWERS.

- (1) exercise the powers granted to insurers under the laws of the state;
- (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. 21.56.040. PLAN OF OPERATION.

The director may, after notice and hearing, approve the plan of operation that should include but not be limited to:

- (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 provision 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. 21.56.050. HEALTH CARE REINSURANCE.

This section establishes the procedures, premiums and assessment mechanisms for the reinsurance association to follow. All plans of implementation are subject to director approval and contain time guideline before the director may act.

Sec. 21.56.060. HEALTH BENEFIT PLAN COMMITTEE.

This section establishes the members who will recommend benefit levels, cost sharing levels, exclusion and limitations for the basic and standard health benefit plan. The plan may contain cost containment features. The members are 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.

Sec. 21.56.070. 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.

Sec. 21.56.080. ADMINISTRATIVE PROCEDURE ACT.

The association is exempt from AS 44.62 (Administrative Procedure Act).

Sec. 21.56.090. 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. 21.56.100. 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.

Sec. 21.56.110. APPLICABILITY.

Sets the conditions that must be met for the individual or group health benefit plan to apply. Other provisions of law requiring coverage or benefits do not apply to these plans unless stated in this chapter.

Sec. 21.56.120. PREMIUM RATE RESTRICTIONS DISCLOSURES; REPORTS; CONFIDENTIALITY.

This section establishes the premium basis that small employer insurers may charge. They include maximums by percentage. Underwriting characteristics are established and disclosure is required by the insurer giving coverage. Information and specific groups or employers, employees filed with the director will be held in confidence.

Sec. 21.56.130. RENEWABILITY OF COVERAGE.

- (a) A health benefit plan subject to this chapter shall be renewable

at the option of the small employer, except for nonpayment of the required premiums; fraud or misrepresentation of the small employer or, with respect to coverage of individual insureds, the insureds or their representatives; noncompliance with the minimum participation or employer contribution requirements; repeated misuse of a provider network provision.

The director may find that the continuation of the coverage would not be in the best interests of the policyholders or certificate holders; or impair the insurer's ability to meet its contractual obligations than it may not be renewed.

(b) A small employer insurer that elects not to renew a health benefit plan for any reason and pulls out of the market 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 operation in that established service area.

Sec. 21.56.140. REQUIRED OFFER OF COVERAGE.

(a) 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.

(b) A small employer insurer shall file basic health benefit plans and the standard health benefit plans to be used by the insurer.

(c) The director at any time may 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. 21.56.150. REQUIRED HEALTH BENEFIT PROVISION

This section establishes mandatory benefits if a plan is to be considered under this chapter. It also establishes guidelines for preexisting condition clauses to be used in plan coverage.

Sec. 21.56.160. EXEMPTION FROM REQUIRED OFFER OF COVERAGE.

This section establishes exemptions for small employer insurers which include but are not limited to geographical area, authorization of certificate of authority, and financial conditions.

Sec. 21.56.170. CONDITIONS FOR CEASING TO DO BUSINESS.

A small employer insurer, welfare arrangement may cease doing business in the state but must notify policy/contract holder and cannot participate in the small employer market for five years.

Sec. 21.56.180. FAIR MARKETING STANDARDS.

Establishing standards of how the standard and basic health plan is to be marketed. Puts limitations on compensation to agents, brokers, MGA, TPA involved in marketing the plan.

Sec. 21.56.250. DEFINITIONS.

Defines various terms used in the legislation.

Sec. 6. 21.86.260(a).

This title does not apply to health maintenance organization unless stipulated in this chapter.

Sec. 7. 21.86.260(a).

Same as above but add medical service corporation or hospital corporation licensed under 21.87 or 21.09.

Sec. 8. 21.87.340.

List other provisions applicable to this chapter.

Sec. 9. 21.87.340.

Same as above.

Sec. 10. PREMIUM RATE RESTRICTION.

This establishes guidelines for premium calculation/administration if a plan is written by an insurer prior to July 1, 1993.

Sec. 11. TRANSITION.

Establishes guidelines for implementation and effective dates for the plan and

the association.

Sec. 12. REPEAL AS 21.36.025 AND 21.56.

Sec. 13.

Sections 4, 7, 9, 12 take effect July 1, 1997.

Sec. 14.

Except as provided in section 13 of this Act, this Act takes effect July 1, 1993.

COMPREHENSIVE SMALL EMPLOYER PACKAGES

	CALIFORNIA	CONNECTICUT
Availability	Guaranteed issue of small employer products (group size 5-50 by 7/1/93; 4-50 by 7/1/94; 3-50 by 7/1/95) (1992 HB 1672) §10700(x), 10705(b);	Guaranteed issue §38a-552, 5682(b)
Group Size	3-50 §10700(x)	1-25 §38a-564(4)
Individual Policies	Individual policies sold to small employers meeting certain requirements are subject to this Act §10702	Insurers may issue individual special health care plans subject to the laws applicable to individual health insurance, provided such policies shall be identical to individual special health care plans made available by the Health Reinsurance Association. §38a-552, 566
Case Characteristics	Includes age (7 categories), geography (9 regions), family composition (4 categories), and plan design which are used to determine the standard employee risk rate §10700(w)	Appears to include everything except claims experience §38a-564(27)
Rating Restrictions	Premium rates may not vary from the standard employee risk rate by more than 120% nor less than 80% until July 1, 1996; effective July 1, 1996, premium rates may not vary from the standard employee risk rate by more than 110% nor less than 90% §10700(v), 10714	Premium rates may not exceed 200% of the lowest new business rate for the same or similar case characteristics §38a-567(5)
Transitional Period	See above	5 years; after July 1, 1995, rating restrictions will be applied to plans issued prior to July 1, 1990 §38a-567(5)
Renewal Rating	10% permitted for risk adjustment factors; renewal rates are effective for at least six months §10714(b)(2)	Trend plus 20% plus changes in case characteristics §38a-567(6)
Renewability	Guaranteed renewable except "for cause" §10705(b), 10713	Guaranteed renewable except "for cause" §38a-567(3)
Whole Groups	Carriers are required to take the whole group §10707	Cannot exclude eligible employees or dependents on the basis of an actual or expected health condition §38a-567(4)
Continuity of Coverage	Preexisting condition limitation of 6 months; credit shall be given if a person was covered under qualifying previous coverage if previous coverage was continuous 30 days prior to the new coverage, exclusive of applicable waiting periods; if employment is terminated or employer's contribution toward the coverage has terminated, there is a 90-day period allowed for continuity of coverage §10706, 10708(a,b), 10709(a)	Preexisting condition limitation of 12 months; credit shall be given if a person was covered under qualifying previous coverage if previous coverage was continuous 30 days prior to the new coverage, exclusive of applicable waiting periods: §38a-567(1,2)
Reinsurance type	Prospective/with opt out §10719, 10720(d)	Prospective/mandatory (effective 5/1/91) §38a-569
Reinsurance Price	No provision	Whole Group: 150% Individual: 500% §38a-569(c)
Cost Sharing	No provision	\$5000 for all plans except those which supplement the basic hospital or hospital surgical plans, in which case the deductible is \$2000 §38a-569(b1)
Assessments	No cap §10721	(1) Apportioned among all members in proportion to their respective shares of the total premiums earned from small group plans, (2) apportioned among all members in proportion to their respective shares of total premiums earned from other plans; members' assessments cannot exceed 40% of the total assessment for the first year; 50% for the second §38a-569 e(2)
Other	Establishes a purchasing pool for small employers §10730	
Effective Date	July 1, 1993, but see phase-in effective dates above	July 1, 1990

	DELAWARE	FLORIDA
Availability	Guaranteed issue (groups of 2-25) §7207(a)3	Guaranteed issue with cap (group size 3-25) (1992 SB 2390) §627.6699(3)c, (5)a
Group Size	1-25 §7202(cc)	1-25 §627.4106(c)a
Individual Policies	Does not apply to individual health policies §7203	With regard to rating and renewability provisions, does not apply to individual policies if the insurer certifies to the department that the policy was issued in good faith with no knowledge or intent that the policy is paid by or the premiums are reimbursed by a small employer §627.4106(f)
Case Characteristics	Demographic or other objective characteristics of small employer as considered by carrier in determination of premiums; Claims experience, health status, and duration of coverage are not case characteristics; small employer carrier shall not use characteristics other than age, gender, industry, geographic area, family composition, unhealthy lifestyle choices, and group size without prior approval of Commissioner §7202(g), 7204, 7205(4)	Demographic or other objective characteristics of small employer as considered by carrier in determination of premiums; Claims experience, health status, and duration of coverage are not case characteristics §627.4106(2)a
Rating Restrictions	Index rate for one class of business may not exceed the index rate for any other class of business by more than 20%; for a class of business, the premium rates charged small employers with similar benefit plans shall not vary from the index rate by more than 35%, with an additional combined variation of no more than 10% for gender and geography, and the actuarially justified adjustment for age and family composition, provided that the carrier file age and family composition tables with the Commissioner §7205(1,2)	Index rate for one class of business may not exceed the index rate for any other class of business by more than 20%; for a class of business, the premium rates charged small employers with similar case characteristics shall not vary from the index rate by more than 25% §627.4106(5)1,3
Transitional Period	For plans delivered or issued for delivery prior to the effective date of this chapter, a premium rate may have a one-year transition period §7205(7)	5 years §627.4106(9)
Renewal Rating	Trend plus 15% plus changes in case characteristics §7205(3)6	Trend plus 15% plus changes in case characteristics §627.4106(5)b
Renewability	Guaranteed renewable except "for cause" §7206	Guaranteed renewable except "for cause" §627.4106(6)
Whole Groups	Carriers must offer coverage to all eligible employees and dependents §7207(e)	Carriers must offer coverage to all eligible employees and dependents §627.6699(5)a(7)
Continuity of Coverage	Preexisting condition limitation of 12 months; credit shall be given if a person was covered under qualifying previous coverage if previous coverage was continuous 60 days prior to the new coverage, exclusive of applicable waiting periods §7207(c)	Preexisting condition limitation of 12 months; credit shall be given if a person was covered under qualifying previous coverage if previous coverage was continuous 30 days prior to the new coverage, exclusive of applicable waiting periods §627.6699(5)a(1)(2)
Reinsurance type	Prospective/with an opt-out §7210	Prospective/with an opt-out §627.6699(8)
Reinsurance Price	Whole Group: 150% Individual: 500% §7210(f)4	Whole Group: 150% Individual: 500% §627.6699(8)h(1)a,b
Cost Sharing	\$5,000 plus 10% of the next \$50,000 §7210(L)2b, (L)3a	\$5000 per year plus 10% of incurred claims during a calendar year §627.6699(8)9(4)
Assessments	Formula to be set by Board but must be 50% - 150% of carrier's proportional share of all reinsuring carriers' small employer premiums; maximum amount shall be 5% of total premiums earned in previous year from small employer plans §7210(L)2(b), (L)3a	1st tier: an amount not to exceed 5% of small employer premiums; 2nd tier, if necessary: an amount not to exceed .5% of premiums collected on all health benefit plans issued by small and large group carriers §627.6699(8)J(2)
Other	Allows reinsurance of existing business §7210(f)3	Carriers paying 2nd tier assessments will receive a credit for assessments paid to the Florida Risk Pool §627.6699(8)J(2)b
Effective Date	January 4, 1993	October 1, 1992 (rating & renewability provisions 10/1/91)

	HAWAII	IOWA
Availability	State run, employment based program; all residents are eligible	Guaranteed issue §513B
Group Size	No provision	1-25; however, must have at least 3 participating employees at the date of issue of health benefit plan §513B.3(12)
Individual Policies	No provision	Does not apply to individual policies which are subject to policy form and premium rate approval §513B.3
Case Characteristics	No provision	Case characteristics include age, industry classification, geographic area, family composition, and group size; gender may be used provided the insurance division has conducted an independent, actuarial study that determined use of gender to be actuarially justified; other case characteristics shall not be used without prior approval of commissioner §513B.2(4)
Rating Restrictions	No provision	Index rate for one class of business shall not exceed the index rate for any other class of business by more than 20%; for a class of business, the premium rates charged small employers with similar case characteristics shall not vary from the index rate by more than 25% §513B.4
Transitional Period	No provision	3 years §513B.4
Renewal Rating	No provision	Trend plus 15% plus changes in case characteristics §513B.4
Renewability	No provision	Guaranteed renewable except "for cause" §513B.5
Whole Groups	No provision	Must offer to whole group, except as permitted with regard to late enrollees §513B.7A(3)
Continuity of Coverage	No provision	Preexisting condition limitation of 12 months; credit shall be given if a person was covered under qualifying previous coverage if previous coverage was continuous 30 days prior to the new coverage, exclusive of applicable waiting periods §513B.7A(3)3
Reinsurance Type	No provision	Prospective/with an opt-out §513b.7(D)
Reinsurance Price	No provision	Whole Group: 150% Individual: 300% §513B.7(D)9(b)
Cost Sharing	No provision	\$5,000 and 10% of the next \$50,000 of incurred claims during a calendar year; liability maximum of \$10,00 in any one calendar year with respect to any reinsured individual §513B.7(D)8(D)
Assessments	No provision	Formula to be set by Board but must be 50% - 150% of carrier's proportional share of all reinsuring carriers' small employer premium; amount shall be 5% of total premiums earned in previous year from small employer plans §513B.7(D)11(2)
Other	Employees required to pay 1.5% of wages, or half the premium whichever is less; employers provide the balance for each employee working more than 20 hours per week; dependent coverage is optional; unemployed residents above poverty level pay a small fee for doctor visits and a portion of the premium with the remainder being funded by the State; poor are covered by Medicaid	
Effective Date		July 1, 1992

	KANSAS	MAINE
Availability	Guaranteed issue (group size: 3-25) (1992 SB 561) §4(b), 12(a)	Guaranteed issue (1992 HP 507) §2808-B 4(A)
Group Size	1-25 §3(2)	1-24 §2808-B 1(D)
Individual Policies	Individual policies issued to individuals and dependents totally independent of any group, association, or trust arrangement shall not be subject to this Act §4(e), 4(a)3(e)	No provision §2808-B(7)
Case Characteristics	Case characteristics include the geographic area, age and sex, industry classification, number of employees and dependents, family composition, and other objective criteria as may be approved by the commissioner; claims experience, health status, and duration of coverage are not case characteristics §3(g)	A carrier may not vary the premium due to the health status, claims experience or policy duration of the eligible group; age, gender, industry, and geography within the bands; family status, smoking status, participation in wellness programs, and group size may be used outside rate bands §2808-B 2(B)
Rating Restrictions	Index rate for one class of business shall not exceed the index rate for any other class of business by more than 20%; for a class of business, the premium rates charged small employers with similar case characteristics shall not vary from the index rate by more than 25% §7(1)(2)	Premium rates for age, gender, industry, and geographic area may not vary by +/- 50% of the community rate until 7/14/94, +/- 33% of the community rate until 7/14/95, +/- 20% of the community rate until 7/14/96, +/- 10% of the community rate until 7/14/97, and 0% of the community rate by 7/14/97; restrictions are repealed 7/14/94 unless continued or modified §2808-B 2(D)
Transitional Period	3 years §7(6)	None
Renewal Rating	Trend plus 15% plus changes in case characteristics §7(3)(b)	No provision
Renewability	Guaranteed renewable except "for cause" §5(c)	Guaranteed renewable except "for cause" §2808-B (4)B
Whole Groups	Prohibits carrier from excluding any employee or dependent on the basis of an actual or expected health condition §5(c)6(e)	(1990 - applies to all groups) Prohibits carriers from excluding any person from group; all new eligible employees must be added; may reject group until guaranteed issue is effective §2829-B
Continuity of Coverage	Preexisting condition limitations of 12 months and waiting periods not to exceed one year; waiting periods may be waived if individual was covered by a group policy prior to the effective date of coverage with no gap in coverage §5(a)(b)	(1990 - applies to all groups) Requires continuity for any person eligible for coverage in prior 3 months in a group replacement situation or for person moving from individual to group or group-to-group coverage; limit on 10% on premium rate increases for preexisting conditions during first 12 months of employment; preexisting condition limitations of 6 months for individual policies, except up to 24 months for any condition that as of the effective date of coverage requires ongoing medical treatment (H 1641) §2849-2(B)B,6 §2850(2)
Reinsurance Type	Prospective/with an opt-out §11(a)	Requires the Bureau of Insurance to report to the Banking and Insurance Committee on or before January 1, 1993, on reinsurance models with opt-out §5
Reinsurance Price	To be established by the reinsurance board §13(g)6	No provision
Cost Sharing	\$10,000 plus 10% of the next \$50,000; maximum in one calendar year shall not exceed 20% of total premiums §11(h)6(f)	No provision
Assessments	Not to exceed 5% of small employer plan premiums; second tier not to exceed 1% of total premium upon which assessment is based §11(k)2(c)	No provision
Other	Must reinsure the entire group; all carriers, whether reinsuring or not, subject to second tier assessment §11(k)2(b)	Marketing standards; superintendent will develop standardized plan §2808-B (5)
Effective Date	July 1, 1992	July 15, 1993 (for rating and guaranteed issue)

	MASSACHUSETTS	MINNESOTA
Availability	Guaranteed issue; however, until December 31, 1994, a carrier can limit the guaranteed issue requirement to 90 consecutive days a year; certain association groups are exempted from all but the reinsurance portion of the bill (1991 HB 6307) §2(b), 4(a)	Guaranteed issue of all products sold in small employer market (1992 HB 2400, SB 2603) §3 subd. 1, 4 subd. 1
Group Size	1-25 §1	2-29 §subd. 26
Individual Policies	Does not apply to individual policies §2(a)	All provisions except guaranteed issue apply to individual policies §12 subd. 1, 2, 6 subd. 27(f)(i)
Case Characteristics	Age, sex, rate basis type, industry, number of eligible persons, and participation rate of a group §1	Relevant characteristics of small employer as determined by carrier in determination of premiums; claims experience, health status, industry, duration of coverage, and gender are not case characteristics §2 subd. 6, 3 subd. 6
Rating Restrictions	Premium rates are limited to a 2-1 rate band; however, the following adjustments are permitted outside that band: benefit level, geography +/- 20%, group size +/- 5%, wellness discount -5%, phase out adjustment for experience and duration rating on existing business to reach +/- 15% by 12/31/94, age +/- 33% until 12/31/93 §3(a)1, 3(a)3(4), 3(a)7	Rates must not vary by more than +/- 25% of the index rate for same or similar coverage; inside the rating band, variations can be based only on health status (includes refraining from tobacco use or other actuarially valid lifestyle factors), claims experience, industry, and length of time employer has been covered; adjustments outside the band: age +/- 50%, geography +/- 20%, rate cells are permitted based on number of adults and children covered under the policy §8 subd. 2, 3, 4, 5, 6
Transitional Period	Phase out of rating restrictions §3(a)8	None
Renewal Rating	Trend plus 10% plus changes in case characteristics §3(b)	No provision
Renewability	Guaranteed renewable except "for cause" §4(b)(1)(2)	Guaranteed renewable except "for cause" §3 subd. 5
Whole Groups	Prohibits policies from excluding eligible employees or eligible dependents on the basis of an actual or expected health condition of such person §5(a)	Application must include all eligible employees §4 subd. 1
Continuity of Coverage	Preexisting condition exclusion of 6 months; credit shall be given if a person was covered under qualifying previous coverage if previous coverage was continuous 30 days prior to the new coverage and if previous coverage was reasonably actuarially equivalent to new coverage §5(b)	Preexisting condition exclusion of 12 months; requires credit for time covered under qualifying prior coverage; permits 18 month preexisting condition limitation for late entrants §3 subd. 4
Reinsurance Type	Prospective/mandatory, for commercials §8	prospective/with an opt-out §13, 18(1)
Reinsurance Price	Whole Groups: 150% Individuals: 500% §8(1)(2)	Whole Groups: 150% Individuals: 500% §21(1)
Cost Sharing	\$5,000 §8	\$5,000, plus 10% of the next \$50,000 §20(1)
Assessments	5% of small employer premiums; if inadequate, other funding sources will be recommended §8(7)	Initially, \$100; in addition, not to exceed 4% of the member's small group market premium (if it is determined that premium charges are insufficient to cover the losses) §22(2)(3)
Other		Loss ratios: Initially 65% for individual policies, 75% for group policies; increases by 1% per year to 70% and 80%, respectively §8(1)
Effective Date	April 1, 1992	Most provisions July 1, 1993

	MISSOURI	NEW HAMPSHIRE
Availability	Guaranteed issue (1992 SB 796) §6	No provision (1992 HB 321)
Group Size	3-25 §1(28)	2-50 §420-F:1(XI)
Individual Policies	No provision §2(1)(2)(3), 3	Does not apply to individual health policies which are subject to policy form and premium rate approval §420-F:2(II)
Case Characteristics	Relevant demographics of small employer as considered by carrier in determination of premiums; claims experience, health status, and duration of coverage are not case characteristics §1(9), 4(10)	Relevant demographics of small employer as considered by carrier in determination of premiums; claims experience, health status, and duration of coverage are not case characteristics §420-F:1(IV)
Rating Restrictions	Index rate for one class of business shall not exceed the index rate for any other class of business by more than 20%; for a class of business, the premium rates charged small employers with similar case characteristics shall not vary from the index rate by more than 25% §4(1)(2)	Rates charged during a rating period to small employers with similar case characteristics for same or similar coverage shall not vary from the index rate by more than 30% §420-F:3(Ta)
Transitional Period	1 year §4(3)b	5 years §420-F:3(T)(3)c
Renewal Rating	Trend plus 15% plus changes in case characteristics §4(3)b	Trend plus 15% plus changes in case characteristics §420-F:3(T)2
Renewability	Guaranteed renewable except "for cause" §5	Guaranteed renewable except "for cause" §420-F:4
Whole Groups	Insurer must cover the whole group §6(5)a	Insurer must cover the whole group §420-F:4
Continuity of Coverage	Preexisting condition limitation of 12 months; credit shall be given if a person was covered under qualifying previous coverage if previous coverage was continuous 30 days prior to the new coverage, exclusive of applicable waiting periods §6(2)(2)	Preexisting condition limitations consistent with insurance department rules
Reinsurance Type	Prospective/mandatory with an opt-out after three years §7(1)	No provision
Reinsurance Price	Whole Group: 150% §7(9)2	No provision
Cost Sharing	\$5,000 plus 10% of the remaining incurred claims; maximum limit of \$25,000 §7(8)3	No provision
Assessments	Formula to be set by Board but must be 50% - 150% of carrier's proportional share of all reinsuring carriers' small employer premiums; maximum amount shall be 5% of total premiums earned in previous year from small employer plans §11(2)b, 11(3)c	No provision
Other		
Effective Date	Guaranteed issue and continuity of coverage provision effective July 1, 1994; all other sections effective July 1, 1993	January 1, 1993

NEW JERSEY	
Availability	Continuous open enrollment (guaranteed issue) §3b
Group Size	2-49 §1
Individual Policies	Applies to all health benefit plans covering eligible employees of one or more small employers §2
Case Characteristics	Prohibits the use of age, sex, health status, residence or occupation with community rating. §1
Rating Restrictions	Rates may not exceed 4 times the base premium rate charged to the lowest-rated group. Plans must be community rated by 1/1/97. 1/1/94 to 12/31/95, premium rates charged to highest rated group shall not be greater than 300% of rate charged to lowest rated group. 1/1/96 to 12/31/96 greater than 200%. §9
Transitional Period	Policies whose term extends beyond 12/31/93. Policies contracted on or after 1/1/94. §9(h)(i)
Renewal Rating	Beginning 1/1/95 may make informational filing with commissioner of increase or decrease provided the loss ratio not be less than 75% of the premium. §9g
Renewability	Guaranteed renewable except "for cause" §7
Whole Groups	Must offer coverage to all employees and their dependents. Cannot exclude based on actual or expected health condition. §2
Continuity of Coverage	Generally no preexisting condition limitation. Pre-ex may apply to a group of 2-5 if the period is 180 days forward and 6 months back, however, if 10 or more late enrollees request coverage pre-ex does not apply. Credit shall be given if a person was covered under qualifying previous coverage if previous coverage was continuous 30 days prior to the new coverage, exclusive of applicable waiting periods. §6
Reinsurance Type	Prospective §12
Reinsurance Price	Whole Group: 150% Individual: 500% §20
Cost Sharing	Receive reimbursement in accordance with standards developed by board. §19a
Assessments	Apportioned among all reinsuring members in proportion to their respective shares of the premiums earned from small group plans. Additional assessments of all members not to exceed 1% of premiums. §21e
Other	No pre-ex permitted - see continuity of coverage. Some earning-paying 2nd tier assessments will receive a credit. §21c
Effective Date	

	NEW YORK	NORTH CAROLINA
Availability	Continuous open enrollment (guaranteed issue) (1992 A 12350-A) §3231	Guaranteed issue §58-50-125(d)
Group Size	5-50 for open enrollment §3231	3-25 §58-50-110(22)
Individual Policies	Must be community rated and must be offered through open enrollment §3231	Does not apply to individual health policies §58-50-115
Case Characteristics	Prohibits the use of age, sex, health status, or occupations; geography is permitted on a county-wide (or larger) basis; Since not prohibited, presumably group size, participation, wellness, and other case characteristics are permitted §3231(a,b)	Relevant demographics of small employer as considered by carrier in determination of premiums; claims experience, health status, and duration of coverage are not case characteristics §58-50-110(6)
Rating Restrictions	No statutory restrictions on permitted case characteristics, but Department has rate approval authority for initial rates §3231(c)(c)	Index rate for one class of business shall not exceed the index rate for any other class of business by more than 25%; for a class of business, the premium rates charged small employers with similar case characteristics shall not vary from this index rate by more than 35% §58-50-130(b)1,2
Transitional Period	The one-year delay in effective date is viewed as the transition period	3 years §58-50-130(b)7
Renewal Rating	Prior rating approval; beginning April 1, 1994, rates shall be deemed approved if policy has an anticipated loss ratio of not less than 75% §3231(a), 3231(2)a	Trend plus 15% plus changes in case characteristics §58-50-130(b)5(b)
Renewability	Coverage may not be terminated due to claims experience §3231	Guaranteed renewable except "for cause" §58-50-130a(3)
Whole Groups	Carriers must offer coverage to all employees and their dependents §3231	No provision
Continuity of Coverage	Plans must credit the time a person was covered under previous health insurance plan or benefit arrangement if the previous coverage was continuous to a date not more than 60 days prior to the effective date of new coverage §3232(a), 4318(a)	Preexisting condition limitation of 12 months; credit shall be given if a person was covered under qualifying previous coverage if previous coverage was continuous 30 days prior to the new coverage, exclusive of applicable waiting periods §58-50-130
Reinsurance Type	Regulations shall include reinsurance or pooling process designed to share the risk of high claims costs; cost variations based on demographic factors and possible adverse selection §3233(c)	Prospective/with an opt-out §58-50-150
Reinsurance Price	No provision	Whole Group: 130% Individual: 500% §58-50-150(g)2(g)
Cost Sharing	No provision	\$5,000 plus 10% of the next \$50,000 §58-50-150(e)2(c)
Assessments	No provision	First 3 years: 50% - 150% of amount it would have been had assessments been based on proportional relationship of small carrier's total premiums; not to exceed 4% §58-50-150(i)
Other	1 and 2 live employers must be classified in either the individuals or small groups rating category by the insurer §3231(b)	
Effective Date	Community rating and open enrollment take effect April 1, 1993; continuity of coverage takes effect January 1, 1993 §21	January 1, 1992

OHIO	
Availability	Modified open enrollment. Carriers must open enroll 1/2 of 1% of total block of business.
Group Size	2-50 §3923.58
Individual Policies	Subject to law if any portion of the premium or benefits is paid by the employer, or any individual is reimbursed for any portion of the premium. §3924.02(A)
Case Characteristics	Geography, age, sex and industry classification. Does not include claims experience, health status or duration of coverage. §3924.01(B)
Rating Restrictions	Premium rates for small employer plans with similar case characteristics may not vary from the midpoint rate for those small employers by more than 35% of that midpoint rate. §3924.04
Transitional Period	Rates that exceed rate band may not use experience.
Renewal Rating	Trend plus 15% changes in case characteristics. §3924.04(C)
Renewability	Guaranteed renewable except "for cause." §3924.03(C)
Whole Groups	Cannot exclude eligible employees or dependents on the basis of an actual or expected health condition. §3924.03(F)
Continuity of Coverage	Preexisting condition limitation of 12 months relating to conditions 6 months before coverage. Waiting periods shall not be more than 90 days. Plans shall credit the time a person was covered under a previous health plan for 30 days prior to the effective date of the new coverage, exclusive of any applicable waiting period. Late enrollees may be excluded up to 24 months. §3924.03 (A)(B)
Reinsurance Type	§3924.07
Reinsurance Price	Whole Group: 150% Individual: 500% §3924.12(A)
Cost Sharing	
Assessments	Apportioned among all members in proportion to their respective shares of the total premiums earned from small group plans. Assessment will not exceed 1%. §3924.13(B)
Other	
Effective Date	

	OREGON	RHODE ISLAND
Availability	Guaranteed issue (1991 SB 1076) §6(4)	Guaranteed issue (groups of 3-25) (1992 H 9011 Sub. A) §27-49-8(A)
Group Size	3-25 §3(25)	1-50 §27-49-4(AA)
Individual Policies	Applies to individual policies providing health benefits covering one or more employees of a small employer; provisions of OR 742.005 do not apply to individual policies subject to this law §5(1)(2)	Does not apply to individual health policies. §27-49-4
Case Characteristics	Geography and differences in family size and composition §7(6)b	Relevant demographics of small employer as considered by carrier in determination of premiums; claims experience, health status, and duration of coverage are not case characteristics §27-49-3(F)
Rating Restrictions	Premium rates may not vary from the geographic average rate by more than 33% except that the premium rate may be adjusted to reflect the provision of additional benefits not covered by the basic health care plan and differences in family size and composition §7(6)b	Index rate for one class of business shall not exceed the index rate for any other class of business by more than 20%; for a class of business, the premium rates charged small employers with similar case characteristics shall not vary from the index rate by more than 25% §27-49-6(1,2)
Transitional Period	Effective on the date the reinsurance pool becomes operational §7(10)a	3 years §27-49-6(7)
Renewal Rating	Trend plus 15% plus adjustments to reflect provision of benefits not required to be covered by basic health care plan §7(6)c(B)	Trend plus 15% plus changes in case characteristics §27-49-6(3)b
Renewability	Guaranteed renewable except "for cause" §7(4)	Guaranteed renewable except "for cause" §27-49-7
Whole Groups	Prohibits carriers from excluding individuals on the basis of actual or expected health condition §7(3)	Carriers are required to take the whole group §27-49-8c(5a)
Continuity of Coverage	Preexisting condition limitation of 6 months; credit shall be given if the person was covered under a previous group or individual plan if the previous coverage was continuous 30 days prior to the new coverage, exclusive of applicable waiting periods §7(1)(2)	Plans must credit the time a person was covered by qualified previous coverage provided the coverage was continuous; qualified previous coverage is defined as Medicare, Medicaid, employer-based health insurance, or individual insurance providing similar or exceeding benefits. §27-49-8(e)
Reinsurance Type	Prospective/with an opt-out §10,11	Prospective/with an opt-out §27-49-11
Reinsurance Price	Existing business: none Whole Group: 150% Individual: 300% §11(8)a,b	Whole Group: 150% Individual: 500% §27-49-11(9)(2)
Cost Sharing	\$5,000 plus 15% of the next \$100,000 §11(7)d	First \$5,000 of reinsured claims §27-49-11(9)(4A)
Assessments	Maximum assessment is 4% of small employer premium plus 1% of members' total health insurance premiums §11(12)a	5% of total premiums earned in small employer market §27-49-11(L)(3)c
Other		Standard and economy health benefit plans are included within the law and are based on Rhode Island's low-cost limited mandated benefit law. Copayment, deductibles, and coinsurance are outlined. §27-49-12
Effective Date	On or after the date the Oregon Small Employer Reinsurance Pool becomes operational	July 21, 1992

SOUTH CAROLINA	
Availability	No provision
Group Size	1-25 §38-71-920(1)
Individual Policies	Does not apply to individual health policies subject to policy form and premium rate approval §38-71-930(A,B)
Case Characteristics	Relevant demographics of small employer as considered by carrier in determination of premiums; claims experience, health status, and duration of coverage are not case characteristics §38-71-920(3)
Rating Restrictions	Index rate for one class of business shall not exceed the index rate for any other class of business by more than 20%; for a class of business, the premium rates charged small employers with similar case characteristics shall not vary from the index rate by more than 25% §38-71-940
Transitional Period	5 years §38-71-940(A)4
Renewal Rating	Trend plus 15% plus changes in case characteristics §38-71-940(A)3(B)
Renewability	Guaranteed renewable except "for cause" §38-71-950
Whole Groups	Prohibits carriers from excluding any individual from the group; however, in groups of 10 or less, evidence of individual insurability may be required §38-1-730(3)
Continuity of Coverage	Preexisting condition limitations of 12 months; credit shall be given for time served under a prior plan if the coverage is selected when the person first becomes eligible and the coverage is continuous; service waiting periods are not considered to interrupt continuous service §38-71-730(4)
Reinsurance Type	No provision
Reinsurance Price	No provision
Cost Sharing	No provision
Assessments	No provision
Other	
Effective Date	January 1, 1992

	TENNESSEE	VERMONT
Availability	Guaranteed issue (1992 SB 2578) §8(E)	Guaranteed issue §4080a(4)d(1)
Group Size	3-25 §3(24)	1-49 §4080a(1)
Individual Policies	Does not apply to individual policies §6(a,b)	May not offer a health benefit plan or insurance policy to individual employees or members of a small group as a means of circumventing the act §4080a(4)h(3)m
Case Characteristics	Relevant demographics of small employer as considered by carrier in determination of premiums; claims experience, health status, and duration of coverage are not case characteristics §3(6)	The following risk classification factors are prohibited: demographic rating, including age and gender, geographic area rating, industry rating, medical underwriting and screening, experience rating, tier rating, or durational rating; Commissioner may by rule permit carriers to use one or more risk classifications §4080a(h)l
Rating Restrictions	Index rate for one class of business shall not exceed the index rate for any other class of business by more than 25%; for a class of business, the premium rates charged small employers with similar case characteristics shall not vary from the index rate by more than 35% §9(b)	Premiums may not deviate by more than +/- 20% of the community rate filed by the small employer carrier §4080a(h)2
Transitional Period	3 years §9(b)7	In force business will not be subject to the provisions of the Act until the later of the date of renewal, anniversary, or July 1, 1992 §5112(5)b
Renewal Rating	Trend plus 15% plus change in case characteristics 9(b)3(B)	No provision
Renewability	Guaranteed renewable except "for cause" §9(3)	Must guarantee rates for six months; must guarantee acceptance §4080a(k)
Whole Groups	No provision	Carrier must take entire group §4080a(a)4(d)
Continuity of Coverage	Preexisting condition limitation of 12 months; plans shall credit the time person was covered under a previous group health benefit plan if previous coverage was continuous 30 days prior to the new coverage §9(1,2)	Preexisting condition limitation of 12 months; limitation shall be waived if there is evidence of substantially equivalent continuous coverage during previous 9 months §4080a(g)
Reinsurance Type	Prospective/with an opt-out §13(s)	Prospective/mandatory for commercials; participants must guarantee solvency w/out limitation on a pro-rata basis §4080a(u)
Reinsurance Price	Whole Group: 150% Individual: 500% §13(g)2(c)	No provision
Cost Sharing	\$5,000 plus 10% of the next \$50,000 §13(g)2(e)	No provision
Assessment	Capped at 5% of small employer premiums; formula to be set by board but may be 50% to 150% of carrier's proportional share of all reinsuring carriers' small employer premiums §13(h)2,4	No provision
Other	Guaranteed issue requirement suspended if assessment cap is reached §13(b)4	Participation requirement = 75% of employees; most provisions do not apply to registered carriers who on 1/1/91 and thereafter have written or collected less than \$100,000 in annual gross premiums for group health benefit plans §4080a(1)h(3)l
Effective Date	July 1, 1992; January 1, 1993 for preexisting condition and guaranteed renewable provisions	July 1, 1992

	VIRGINIA	WISCONSIN
Availability	Guaranteed issue. * §38.2-3431(D) (*1993 HB 2353 amendments awaiting Governor's signature)	Guaranteed issue (1992 A 655) §635.26
Group Size	2-23 for primary small group, 2-50 for small group §38.2-3431(B)	2-25 §635.20(12)a
Individual Policies	Subject if any portion of the premiums or benefits is paid by the employer, if the employee is reimbursed or if the plan is treated as part of a program for the purpose of the US Internal Revenue Code. §38.2-3431(A)	Applies to individual policies §635.02(B)
Case Characteristics	Based on a community rate subject to demographic rating including age, gender and geography. May not use claim experience, health status or duration. *	Relevant demographics of small employer as considered by carrier in determination of premiums; claims experience, health status, and duration of coverage are not case characteristics §6305.05(2)(3), 635.18(4)
Rating Restrictions	Premium rates charged by a small employer may deviate above or below the community rate by no more than 20% for claim experience, health status and duration only during a rating period for such groups within similar demographics for the same or similar coverage. Rating factors, including case characteristics will be applied consistently with respect to all primary small employers in similar demographics. Adjustments in rates for claim experience, health status and duration from issue may not be applied individually. *	Premium rates for small employer plans with similar case characteristics may not vary from the midpoint rate for those small employers by more than 35% of that midpoint rate §635.05(1)
Transitional Period	No provision	3 years
Renewal Rating	No provision	Trend plus 15% plus changes in case characteristics §635.05(2)2
Renewability	Guaranteed renewable except "for cause" §38.2-3432(P)	Guaranteed renewable except "for cause" §635.07
Whole Groups	Prohibits carriers from excluding individuals because of health status §38.2-3432(1)(3)	Insurer must offer coverage to the entire group §635.25(2)
Continuity of Coverage	Preexisting condition limitation of 12 months; time shall be credited to a person covered under previous individual or group coverage in the small employer market of equal or greater value if coverage was continuous 30 days prior to new coverage, exclusive of applicable waiting periods. Late enrollees may be excluded for 18 months. §38.2-3432(1)(3)	Preexisting condition limitation of 12 months; credit shall be given to individuals who were previously covered by qualifying coverage if the coverage was continuous 30 days prior to the new coverage, exclusive of applicable waiting periods §635.17
Reinsurance Type	No provision	Reinsurance type and assessments shall be studied by the Health Insurance Board §635.23
Reinsurance Price	No provision	No provision
Cost Sharing	No provision	No provision
Assessments	No provision	No provision
Other		
Effective Date	April 1, 1994	Day after publication

WYOMING	
Availability	Guaranteed issue §26-19-306
Group Size	2-25 §26-19-302(xvii)
Individual Policies	Does not apply to individual policies which are subject to approval for policy form §26-19-303
Case Characteristics	Relevant demographics of small employer as considered by carrier in determination of premiums; claims experience, health status, and duration of coverage are not case characteristics §26-19-302(v)
Rating Restrictions	Index rate for one class of business shall not exceed the index rate for any other class of business by more than 20%; for a class of business, the premium rates charged small employers with similar case characteristics shall not vary from the index rate by more than 25% §26-19-304
Transitional Period	3 years §26-19-304(e)viii
Renewal Rating	Trend plus 15% plus changes in case characteristics §26-19-304(e)iii(B)
Renewability	Guaranteed renewable except "for cause" §26-19-305
Whole Groups	Insurers are required to offer coverage to the entire group §26-19-306(c)vi
Continuity of Coverage	Preexisting condition limitation of 12 months; credit shall be given for time person was previously covered if previous coverage was continuous 30 days prior to new coverage, exclusive of applicable waiting periods, or for a person who becomes unemployed and are provided coverage if the person obtains employment and coverage within 60 days §26-19-306(c)i
Reinsurance Type	Prospective/mandatory §26-19-307
Reinsurance Price	Whole Group: 150% Individual: 500% §26-19-307(k).ii
Con Sharing	\$5,000 §26-19-307(l)x.v
Assessments	Not to exceed 5% of the total small group premiums §26-19-307(n)A
Other	
Effective Date	No earlier than March 31, 1993

COMPREHENSIVE SMALL EMPLOYER PACKAGES

	HIAA	NAIC
Availability	Guaranteed issue	Guaranteed issue (groups of 3-25)
Group Size	3-25	1-25
Individual Policies	Individual policies sold to small employer subject to Act; however, if state has effective rate regulation, the rating requirements do not apply	Does apply to individual policies; although drafting note says that states may wish to consider exempting individual health policies from the rating provisions
Case Characteristics	Geography, age, sex, size of employer, and other objective criteria; but does not include claims experience, health status, or duration of coverage	Small employer carriers may not use case characteristics other than age, gender, industry, geographic area, family composition, and group size without prior approval of Commissioner
Rating Restrictions	Premium rates for small employer plans with similar case characteristics may not vary from the midpoint rate for those small employers by more than 35% of that midpoint rate	Index rate for one class of business may not exceed the index rate for any other class of business by more than 20%; for a class of business, the premium rates charged small employers with similar case characteristics shall not vary from the index rate by more than 25%
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	Carriers must take the entire group	Carriers must take the entire group
Continuity of Coverage	Plans must credit the time a person was covered under a previous employer-based plan if coverage was continuous.	Plans must credit the time a person was covered by qualified previous coverage provided the coverage was continuous; qualified previous coverage is defined as Medicare, Medicaid, employer-based health insurance, or individual insurance providing similar or exceeding benefits
Reinsurance Type	Prospective/mandatory	Individual states will determine whether to make participation in reinsurance mandatory or voluntary
Reinsurance Price	Whole Group: 150% Individual: 300%	Whole Group: 150% Individual: 500%
Cost Sharing	None	First \$5000 of reinsured claims plus 10% of next \$50,000
Assessments	4% of the premium of small employer market net of reinsurance premiums paid	5% of the premium of the small employer market
Other	Carriers may reinsure existing business and new adds	
Effective Date		

HIAA

ON

HEALTH CARE

FINANCING

FOR ALL

AMERICANS

HOW REINSURANCE WORKS

For more than two years, the Health Insurance Association of America (HIAA) has been developing the components of a reform package designed to address the unique requirements of the small employer market. These reforms, when taken as a whole, will ensure fair access to and continuation of coverage for small employers and their employees. These reforms constitute a meaningful basis for enhancing and expanding health care coverage.

Small employers, unlike their larger counterparts, are likely to go into and out of business frequently. Similarly, their employees tend to move from job to job frequently. Finally, small employers change insurance carriers more often in an attempt to obtain more favorable rates. All of these factors, combined with growing health care cost pressures, make it exceedingly difficult for insurance carriers to provide coverage to the small employer and they also make it more likely that individuals within this market will lose health care coverage at some point. HIAA's small employer market reforms tackle these problems in a reasonable and workable manner.

The HIAA proposal would ensure that any small employer may obtain coverage (regardless of the health condition of its employees or the inherent administrative burdens they pose). The following examples illustrate how this would work.

SITUATION: Tom's Tree Trimmers opens for business with a full-time work force of five employees. With workers engaged in dangerous work, where statistics suggest that personal injury is far more likely to occur than in, say, a computer sales and repair outlet, obtaining affordable health insurance may be difficult. Let us suppose that two employees, Harry and Sam, have serious health problems, which insurance companies term **pre-existing conditions**. To obtain coverage, the president of Tom's Tree Trimmers could face the following options: terminate Harry's and Sam's employment, insure everyone except Harry and Sam, or provide no insurance for any of the employees.

SOLUTION: Under the HIAA reform proposal, Tom's Tree Trimmers would not be excluded from coverage because it is engaged in dangerous work or because two of its employees, Harry and Sam, have pre-existing conditions. Also, the carrier selling insurance to the company would be permitted to reinsure Harry and Sam, the high risk employees (unbeknownst to Harry, Sam, and their employer), by paying a reinsurance premium. In exchange for the reinsurance premium, the reinsurer would agree to reimburse the insurer for Harry's and Sam's costs.

SITUATION: During the course of the year a third employee at Tom's Tree Trimmers, George, becomes seriously ill. Will his condition threaten coverage for himself or his coworkers?

Health Insurance Association of America

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

SOLUTION: Under HIAA's reform proposal, insurance coverage would be maintained for all employees, regardless of any of the employees' conditions. Tom's Tree Trimmers' insurance carrier would be obligated to renew the contract (unless the company failed to pay its premiums in a timely fashion or was dishonest with the carrier).

SITUATION: George, who has had several months of poor health, is on the road to recovery. He decides to leave Tom's Tree Trimmers to gain experience at a small computer sales and repair outlet, the Corner Computer Company. He is concerned that he will not be able to obtain coverage with his new employer because of his health record with Tom's Tree Trimmers. He is aware that, prior to the reforms in the small employer market, employees who changed jobs or employers that changed carriers could face recurring pre-existing condition limitations. George realizes that this could leave him without health care coverage.

SOLUTION: Under the HIAA proposal, George would be guaranteed continuity of coverage and would not be subject to any new pre-existing condition limitations if he changes jobs or his employer switches carriers, since he satisfied those while employed by Tom's Tree Trimmers (this assumes that George did not allow his coverage to lapse for a sustained period of time).

SITUATION: Both Tom's Tree Trimmers and the Corner Computer Company are concerned that their health premiums will rise inordinately if one or more employees is found to be seriously ill.

SOLUTION: Under the HIAA proposal, an insurance carrier would have to limit how much its rates, based upon the group's health history, varied. Carriers could vary their rates for similar small employer groups (those with similar demographics, plan type, and geographic area) by no more than 35 percent above or below their midpoint rate (the midpoint rate is halfway between the carriers lowest and highest rate). Carriers would also have to limit their industry rating adjustment to 15 percent. Finally, the year-to-year premium increase for a group could be no more than 15 percent above the carriers "trend" (defined as the increase in the lowest new business rate). To reflect cost differentials between managed care and non-managed care products, carriers could establish separate trends.

SITUATION: A new firm, Tree Doctors, Inc., opens for business in the same community as Tom's Tree Trimmers. Like its competitor, Tree Doctors employs five employees. At the time it opens for business, all of its employees are healthy. The president of Tree Doctors, Inc. knows that he is in stiff competition with Tom's Tree Trimmers. He is concerned that he may be at a competitive disadvantage if any of his costs are higher than those of Tom's Tree Trimmers. Since Tom's Tree Trimmers has been in business for some time, the owner of Tree Doctors, Inc. is concerned that he may not be able to purchase health insurance coverage at a rate that will be similar to the rates charged to his competitor.

SOLUTION: Under the HIAA proposal, the availability of reinsurance combined with the premium rate limits would moderate the premium difference between groups. The HIAA plan would ensure that Tree Doctors, Inc. did not incur inordinately high premiums relative to demographically similar firms.

HIAA

Health Insurance Association of America

STATEMENT OF HIAA

ON

SMALL GROUP MARKET REFORM

SENATE BILL 40

PRESENTED BY

JAN ANDREA MEISELS

LEGISLATIVE DIRECTOR

BEFORE THE

ALASKA SENATE COMMITTEE ON LABOR AND COMMERCE

March 23, 1993

22111 Clarendon Street, Suite 220
Woodland Hills, CA 91367-6321
818-704-9271

I am Jan Andrea Meisels, Legislative Director, Health Insurance Association of America. HIAA is a trade association of the nation's leading commercial insurance carriers that provide health insurance for approximately 95 million Americans. HIAA actively supports SB-40.

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.

Mr. Chairman 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. Thus far 24 other states have enacted small group market reform which includes similar reforms as reflected in SB-40. SB-40 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-40 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 40 ensures fair access to and continuity of coverage for small employers and their employees. The issues embraced in SB 40 are:

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; 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 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.

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-40 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-40 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.

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 maybe incorporated into the small employer health plans developed by the Small Employer Health Reinsurance Board. Small employers are also the affected party when various legislators 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-40 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-40:

Section 1. Purpose -- describes the purpose of the bill by summarizing the issues addressed in SB-40.

Section 2. Prohibits unfair marketing practices delineated in 21.56.180.

Section 3. Exempts small employer health plans from any laws that would impose restrictions on insurers negotiating with providers for services or prices of services.

Section 4. Exempts small employer health plans from any laws that would impose restrictions on insurers negotiating with providers to include specific benefits or services rendered by certain providers.

Section 5. Small Employer Health Reinsurance Association. 21.56.10 -- 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 multiple employer welfare arrangements (which is not Medicaid, but a "term of art" describing unrelated multiple employers joining together for purposes of providing benefits plans).

21.56.020 -- 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.

21.56.030 -- discusses the various powers of the Association board defining an array of health coverage products by which reinsurance will be provided and issued, as well as developing the methodology for determining the reinsured product premium rates.

21.56.040 -- 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 permits the Director of Insurance, after notice and hearing, to adopt reasonable regulations.

21.56.050 -- establishes specific provisions for reinsurance of eligible employees of a small employer or dependents of eligible employees. By requiring carriers to accept groups/individuals within groups with greater than normal risks, insurers need assistance in spreading the greater risk, therefore, the establishment of the Reinsurance Association. Carriers are required to pay the first \$5,000 of claims before reinsurance assumes the risk because reinsurance would be aimed at employer groups and employees known to be high risk, and because the premium price (paid by the insurer to the reinsurance mechanism) 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 five percent of premiums charged for health benefit plans covering small employers.

To assure that insurers only cede (place) 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.

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. 21.56.060 -- establishes the member health benefit plan committee (including insurers, small employers, health care providers and

agents or brokers. The committee recommends benefit levels, cost sharing provisions for the basic and standard plan. 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.

21.56.070 -- requires that every two years the board will report to the insurance director and legislature on effectiveness of the act.

21.56.080-21.56.100 -- exempts the Association from the Administrative Procedures Act, imposition of taxes and limits the liability of the Association board.

21.56.110 -- 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 2-25 eligible 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.

21.56.120 -- Premium Rating Requirements. This provision provides stability and predictability of rates.

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 from the carrier's index rate (arithmetic average of applicable base rate and highest 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.

Carriers are also required to disclose in its solicitation and sales material how the premium rates from specified small employers are establishing provisions of the plan and file an annual actuarial certification with the director.

21.56.130 -- Renewability of Coverage. Lists specified reasons why a health plan may not be renewed, i.e., nonpayment of premiums, fraud or misrepresentation by a small employer; noncompliance with minimum participation or employer contributions, etc. Specifies steps a carrier must take if the insurer decides to nonrenew all of its health benefit plans.

21.56.140 -- Required offer of Coverage. As a condition of doing business in the state with small employers, a small employer

insurer is required to offer a basic and a standard health benefit plan. The basic and standard plans are filed with the director who may disapprove them after a hearing.

21.56.150 -- Required Health Benefit Provisions. Benefit plans may not deny, exclude or limit benefits for more than 12 months due to a preexisting condition. This guarantees the availability of insurance to all small employers and removes the concerns 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. Carriers must offer coverage to all eligible employees and dependents and may not select only certain individuals.

21.56.160 -- Exemption From Required Offer of Coverage. Delineates when an insurer does not have to offer coverage, i.e. the small employer not located in carrier's geographic area; the carrier does not have capacity to deliver service adequately to members; the carrier is only maintaining in force business and ceased enrolling new employer groups before January 1, 1993.

21.56.170 -- 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.

21.56.180 -- Fair Marketing Standards. Specifies standards for insurers to follow including the requirement to affirmatively market basic and standard health plans, an insurer may not deny compensation to an agent/broker due to adverse health status, claims experience, etc. of small employers.

21.56.190 -- Mandatory Reissue of Coverage. In order that carriers not selectively "dump" their business before the effective date of the bill, the director may adopt regulations to require a carrier to reissue a health benefit plan to a small employer if it was nonrenewed after January 1, 1993.

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

Sections 6,7. 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. Sections 6 and 7 achieve this purpose.

Sections 8,9. 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 10. Premium Rate Restriction. This addresses premiums for policies that are delivered prior to the effective date of the bill, by allowing the premium rating restrictions to be phased in over three years, thereby limiting any potential "sticker shock" small employers may experience to the premium rate restrictions.

Section 11. 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, 1993 effective date.

Section 14. Lists the effective date of the chapter as July 1, 1993.

MAR 02 1993

ALASKA STATE

HOSPITAL & NURSING HOME

ASSOCIATION

Ken

March 1, 1993

Senator Tim Kelly
Chairman
Health, Education & Social
Services Committee
Alaska State Senate
State Capitol
Juneau, AK 99801

Re: Support SB 40; Health Insurance
Small Employers

Dear Senator Kelly:

ASHNHA, representing community hospitals and nursing homes across the state supports SB 40, providing for group health insurance for small employers.

The lack of availability and cost of health insurance for small employers are the major reasons many small Alaska businesses do not provide health insurance benefits to themselves or their employees.

We would urge the committee to move ahead in approving SB 40 as a positive step towards reforming Alaska's health care system.

Any health reform proposal can encompass what will be accomplished under SB 40.

Sincerely,

Harlan R. Knudson
Harlan R. Knudson
President/CEO

✓ cc: Senator Drue Pearce

NFIB Alaska

National Federation of
Independent Business

POSITION PAPER

OF

NATIONAL FEDERATION OF INDEPENDENT BUSINESS
NFIB/ALASKA

IN
SUPPORT
OF

SB 173 HEALTH INSURANCE FOR SMALL EMPLOYERS

9159 Skywood Lane
Juneau, AK 99801



The Guardian of
Small Business

Chairman, members of the Committee, my name is Rosa Jerrel, and I am the State Director for the National Federation of Independent Business - NFIB/Alaska. I am happy to be here today in support of SB 173.

BACKGROUND

NFIB/Alaska is comprised of 5,000 small and independent business owners. The legislative agenda of NFIB/Alaska is determined by our ballot. The ballot is our annual poll of our members on a series of issues deemed critical to small business. A majority vote, of the members in response to the poll, sets our policy and position on legislative issues.

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

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

Yes 72% No 17% Undecided 11%

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

Yes 50% No 19% Undecided 31%

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

Yes 90% No 5% Undecided 5%

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

On 1992 ballot we asked our members in Alaska to choose from eleven (11) problem areas - the most costly or burdensome problem they faced

and the top two were: #1 workers compensation cost and, #2 health insurance for employees.

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

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

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

SMALL BUSINESS MARKET REFORM

Small business owners desire to build on the existing health care system. SB 173 is a voluntary health insurance program to provide more accessibility, renewability, predictability and stability for small businesses. It is a viable means of providing health insurance to the uninsured population in Alaska.

State mandates cumulatively can raise the cost of health insurance for small businesses. SB 173 has a provision that state mandates do not apply to health benefit plans provided to small employers. This will allow the insurance industry to design basic health insurance policies.

It also, requires the small employer insurers to disclose information relating to premium rates and health benefit plans. It requires insurers to describe in detail their rating practices and renewal underwriting practices. Providing this information will help small

business owners to be better informed. The Congressional Budget Office believes that "giving consumers the information they need to make more informed decisions might enhance both the quality and cost-effectiveness of care."

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

SMALL EMPLOYER MARKET REFORMS

Pre-1991

Comprehensive Package

states which have enacted a comprehensive, or near-comprehensive small employer package

Connecticut (1990)†
Hawaii (1974)

Partial Package

states which have enacted select precepts of small employer market reform**

Georgia (1990)

1991

Comprehensive Package

passed in 1991

Massachusetts
North Carolina†
Oregon
South Carolina‡
Vermont

Partial Package

effective 1991

Colorado
Nebraska
New Mexico
North Dakota
West Virginia

1992

Comprehensive Package

passed in 1992

California	New Hampshire‡
Delaware†	New York
Florida†	Rhode Island†
Iowa†	Tennessee†
Kansas†	Virginia‡
Maine	Wisconsin
Minnesota	Wyoming†
Missouri†	

Partial Package

effective 1992

Arkansas
Indiana
Louisiana
South Dakota

Comprehensive Package Proposals

strong prospects for passage in this session

New Jersey
Ohio
Pennsylvania

Other

passed at least one chamber prior to adjournment

Alaska	Maryland
Arizona	Washington
Colorado	
Georgia	
Idaho	

* For listing of specific precepts, refer to following chart
‡ Does not require insurers to guarantee issue coverage

† Generally follows HIAA/NAIC model
** Awaiting Governor's signature

	<i>Guaranteed Access</i>	<i>Coverage of Whole Groups</i>	<i>Renewability of Coverage</i>	<i>Continuity of Coverage</i>	<i>Premium Pricing Limits</i>	<i>Ref. *</i>	<i>Year</i>
Arkansas						§23-86-204,205	1992
California						AB 1672	1992
Colorado						§10-8-116.5	1991
Connecticut**						§38a-567	1990
Delaware**						HB 571	1992
Florida**						HB2457/SB2390	1992
Georgia						§33-27-8	1990
Hawaii						HRS §1-51	1974
Indiana						IC 27-8-15	1992
Iowa**						HB 2370	1992
Kansas**						SB 561	1992
Louisiana						H1994/S913,925	1992
Maine						LD 701	1992
Massachusetts						Chapter 176J	1992
Minnesota						HF2800/SF2603	1992
Missouri**						SB 796	1992
Nebraska						LB 419 §23,24	1991
New Hamp.						HB 321/HB 411	1992

■ *Legislation covering this precept has been enacted, or is on Governor's desk*

▒ *Legislation covering this precept is under serious consideration in the current session (1992)*

* *Statutory citations or bill numbers. For states which have enacted partial packages and are presently considering comprehensive reform, the listing refers to the proposed legislation.*

** *Package is substantially similar to the NAIC Model.*

New Jersey**						AB 757/SB 371	1992
New Mexico						SB 50445.A, 6.A	1991
New York						AB 12350-A	1992
No. Carolina**						§58-50-130	1991
North Dakota						HB 1539	1991
Ohio						HB 478, SB 240	1992
Oregon						SB 1076	1991
Pennsylvania						SB1666, HB2586	1992
Rhode Island**						HB 9011	1992
So. Carolina						§38-71-920-950	1991
South Dakota						SB 229 §3,4	1992
Tennessee**						HB2449/SB2578	1992
Vermont						§4080a	1991
Virginia						SB 505	1992
West Virginia						§33-160-5,7	1991
Wisconsin						AB 655	1992
Wyoming**						SF 22	1992
	Guaranteed Access	Coverage of Whole Groups	Renewability of Coverage	Continuity of Coverage	Premium Pricing Limits	Ref.	Year

SMALL EMPLOYER MARKET REFORMS

	<u>NAIC</u>	<u>SB 173</u>
<u>Availability</u>	Guaranteed issue	Guaranteed issue
<u>Group Size</u>	1-25	2-25
<u>Case Characteristics</u>	Geography, age, sex, size of employer, and other objective criteria but does not include claim experience, health status or duration of coverage	Geography, age, sex, size of employer, and other objective criteria but does not include claim experience, health status or duration of coverage
<u>Rating Restrictions</u>	Within a class of business, the rates for similar groups may not vary from the index rate by more than 25%. The index rate for any insurer's class of business may not exceed another class of business by more than 20%.	An insurer's rates for similar groups may not vary from applicable index rate by more than 35%.
<u>Transitional Period</u>	3 years	3 years
<u>Renewal Rating</u>	Trend plus 15% plus changes in case characteristics	Trend plus 15% plus changes in case characteristics
<u>Renewability</u>	Guaranteed renewable except "for cause"	Guaranteed renewable except "for cause"
<u>Whole Groups</u>	Must take whole group	Must take whole group
<u>Continuity of Coverage</u>	Plans must credit the time a person was covered under a previous employer-based plan if the coverage was continuous	Plans must credit the time a person was covered under a previous employer-based plan if the coverage was continuous

	<u>NAIC</u>	<u>SB 173</u>
<u>Reinsurance</u>	Prospective with opt out. Insurers elect whether to participate in the reinsurance mechanism.	Mandatory prospective. Insurers <u>must</u> participate in the reinsurance mechanism.
<u>Reinsurance Price</u>	150% for whole groups 500% for individuals	150% for whole groups 500% for individuals
<u>Cost Sharing</u>	First \$5000 of claims and 10% of next \$50,000 in claims	First \$5000 of claims
<u>Assessments</u>	5% of the premium of small employer market	5% of the premium of small employer market
<u>Minimum Participation Requirements</u>	Consideration of dual participation required	Not included
<u>Class of Business Rating</u>	Included	Not included
<u>Industry Rating</u>	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.
<u>Reinsurance Board</u>	Eight members, with Insurance Director as ex-officio member. Director appoints. Members to include representatives of small employers and insurers, with at least 5 representatives of reinsuring carriers.	Nine members, selected by participating members, approved by Director. At least two-thirds of members shall be small employer insurers. At least one member shall be insurer principally in small employer market; one principally in large employer market; one to represent HSO, HSC, or MSO; one to represent HMO; one to represent other benefit arrangement.

NAIC

SB 173

Health Benefit
Plan Committee

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

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

Reporting

No reference

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

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

Not Included

Guarantees issue only to those permitted by charter.

Provision for
Sunset

Not Included

Four years (July 1, 1997)

**THE FOLLOWING PAGE MAY NOT FILM LEGIBLY
BECAUSE OF THE POOR QUALITY OF THE ORIGINAL.**



MarketPlace Report

A MONTHLY ACTIVITY SUMMARY

The Connecticut Small Employer Health Reinsurance Pool (SEHRP) is a reinsurance pool created by the Connecticut Legislature Public Act 90-134, which permits any place of business, individual or group, to make available and encourages the making of group health insurance for full-time (eligible employees) which may be no longer underwritten.

September 1992

Activity in the MarketPlace and in the Pool

Sales Activity

4,687 PLANS SOLD TO UNINSURED SMALL BUSINESSES

- Includes 4,323 other plans sold by carriers during the same period.
- In addition, 85 Special Plans and 279 Small Employer Plans have been sold to the previously uninsured.

1,324 SMALL EMPLOYER AND SPECIAL PLANS SOLD

The activity for the Small Employer and the Special Plans sold include sales to previously insured businesses as well as sales to businesses who have had insurance. Renewed plans will be included in later reports as in-force business.

Based on responses by all of the 47 Connecticut Small Employer Carriers and the Health Reinsurance Association of Connecticut (HRA), continued growth in sales is reported for the first sixteen months:

- 1,236 Small Employer Plans: The basic plan for businesses of 1 to 25 employees.
- 88 Special Plans (non-HRA): The plan for businesses that have not been insured for at least two years.
- 300 Special Plans (HRA): The plan with a special version for individuals or groups who meet the eligibility and income requirements of the new law.

Reinsurance Activity

3,328 PLANS REINSURED WITH THE POOL

As of the September ceding by 22 Small Employer Carriers, the type of plan that is coded the most is the Small Employer Plan.

Whole Group reinsurance still exceeds Individual reinsurance.

- 1,606 plans reinsured as Whole Groups.
- 1,722 plans with Individual Reinsurance.

923 NEWLY SOLD PLANS REINSURED WITH THE POOL

New business that was reinsured with the Pool was 20% of the total plans sold to previously uninsured (923/4,687).

2,405 PREVIOUSLY INSURED PLANS REINSURED WITH THE POOL

Ceding from the existing book of business commenced January 1, 1992.

9,368 PERSONS REINSURED

The average size of Whole Groups coded to the Pool is 4.6 persons, including dependents. The average group size has been in the 2-5 person range since the inception of the Pool.

- 7,365 persons reinsured as Whole Groups from 1,606 plans with Whole Group reinsurance a 4.6 average group size.
- Reinsured lives from newly sold plans total 2,514.
- Reinsured lives from previously insured plans total 6,854.

G. N. S.

Improving Access: The Connecticut Experience Under Public Act 90-134

BACKGROUND

At the end of the 1980s, Connecticut was faced with about a quarter million uninsureds in the state (about 9 percent of the state's population). The Governor convened a Blue Ribbon Commission to study this problem and propose a solution. The solution that was recommended led to the enactment of CT Public Act 90-134. PA 90-134 was viewed from the start as an incremental step toward addressing this problem on the uninsured in CT. Toward that end, it was expected to expand Medicaid, increase support for primary care providers, reform the small group health insurance market, and subsidize insurance for pregnant women, children, the disabled and the chronically ill. In addition, a Health Access Commission was established to monitor implementation of the Act, develop a long-term plan to control rising health care costs and guarantee universal access to high quality care.

PA 90-134 consists of two parts:

- a state-funded effort to expand government health insurance programs to the poor and near-poor, with special emphasis on pregnant women and young children, and
- reform of the small group insurance market designed to help get insurance coverage to Connecticut's employed uninsured and their families.

Implemented in tandem, these two elements were expected to reach a good portion-- about one quarter, initially-- of the identified uninsured in Connecticut.

In short, this legislation included both public and private insurance reforms that were expected to expand insurance coverage and increase access to health care for the most vulnerable of the uninsured. PA 90-134 was widely recognized as a first step in a longer-term process to make insurance more widely available and affordable to all residents. This legislation's private insurance reforms focused primarily on reforming certain insurer practices to make insurance more widely available. The issue of

affordability was only addressed by increasing the stability of rates from year to year and imposing rate limits for higher risk groups. It was recognized that additional changes to the law might be needed. Additional health care initiatives, beyond the insurance reforms in PA-134, were expected to be necessary to make health care, and thus health insurance, more affordable.

To implement the private insurance reform section of 90-134, the insurance industry completed all of the product development and market changes required by the Act on schedule and has amended the law as needed in subsequent years. The state government, however, has never fully fund its part of the program and, since enactment of PA 90-134, has passed up clear opportunities to do so. Thus, today, more than two years after passage into law, the effect of this experiment is difficult to judge because the Act has never been fully funded or fully implemented.

KEY PROVISIONS OF INSURANCE REFORM SECTION OF PA 90-134

- **Guaranteed issue** of small employer and special health care plans to small employers (1-25 eligible employees) without regard to health status. (However, there is no mandate that employers provide coverage.)
- **Guaranteed eligibility** ensures that eligible employees and their families cannot be refused coverage under an employer's plan.
- **Rating limits** restrict the maximum rates for small employers and limit periodic rate increases.

The maximum rate for small employers is restricted to 150 percent of the lowest rate for any other employer group in the same actuarial class. Originally the maximum was 200 percent, but it was revised after enactment.

Periodic rate increases are limited to the sum of the increase in the base premium rate, plus any adjustment as a result of changes in case characteristics, plus 15 percent of the base premium rate (originally 20 percent).

- **Guaranteed renewability** requires carriers to renew coverage at the policyholder's option.
- **Restrictions on preexisting condition limits** prohibit carriers from applying more than a 12-month preexisting condition limit and requires plans to credit the time a person was continuously covered under a previous group plan toward any preexisting condition limitation. Coverage is considered continuous if there has been less than a 30-day lapse in coverage.

- Reinsurance pool provisions create a nonprofit prospective reinsurance pool to protect carriers from insuring a disproportionate share of high risk individuals or groups.

In addition to amendments to the rating limits mentioned above, additional amendments since enactment include:

- Requirements for replacement of another carrier's coverage when that carrier leaves the small group market.
- Reenrollment criteria for coverage that was not renewed for cause--such as fraud or misrepresentation.
- Variations in premium rates among employees of a particular employer may not be based upon health status, claims experience or duration of coverage. That is, an employer could not make it's high risk employees pay more for coverage.
- Preexisting condition limit credits have been liberalized to allow credit for individuals covered under plans other than as Connecticut residents.
- Changes to general and administrative requirements such as actuarial certification, fair marketing practices, documentation of rating and underwriting practices, and provisions for suspending rating restrictions.

THE EFFECT OF REFORMS

Private insurance reforms have been implemented, on schedule, without any real surprises and with some lessons for the future.

Since May of 1991, CSEHRP has been reinsuring high risk employers and participating carriers have been selling health plans to small employers.

Forty-seven carriers in CT are participating members in the reinsurance pool--although only 22 have actually reinsured any groups or individuals.

Another lesson learned was that groups that were outside of the rating bands before reforms need special regulations or procedures for bringing their rates into the rating bands.

Some of the lessons we have learned are reflected in the amendments above. In addition we have learned that different provisions of the law are sometimes in conflict, especially during initial implementation. For example, a group with a current rate that is half of the lowest rate after reforms would receive a 100 percent rate increase to conform to the new rating limits. Obviously, this

creates a conflict between the maximum annual rate increase allowed and the rating bands. A decision has to be made as to which provision takes precedence.

Lastly, we have learned that most of the 30,000 uninsured small employers in CT have 10 or fewer employees. Traditional marketing approaches by carriers and agents had to be reconsidered in order to target these smaller groups. Mass marketing techniques such as direct response mailings are being utilized instead.

Since its inception, PA 90-134 has provided coverage to between 19,000 to 25,000 previously uninsured Connecticut employees and their families.

As of the end of September 1992, carriers had sold 4,687 plans to previously uninsured employers. On average, this would imply that about 19-25 thousand uninsured have been provided coverage. However, this figure has not yet been adjusted for withdrawals, so the actual number of newly insureds is probably a little less.

As of the same date, CSEIRP had reinsured 3328 plans (9368 insureds): 1606 plans (7365 insureds) with whole group coverage, 1722 plans (2003 insureds) with individual coverage.

Public program reforms (including Medicaid expansion and subsidies) have been only marginally funded, seriously jeopardizing the ability of this legislation to provide health care to more than a handful of the 60,000 uninsureds it was intended to help.

Private insurance reforms alone have already helped many uninsureds to get health insurance and will continue to do more to expand coverage to the uninsured. However, without fully funding the public program reforms, Connecticut can only hope to make a dent in its uninsured problem.

Rating reforms and guaranteed issue have not generated large increases in the average rates that many opponents feared.

Critics who cite theoretical studies with doomsday estimates of premiums rising up to 40 percent on average should study some real results in CT. Rating reforms have caused the rates for some employers to go up and others to go down. In total, the costs for these reforms range from HIAA's estimate of less than 4 percent, on average, to some other estimates of as much as 10 percent, on average. However, it must be remembered that these estimates are averages and specific employers and insurers will see their rates increase or decrease based upon their specific mix of employees and business.

For fiscal year 1992, the CT Reinsurance Pool has an accrued assessment of just over 1 percent of small employer carrier premiums.

For fiscal year 1992, the first full year of operation, the accrued reinsurance assessment amounts to \$6.6 million. This assessment will be spread over a small employer premium base of \$513-530 million. Thus, the 1992 assessment would be about 1.3 percent of premium.

SUMMARY

The state must find a way to fund the public programs in PA 90-134 to help the poor and near-poor who are uninsured.

Affordability of health care and health insurance is still an issue for the majority of patients and insureds in Connecticut. This problem still needs addressed.

Connecticut's market reforms and reinsurance pool are working as expected, fixing those areas in the private insurance market that needed to be fixed.

While PA 90-134 will never live up to its full potential as long as the public program reforms are not funded, the results so far have proved it to be an innovative, workable solution to the access problem, to the extent that it has been implemented.

SENATE COMMITTEE REPORT
FIRST COMMITTEE OF REFERRAL

DATE: 3/25/93

FURTHER: FINANCE

Date of 5-Day Notice: 3/25/93
(in accordance with Uniform Rule 23)

DATE TURNED INTO OFFICE: 3-30-93

L&C Committee considered SB 173

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

and recommends:

and a majority of the committee recommends do pass

replace with _____ CS _____ ()

same title
 new title
 technical title change (HB only)

attaches amendment(s)

adopts _____ Letter of Intent

further referral to the _____

do pass

do not pass

no recommendation

individual recommendations

FISCAL NOTE INFORMATION

Department	Date	Zero	Fiscal
DCEO	3/26	<input checked="" type="checkbox"/>	

Department	Date	Zero	Fiscal

Appropriation No Fiscal Note

Governor's Bill with Previous Fiscal Notes (enter information above)

DO PASS:

OTHER RECOMMENDATIONS:

Bart Adams *Shr*
Steve King *Bege*
J. E. Sato *Sato*

Demetrius...

Chair: Signature and Recommendation
Kelly