SB

104

5-8-97

Amendment History of SB 104

Senate Finance:

Two amendments were added to SB 104 in Senate Finance.

The most significant amendment was the amendment to include the minimum fe[illegible] standards in the Health Insurance Portability and Accountability Act of 1[illegible] nnedy/Kassebaum legislation). **These minimum standards must be[illegible]e effective in Alaska by July 1, 1997**. If these provisions are not enacted in this legislative session the federal Department of Health and Human Services will take over regulation of these standards in individual and group health insurance market in Alaska. The amendment added almost 50 pages to the bill. However, the provisions in this amendment make only the minimum required changes in order to meet the minimum federal standards. (note section 1 of version CSSB 104(FIN) am outlines the specific sections in the bill relating to this amendment)

The other amendment was sponsored by Senator Donley and has the effect of establishing the payment priority for liability and physical damage under automobile policies for rented motor vehicles. (note this amendment is in section 109 of version CSSB 104(FIN) am)

Senate Floor:

Two amendments were added to CSSB 104(FIN) on the Senate floor.

One amendment was sponsored by Senator Donley. The amendment modified the underinsured/uninsured motorist coverage provisions to require that coverage for uninsured and underinsured motorists be provided even if the limits of liability bonds and policies that apply have not been used up by payments, judgements or settlements. This amendment is in sections 114 and 115 of version CSSB 104(FIN) am.

Another amendment was sponsored by Senator Duncan. The amendment allows an insured to exclude a relative or person living in the same household as the insured from their automobile insurance coverage. This amendment is in section 113 of version CSSB 104(FIN) am.

House Finance:

May 7, 1997 (2:08pm)

Two amendments were made to CSSB 104(FIN) am in House Finance.

One amendment was sponsored by Senator Donley. This amendment was made in order to correct the amendment also sponsored by Senator Donley which was added on the Senate floor relating to underinsured/uninsured motorist coverage. This amendment clarifies the intent of the sponsor which is that underinsured motorist coverage be excess coverage. This means that an injured party would be entitled to collect the minimum of the actual amount of damage or the sum of the injured party's coverage and the underinsured motorist's coverage. This amendment is in Sec. 114 and 115 of HCS CSSB 104(FIN).

The other amendment was requested by Mike Lessmeier representing State Farm Insurance. The amendment changes the time period for maintenance of records from 10 years to 5 year.

May 7, 1997 (2:08pm)

5-8-97

Sponsor Statement
HCS CSSB 104(FIN)

This bill was requested by the Division of Insurance and contains numerous provisions that will enhance the effectiveness, efficiency and quality of insurance regulation for the Alaskan consumer and industry. The majority of the provisions in this bill implement the minimum federal standards for individual and group health insurance plans as established under the federal Health Insurance Portability and Accountability Act of 1996 (commonly referred to as the Kassebaum/Kennedy bill) which **must become effective in Alaska by July 1, 1997**. If these provisions are not enacted in this legislative session the federal Department of Health and Human Services will take over regulation of these standards in individual and group health insurance market in Alaska.

Summary of the federal Health Insurance Portability and Accountability Act of 1996 minimum standards in this bill:

- In August 1996 the Health Insurance Portability and Accountability Act of 1996 was signed into federal law. The Act received wide bipartisan support in Congress and many organizations including the American Medical Association, the Independent Insurance Agents of America, U.S. Chamber of Commerce, American Hospital Association and many others.

- The federal law establishes minimum standards for all individual and group health care plans that must become effective July 1, 1997. These standards ensure that health coverage is portable, available and renewable for many individuals.

- **If Alaska fails to enact the federal reforms or otherwise provide for enforcement of the federal reforms, the federal government will enforce compliance in Alaska beginning January 1, 1998.**

- Alaska has the option to implement an alternative to the minimum individual health insurance standards in the federal law. This legislation provides for the necessary amendments to the insurance code to implement such an alternative as well as other amendments necessary to implement the minimum group reforms.

- This bill provides for a federally acceptable alternative by modifying the eligibility requirements for the Comprehensive Health Insurance Association(CHIA). This alternative is the least disruptive to Alaska's small individual health insurance market.

- **Alternatively, without this legislation the more restrictive federal individual market reforms will be enforced on all health insurers writing business in the Alaska individual market including the CHIA.**

- By the required federal deadline of April 1, 1997 Alaska filed with the U.S.

Department of Health and Human Services that it intends to enact the necessary legislation to provide an alternative.

- **The minimum standards proposed in this bill have wide support by both insurers and consumers and result in no additional cost to the state.**

- **Again, if Alaska wants to avoid federal regulation of the health insurance market in Alaska, legislation must be passed in this session.**

The miscellaneous insurance provisions in this bill will:

- Establish procedural requirements designed to ensure that insurers conducting the business of insurance in this state are solvent, records are properly maintained, and appropriate reports are made to the division.

- Eliminate unintentional barriers to companies seeking to transact business in this state

- Clarify licensing statutes which are consistent with child support enforcement legislation enacted in 1996

- Require insurers and licensees to report any suspected producer defalcation or embezzlement inmmediately to the director.

- Require insurers to report any pertinent corporate changes.

- Clarify joint insurance arrangement reporting and risk based capital filings

- Require insurers to maintain records at its principal place of business regarding assets, transactions, complaints and other corporate affairs for all lines of business

- Establish minimum reserve and premium rate standards for all health insurers thereby providing for a more level playing field in the health insurance market in Alaska as well as eliminating archaic hospital and medical service corporation health reserve standards.

- Add stop-loss insurance to the definition of health insurance in order to allow life and health insurers to write this coverage in the state. Under current law only property and casualty insurers may write this coverage.

- Provide that the superior court shall review and adopt the receiver's report on claims by using the substantial evidence standard and extend the period for disapproving claims to 120 days, which will reduce litigation over claims and expedite the closure of a receivorship estate.

- Establish the payment priority for liability and physical damage under automobile policies for rented motor vehicles.

- Allow an insured to exclude a relative or person living in the same household as the insured from their automobile insurance coverage.

- Modify the definition of underinsured motor vehicle in order to provide that a party injured by an underinsured motorist would be entitled to collect the minimum of the actual amount of damage or the sum of the injured party's coverage and the underinsured motorist's coverage.

5-8-97

SECTIONAL ANALYSIS
HCS CSSB 104(FIN)

Section 1. PURPOSE. The purpose of sections 3, 11, 12, 31-34, 43-57, 59-90, 99-102, 108, 111-112, 115-119, and 122 of this Act is to implement the minimum federal standards for health care insurance enacted under P.L. 104-191 (Health Insurance Portability and Accountability Act of 1996).

Sec. 2. AS 21.06.030. Deputies and assistants.
This section reaffirms that persons participating on division advisory committees do not receive payment for transportation or per diem expense. The Division of Insurance has routinely secured public input on insurance regulatory issues using a variety of advisory committees. Volunteers, including many insurance professionals providing technical input, have served without compensation from the state, recognizing that if transportation or per diem expenses were paid by the division the costs would be passed back to them through higher licensee fees or higher insurance premiums reflecting increased administrative costs. The possibility that payment might be required under AS 39.20.180 has recently been brought to the division's attention.

Sec. 3. AS 21.06.085. Uniform data and procedures for health claims.
The changes to this section make the terms consistent with the newly defined health insurance terms under the federal law(HIPAA)

Sec. 4. AS 21.06.110. Director's annual report.
Updates information required to be included in the division's annual report to reflect current practices regarding issuance of certificates of authority and primary regulation of domestic insurers.

Sec 5. AS 21.06.160(a). Examination Cost.
Clarifies this subsection to allow the calculation of a reasonable per hour charge for examination services to include approximated division overhead expenses such as word processing services, facilities and supplies, computer systems, etc. and that out-of-pocket expenses including travel costs shall be paid by the person being examined.

Sec 6. AS 21.09.210(b). Premium Tax Payment - Admitted Insurers.
Allows the director to determine the method of payment of premium taxes to reflect technology changes such as electronic payments and to collect premium taxes quarterly.

Sec 7. AS 21.09.210(d). Premium Tax Payment - Admitted Wet Marine and Transportation Insurers.
Allows the director to determine the method of payment of premium taxes to reflect technology changes such as electronic payments and to collect premium taxes quarterly.

Sec 8. AS 21.09.245. Amendments to Certificate of Authority.
This is a new section that requires an authorized insurer to file with the division within

30 days a name change, domiciliary state change, or other information on its certificate of authority. Amendment to the insurer's articles of incorporation or bylaws, a change of business address or phone number, and other information as designated by the director must be filed within 90 days, and provide for penalties for noncompliance.

Sec 9. AS 21.09.320. Maintenance of Records.
This new section identifies which records are required to be kept by admitted insurers domiciled in another state. Retention times are specified. Domestic insurers are subject to existing and unchanged provisions. The lack of requirements for other admitted insurers has impeded the division's regulatory oversight including examinations and other investigations.

Sec 10. AS 21.12.020(a)(4)(A)(iii). Accredited Reinsurer Qualifications.
This section removes a requirement for a certification of insurer solvency from an insurer's domiciliary regulator because some foreign countries do not provide such certifications. Certification will still be required from the insurer's public accountant.

Sec. 11. AS 21.12.050. Health insurance defined.
This section defines "health care insurance" which is consistent with the definition of "health insuance coverage" in P.L. 104-191 adding Sec. 2791(b) (42 U.S.C. 300gg-91(b)). The federal definition differs from the current state definition and since Alaska's definition is more broad, the federal definition was defined as a subset of the Alaska definition. This section all adds stop loss insurance to the definition of health insurance to affirm that life and health insurers are permitted to write stop loss coverage.

Sec 12. AS 21.12.050.
Definition of health care insurance and stop-loss insurance as referenced in Sec. 11 AS 21.12.050.

Section 13. AS 21.14.010(a). Risk Based Capital Filing.
Clarifies that a domestic insurer must submit its risk based capital report to the director without a specific request.

Section 14. AS 21.14.200(18). Risk Based Capital Instructions.
Clarifies that instructions can be adopted by order of the director after an open meeting since the complexity of the calculation, its continual refinement, and insurer need for nationwide consistency, regulations are an inappropriate way to provide instructions to insurers.

Section 15. AS 21.18.050(4). Capital stock and liabilities charged against assets.
Requires that the minimum reserves for health insurance established in AS 21.18.080-21.18.086 be charged against an insurer's admitted assets for the purpose of determining the insurer's statutory financial condition.

Section 16. AS 21.18.080. Reserve standards for health insurance.
Adopts a more well defined and appropriate standard for minimum reserves for health insurance. Requires that reserve adequacy be determined by a gross premium valuation considering the sum of policy reserves, claims reserves, and premium reserves established under AS 21.18.082-AS 21.18.086.

Section 17. New sections are added to provide for minimum health insurance reserve standards.

AS 21.18.082. Policy reserves for health insurance.
This section defines which policies require a policy reserve and how to calculate the reserve based on minimum standards relating to interest rates, policy termination, morbidity, and reserve method.

AS 21.18.084. Claim reserves for health insurance.
This section establishes that claim reserves are required for all incurred and unpaid claims, including associated expenses, on health insurance policies.

AS 21.18.086. Premium reserves for health insurance.
This section establishes premium reserve requirements that include standards for accounting, discounting, methodology, and minimums levels of unearned premium reserves as they relate to policy reserves.

Section 18. AS 21.21.410. Custodian Agreements.
Requires that a written agreement exist between an insurer and the custodian of its assets, securities, or investments. The agreement must require that the custodian will indemnify for losses if loss results from theft, mysterious disappearance, damage or destruction, or negligence or dishonesty of the custodian's officers, employees, or agents. The agreement must require the custodian to promptly replace an asset or value of the asset. A bank, trust company, or securities firm may serve as custodian if authorized by the insurer and approved by the director.

Section 19. AS 21.27.010(f)(2)(B). License required.
Editorial revision to make "or" the appropriate connector consistent with identical language in (g)(1) of the section.

Section 20. AS 21.27.010(I). Attorney-in-fact License Exemption.
Clarifies that an attorney-in-fact of a reciprocal insurer who meets the qualifications to be exempt from licensure as an attorney-in-fact is not required to be licensed under AS 21.27 as a managing general agent.

Section 21. AS 21.27.040(a). Application for License.
Codifies current procedure that requires an applicant to certify under oath that the information provided on a license application is true and correct.

Section 22. AS 21.27.370(b). Shared Commissions.
Reaffirms that an unlicensed person may not share or receive a commission or any form of remuneration for business transacted in this state, nor may a licensee share commission or other form of remuneration with an unlicensed person.

Section 23. AS 21.27.390(b). Temporary License.
Conforms AS 21.27 with the requirement to issue a temporary license under AS 25.27.244 (Welfare Reform).

Section 24. AS 21.27.405(b). Investigation; cease and desist order.
Updates procedures to allow the director the flexibility to provide service of notice to a person in the most effective and efficient way.

Section 25. AS 21.27.440(a). Fines.
Provides authority for the director to fine an unlicensed person who illegally transacted the business of insurance and received a commission or other form of remuneration.

Section 26. AS 21.27.640(b)(5)(D). Third Party Administrator License Application.
Gives a third-party administrator applicant an option to submit certified financial statements for its period of operation if operations have been for less then two years in order to remove a barrier to start up operations for an applicant who would otherwise be qualified to act as a third-party administrator.

Section 27. AS 21.34.040(c)(4). Unauthorized Insurers - Lloyd's Syndicates.
Establishes solvency requirements for each syndicate or insurer of Lloyds or a similar operation.

Section 28. AS 21.34.040(c)(5). Unauthorized Insurers - Insurance Exchange.
Establishes solvency requirements for each syndicate of an insurance exchange created by the laws of another state.

Section 29. AS 21.34.180(b). Premium Tax Payment - Unauthorized.
Allows the director to determine the method of payment of premium taxes to reflect technology changes such as electronic payments and to collect premium taxes quarterly.

Section 30. AS 21.34.190(a). Unauthorized Filing Fee.
Clarifies that the one percent fee on gross premiums is calculated on the gross premiums reported on the statement of surplus lines tax required under AS 21.34.180(b), which has been amended to allow the director to require reporting more often than annually.

Sec. 31 - Sec. 34., Sec. 43. - Sec. 56. Required Coverages or Offers of Coverage.
References to health insurance terms in these sections were changed to be consistent with the new definitions, "health care insurance" in AS 21.12.050 and "health care insurer" in

AS 21.54.900.

Use of the terms "health care insurance plan" and "health care insurer" generally clarifies that the applicability of these sections include MEWAs and, in three provisions, HMOs. This results from the use of the term "health care insurer" which is defined very broadly to include all entities that transact health care insurance. Note that the definition of "health care insuran e plan" excludes limited benefit policies and supplemental coverages. In the cases where the provision is to apply to these types of policies it is explicitly added.

The changes to these sections were intended to make the sections consistent with each other in terms of applicability and with the newly defined health insurance terms under the federal law.

Note that:

Sec. 43. AS 21.42.345 was modified to conform with the minimum federal standards pursuant to P.L. 104-191 amending the Public Health Service Act (PHSA) to add Sec. 2701(f) (42 U.S.C. 300gg(f)) regarding enrollment periods for dependents. The current provision applies to both individual and group plans while the federal law applies only to group plans. However, for simplicity the changes made to conform to the federal law were made to both individual and group policies.

Sec. 45. - Sec. 46. AS 21.42.347 relating to costs of childbirth was modified to conform with the minimum federal standards pursuant to P.L. 104-191 adding Sec 2751 to PHSA (42 U.S.C. 300gg-51).

Sec. 35. AS 21.36.185. Maintenance of complaint handling records.
Establishes a requirement based on the NAIC Model Unfair Trade Practices Act for an insurer to maintain records regarding the complaints it receives. The record will assist the division in evaluating an insurer's consumer practices.

Sec. 36. AS 21.36.240. Failure to renew.
Clarifies that an insurance policy may only be non-renewed on its annual anniversary. This only applies to personal property and casualty insurance.

Sec. 37. AS 21.36.290. Policy period.
In conjunction with AS 21.36.240, clarifies the annual policy period and assures that rates for personal auto insurance may only be changed once every 6 months, even if the policy is written for a shorter time period.

Sec. 38. AS 21.36.390. Notice to director.
Adds a requirement that insurers and other licensees report producer defalcations, embezzlements, or violations to the director in much the manner as currently is required for reporting claim fraud. Lack of timely reports to the division has resulted in situations

in which harm to the public or other insurers has been exacerbated. Requires licensees as well as insurers to report fraudulent claims.

Sec. 39. AS 21.39.045(b)-- Risk classification: construction industry.
Clarifies that the credit scale recognizing differences in wages paid applies only to the construction industry.

Sec. 40. AS 21.42.130(5). Disapproval of forms.
Clarifies that rates for individual health insurance are not subject to approval consistent with current statutes that do not provide a mechanism or guidelines for such rate review.

Sec. 41. AS 21.42.205. Coordination of benefits.
Requires that benefits provided under health insurance contracts be coordinated. This coordination is applicable only when an individual is covered under more than one health insurance contract.

Sec. 42. AS 21.42.265. Effective date of coverage.
Clarifies that insurance coverage changes required by a law change become effective at renewal unless the law provides an earlier effective date for the changes.

Sec. 57. Sec. 21.53.090. Required regulations.
Under federal law long term care contracts with certain federally defined characteristics may receive favorable tax treatment. Since this creates a separate class of long term care policies and need for additional protections, the amendments to this section expand the director's authority to write specific regulations for this purpose.

Sec. 58. AS 21.54.015. Rate requirements.
Requires that rates for group health insurance contracts not be excessive, inadequate, or unfairly discriminatory to provide a consistent standard for all group health insurers.

Sec. 59.
This section adds several new sections to AS 21.54 to conform with the minimum federal standards for health care insurance in the group market as follows:

Sec. 21.54.100. Unfair discrimination.
This section is added to conform with the minimum federal standards pursuant to P.L. 104-191 adding Sec. 2702 to PHSA (42 U.S.C. 300gg-1) regarding unfair discrimination in the offer of or enrollment under a health care insurance plan.

Sec. 21.54.110. Preexisting condition exclusion.
This section is added to conform with the minimum federal standards pursuant to P.L. 104-191 Sec. 2701(a)-(b) to PHSA (42 U.S.C. 300gg(a)-(b)) relating to preexisting condition exclusions.

Sec. 21.54.120. Creditable coverage.
This section is added to conform with the minimum federal standards pursuant to P.L. 104-191 adding Sec. 2701(c)-(e) to PHSA (42 U.S.C. 300gg(c)-(e)) relating to

creditable coverage. Creditable coverage is used in determining the allowable preexisting condition waiting period or exclusion. Note that the federal law allows the states discretion in determining an allowable break in coverage in determining creditable coverage. AS 21.56 allowed a 90 day break in coverage for small employer groups and this was maintained in this section and as a result would apply to large employers as well.

Sec. 21.54.130. Renewability, termination, and modification of coverage.
This section is added to conform with the minimum federal standards pursuant to P.L. 104-191 adding Sec. 2712 to PHSA (42 U.S.C. 300gg-12) relating to guaranteed renewability, modification and termination of coverage. Subsection (f) of this section was added to allow an insurer to terminate an individual's coverage if the individual has committed fraud or intentional misrepresentation. This is not part of the federal law but was considered an oversight by the NAIC and HCFA.

Sec. 21.54.140. Renewability of coverage for a multiple employer welfare arrangement.
This section is added to conform with the minimum federal standards pursuant to P.L. 104-191 adding Sec. 703 to ERISA (29 U.S.C. 1183) relating to guaranteed renewability for MEWA plans.

Sec. 21.54.150. Mental health benefits.
This section is added to conform with the minimum federal standards relating to mental health benefits parity pursuant to the amendment to P.L. 104-191 adding Sec. 2705 to PHSA (42 U.S.C. 300gg-5).

Sec. 21.54.160. Excepted benefits defined.
This section defines the health plans that are not subject to the minimum federal standards and are termed "excepted benefits" in the federal law. These "excepted benefits" are explicitly defined in P.L. 104-191 adding Sec. 2791(c) to PHSA (42 U.S.C. 300gg-91(c)). These health plans are basically limited benefit and supplemental health insurance plans. The definition of "health care insurance plan" as proposed in this bill excludes "excepted benefits".

Sec. 21.54.170. Determination of size of employer.
This section describes how the size of an employer is to be determined as described in P.L. 104-191 adding Sec. 2791(e)(6) to PHSA (42 U.S.C. 300gg-91(e)).

Article 3. Sec. 21.54.500. Definitions.
This section adds new definitions necessary to conform with the minimum federal standards. The definitions are consistent with the definitions in P.L. 104-191 adding Sec. 2701(b), Sec. 2701(e), Sec. 2705(e) and Sec. 2791 to PHSA (42 U.S.C. 300gg(b), 42 U.S.C. 300gg(e), 42 U.S.C. 300gg-5(e), 42 U.S.C. 300gg-91 respectively)

Sec. 60. - Sec. 68. Comprehensive Health Insurance Association.
These sections amend AS 21.55 relating to the Comprehensive Health Insurance Association. P.L. 104-191 adding Sec. 2744 to PHSA (42 U.S.C. 300gg-44) allows a state to use a qualified high risk pool to guarantee portability of health insurance coverage to federally eligible individuals. The amendments to this section allow a "federally defined

eligible individual" defined in P.L. 104-191 adding Sec. 2741(b) to PHSA (42 U.S.C. 300gg-41(b)) to participate in the CHIA. Use of Alaska's high risk pool (CHIA) would be the least disruptive mechanism allowed under the federal law to reform the individual health insurance market in Alaska and therefore was the selected mechanism. Experience in other states such as Washington, New Jersey, and New York relating to the alternative mechanisms allowed in the federal law has resulted in significant increases in claims and premiums and decreases in the number of individuals insured and the number of insurance companies writing individual health insurance.

Sec. 69. - Sec. 90 Small Employer Health Reinsurance Association.
These sections amend AS 21.56 relating to health insurance coverage for small employers to remove any conflicts with the minimum federal requirements under P.L. 104-191. Certain sections of AS 21.56 were repealed and reenacted under AS 21.54 because under federal law those provisions apply to both large and small employer groups. The sections in AS 21.56 relating to guaranteed issue were amended to conform with the federal minimums for small employer groups pursuant to P.L. 104-191 adding Sec. 2711 to PHSA (42 U.S.C. 300gg-11). To the extent possible the provisions in AS 21.56 were not modified unless they would prevent application of the federal minimums.

Also, several sections are amended to change the term "association" to "reinsurance association" in order to avoid confusion with a "bona fide association" as defined in the federal law.

Sec. 77. AS 21.56.075. Premium report.
This is a new section that requires members of the Small Employer Reinsurance Association to report to the director on an annual basis the total amount of small employer health insurance premiums written in the state. While not required by federal law, this section will significantly improve the ability of the Association to assess Association members for losses.

Sec. 91. AS 21.66.110(a). Premium Tax Payment - Title Insurance.
Allows the director to determine the method of payment of premium taxes to reflect technology changes such as electronic payments and to collect premium taxes quarterly.

Sec. 92. AS 21.66.390(a). Making of rates.
Adds investment income as one of the elements to be considered when evaluating the rates charged by title insurers.

Sec. 93. AS 21.69.310(a). Annual Meeting Location.
Allows the director upon show of good cause to approve a domestic insurer's request to hold its required annual meeting in a city outside of the location of its principal office or place of business.

Sec. 94. AS 21.69.520(a). Borrowed Funds.

Requires director approval for an insurer to borrow funds when a written agreement requires that the money be repaid only out of the insurer's excess surplus and removes permission for an insurer to borrow money in this manner for any purpose of the insurer's business.

Sec. 95. AS 21.75.045(a). Attorney-in-fact License Exemption.
Expands the exception for being licensed as an attorney-in-fact to all reciprocal insurers. The exemption is allowed when the attorney-in-fact is a wholly-owned subsidiary of the reciprocal insurer who only acts for the one reciprocal. Attorneys-in-fact who operate more than one reciprocal insurer must be licensed under this section.

Sec. 96. AS 21.76.020(b). Joint Insurance Arrangement Reporting.
Specifies that the report prepared by a joint insurance arrangement and filed with the legislative budget and audit committee shall also be filed with the director.

Sec. 97. AS 21.76.080(e). Joint Insurance Arrangement Reporting.
Allows for the report filed by the joint insurance arrangement with its board of directors and the director to be an audit based on generally accepted accounting principles rather than requirements established by the director. A report filed with the director is open to public inspection unless specifically precluded by statute.

Sec. 98. AS 21.78.293(b). Receiver's recommendation to the court.
In order to reduce litigation over claims and thereby expedite the closure of a receivership estate (to the benefit of insurance policyholders and other claimants), the superior court shall review and adopt the receiver's report on claims by using the substantial evidence standard. The period of disapproving claims is extended to 120 days.

Sec. 99. AS 21.84.590. Other provisions applicable.
This amendment clarifies that the minimum federal standards apply to Fraternal Benefit Societies.

Sec. 100. - Sec. 102. Health Maintenance Organizations.
These sections amend AS 21.86 relating to HMOs in order to conform with the minimum federal standards pursuant to P.L. 104-191 adding Sec. 2701(g) to PHSA (42 U.S.C. 300gg(g)).

Sec. 103. AS 21.87.140(c)(1). Medical service agreements.
Updates terminology of participant provider contract requirements to reflect managed care compensation arrangements as well as traditional indemnity reimbursement.

Sec. 104. AS 21.87.150(c)(1). Hospital service agreements.
Updates terminology of participant hospital contract requirements to reflect managed care compensation arrangements as well as traditional indemnity reimbursement.

Sec. 105. AS 21.87.180(a). Filing and approval of agreements and contracts.
Conforms form filing requirements for medical and hospital service corporations to similar requirements for other insurers subject to form filing.

Sec. 106. AS 21.87.190(b). Subscription rates, fees, and payments.
Clarifies rate filing requirements. Allows the director discretion to protect medical and hospital service corporations from competitive disadvantage that may arise from disclosing rating formulas when other health insurers are not required to file rates for approval and disclose rating formulas.

Sec. 107. AS 21.87.200. Reserves.
Requires that hospital or medical service corporations have minimum reserve standards and reporting consistent with other health insurers.

Sec. 108. AS 21.87.340. Other provisions applicable.
Amendments in this section clarify that the minimum federal standards apply to Hospital and Medical Service Corporations.

Sec. 109. AS 21.89.020(f). Minimum coverages for automobile liability insurance.
The amendment to this section clarifies the priority in which liability and physical damage payments under automobile insurance policies for rented motor vehicles are made. The required priority would be that payments would first be made from the operator's policy purchased from the person renting the vehicle, then from any other policy covering the operator but not purchased from the person renting the vehicle, and finally from a policy of the person renting the vehicle.

Sec. 110. AS 21.89.020(g) -- Short term auto policy.
Clarifies that the requirements of AS 21.36.210 - 21.36.310 do not apply to seven-day policies.

Sec. 111. AS 21.90.900(29). Definitions for title.
The definition of policy is modified to extend to group certificates issued in Alaska when the group policy is issued and delivered outside of Alaska to ensure consistency in application of state law to all group health care plans covering individuals resident in Alaska. The new minimum federal standards apply to such certificates and without this amendment Alaska may have difficulty asserting regulatory authority over such certificates. Failure to regulate group certificates could result in the federal government determining that Alaska is not substantially enforcing the minimum federal standards resulting in federal regulation of Alaska's health insurance market.

Sec. 112. AS 21.90.900. Definitions for title.
This section adds two new definitions. The term "certified financial statement" is added to clarify its meaning in relation to licensing requirements. This term "medical care" as defined in P.L. 104-191 adding Sec. 2791(a)(2) to PHSA (42 U.S.C. 300gg-91(a)(2)) is

added since it is needed in order to define "health care insurance".

Sec. 113. AS 28.20.440
This is a new section that would allow an insured upon request to exclude from their auto insurance coverage a person who resides in the same household as the insured or a person who is a relative of the insured.

Sec. 114. AS 28.40.100(a)(22).
This section modifies the definition of underinsured motor vehicle in order to provide that a party injured by an underinsured motorist would be entitled to collect the minimum of the actual amount of damage or the sum of the injured party's coverage and the underinsured motorist's coverage.

Sec. 115. Repeal.
This section repeals the sections in AS 21.56 relating to small employer health insurance that conflict with federal law. As stated above many of the provisions were modified and moved to AS 21.54 since they apply to both large and small groups under the federal law.

AS 21.42.375(d) (mammography) and AS 21.42.395(d) (prostate and cervical cancer screening) exclude limited and supplemental benefit plans from the applicability of the provisions and since these are excluded by use of the newly defined term "health care insurance plan" these sections were repealed.

Also this section corrects an oversight by repealing Chapter 81 that was superseded by legislation enacted in 1995 (AS 21.09.310).

AS 28.20.445(h) and AS 28.22.211 are repealed as related to underinsured motorists coverage in Sec. 114.

Sec. 116, Sec. 119, and Sec. 122. Mental health insurance effective dates.
These sections establish the effective date of January 1, 1998 and sunset on September 20, 2001 of the mental health insurance provisions required under the federal law.

Sec. 117. and Sec. 118. Repeal of sunset provisions.
These sections repeal the sunset provisions in AS 21.56 relating to Small Employer Health Insurance and the Dental, Vision and Hearing provision in AS 21.42.385. The repeal of AS 21.56 is necessary since the availability provisions in AS 21.56 are required by federal law which do not sunset.

Sec. 120. and Sec. 121. Effective dates.
Sec. 6, 7, 27-30, and 91 take effect on January 1, 1998. All other sections take effect on July 1, 1997.

INCLUDES KENNEDY / KASSEBAUM PROVISIONS

SECTIONAL ANALYSIS
CSSB 104(FIN)

Section 1. PURPOSE. The purpose of sections 3, 11, 12, 31-34, 43-57, 59-90, 99-102, 108, 110-116, and 119 of this Act is to implement the minimum federal standards for health care insurance enacted under P.L. 104-191 (Health Insurance Portability and Accountability Act of 1996).

Sec. 2. AS 21.06.030. Deputies and assistants.
This section reaffirms that persons participating on division advisory committees do not receive payment for transportation or per diem expense. The Division of Insurance has routinely secured public input on insurance regulatory issues using a variety of advisory committees. Volunteers, including many insurance professionals providing technical input, have served without compensation from the state, recognizing that if transportation or per diem expenses were paid by the division the costs would be passed back to them through higher licensee fees or higher insurance premiums reflecting increased administrative costs. The possibility that payment might be required under AS 39.20.180 has recently been brought to the division's attention.

Sec. 3. AS 21.06.085. Uniform data and procedures for health claims.
The changes to this section make the terms consistent with the newly defined health insurance terms under the federal law(HIPAA)

Sec. 4. AS 21.06.110. Director's annual report.
Updates information required to be included in the division's annual report to reflect current practices regarding issuance of certificates of authority and primary regulation of domestic insurers.

Sec 5. AS 21.06.160(a). Examination Cost.
Clarifies this subsection to allow the calculation of a reasonable per hour charge for examination services to include approximated division overhead expenses such as word processing services, facilities and supplies, computer systems, etc. and that out-of-pocket expenses including travel costs shall be paid by the person being examined.

Sec 6. AS 21.09.210(b). Premium Tax Payment - Admitted Insurers.
Allows the director to determine the method of payment of premium taxes to reflect technology changes such as electronic payments and to collect premium taxes quarterly.

Sec 7. AS 21.09.210(d). Premium Tax Payment - Admitted Wet Marine and Transportation Insurers.
Allows the director to determine the method of payment of premium taxes to reflect technology changes such as electronic payments and to collect premium taxes quarterly.

Sec 8. AS 21.09.245. Amendments to Certificate of Authority.
This is a new section that requires an authorized insurer to file with the division within

30 days a name change, domiciliary state change, or other information on its certificate of authority. Amendment to the insurer's articles of incorporation or bylaws, a change of business address or phone number, and other information as designated by the director must be filed within 90 days, and provide for penalties for noncompliance.

Sec 9. AS 21.09.320. Maintenance of Records.
This new section that identifies which records are required to be kept by admitted insurers domiciled in another state. Retention times are specified. Domestic insurers are subject to existing and unchanged provisions. The lack of requirements for other admitted insurers has impeded the division's regulatory oversight including examinations and other investigations.

Sec 10. AS 21.12.020(a)(4)(A)(iii). Accredited Reinsurer Qualifications.
Removes a requirement for a certification of insurer solvency from an insurer's domiciliary regulator because some foreign countries do not provide such certifications. Certification will still be required from the insurer's public accountant.

Sec. 11. AS 21.12.050. Health insurance defined.
This section defines "health care insurance" which is consistent with the definition of "health insuance coverage" in P.L. 104-191 adding Sec. 2791(b) (42 U.S.C. 300gg-91(b)). The federal definition differs from the current state definition and since Alaska's definition is more broad, the federal definition was defined as a subset of the Alaska definition. This section all adds stop loss insurance to the definition of health insurance to affirm that life and health insurers are permitted to write stop loss coverage.

Sec 12. AS 21.12.050.
Definition of health care insurance and stop-loss insurance as referenced in Sec. 11 AS 21.12.050.

Section 13. AS 21.14.010(a). Risk Based Capital Filing.
Clarifies that a domestic insurer must submit its risk based capital report to the director without a specific request.

Section 14. AS 21.14.200(18). Risk Based Capital Instructions.
Clarifies that instructions can be adopted by order of the director after an open meeting since the complexity of the calculation, its continual refinement, and insurer need for nationwide consistency, regulations are an inappropriate way to provide instructions to insurers.

Section 15. AS 21.18.050(4). Capital stock and liabilities charged against assets.
Requires that the minimum reserves for health insurance established in AS 21.18.080-21.18.086 be charged against an insurer's admitted assets for the purpose of determining the insurer's statutory financial condition.

Section 16. AS 21.18.080. Reserve standards for health insurance.
Adopts a more well defined and appropriate standard for minimum reserves for health insurance. Requires that reserve adequacy be determined by a gross premium valuation considering the sum of policy reserves, claims reserves, and premium reserves established under AS 21.18.082-AS 21.18.086.

Section 17. New sections are added to provide for minimum health insurance reserve standards.

AS 21.18.082. Policy reserves for health insurance.
This section defines which policies require a policy reserve and how to calculate the reserve based on minimum standards relating to interest rates, policy termination, morbidity, and reserve method.

AS 21.18.084. Claim reserves for health insurance.
This section establishes that claim reserves are required for all incurred and unpaid claims, including associated expenses, on health insurance policies.

AS 21.18.086. Premium reserves for health insurance.
This section establishes premium reserve requirements that include standards for accounting, discounting, methodology, and minimums levels of unearned premium reserves as they relate to policy reserves.

Section 18. AS 21.21.410. Custodian Agreements.
Requires that a written agreement exist between an insurer and the custodian of its assets, securities, or investments. The agreement must require that the custodian will indemnify for losses if loss results from theft, mysterious disappearance, damage or destruction, or negligence or dishonesty of the custodian's officers, employees, or agents. The agreement must require the custodian to promptly replace an asset or value of the asset. A bank, trust company, or securities firm may serve as custodian if authorized by the insurer and approved by the director.

Section 19. AS 21.27.010(f)(2)(B). License required.
Editorial revision to make "or" the appropriate connector consistent with identical language in (g)(1) of the section.

Section 20. AS 21.27.010(I). Attorney-in-fact License Exemption.
Clarifies that an attorney-in-fact of a reciprocal insurer who meets the qualifications to be exempt from licensure as an attorney-in-fact is not required to be licensed under AS 21.27 as a managing general agent.

Section 21. AS 21.27.040(a). Application for License.
Codifies current procedure that requires an applicant to certify under oath that the information provided on a license application is true and correct.

Section 22. AS 21.27.370(b). Shared Commissions.
Reaffirms that an unlicensed person may not share or receive a commission or any form of remuneration for business transacted in this state, nor may a licensee share commission or other form of remuneration with an unlicensed person.

Section 23. AS 21.27.390(b). Temporary License.
Conforms AS 21.27 with the requirement to issue a temporary license under AS 25.27.244 (Welfare Reform).

Section 24. AS 21.27.405(b). Investigation; cease and desist order.
Updates procedures to allow the director the flexibility to provide service of notice to a person in the most effective and efficient way.

Section 25. AS 21.27.440(a). Fines.
Provides authority for the director to fine an unlicensed person who illegally transacted the business of insurance and received a commission or other form of remuneration.

Section 26. AS 21.27.640(b)(5)(D). Third Party Administrator License Application.
Gives a third-party administrator applicant an option to submit certified financial statements for its period of operation if operations have been for less then two years in order to remove a barrier to start up operations for an applicant who would otherwise be qualified to act as a third-party administrator.

Section 27. AS 21.34.040(c)(4). Unauthorized Insurers - Lloyd's Syndicates.
Establishes solvency requirements for each syndicate or insurer of Lloyds or a similar operation.

Section 28. AS 21.34.040(c)(5). Unauthorized Insurers - Insurance Exchange.
Establishes solvency requirements for each syndicate of an insurance exchange created by the laws of another state.

Section 29. AS 21.34.180(b). Premium Tax Payment - Unauthorized.
Allows the director to determine the method of payment of premium taxes to reflect technology changes such as electronic payments and to collect premium taxes quarterly.

Section 30. AS 21.34.190(a). Unauthorized Filing Fee.
Clarifies that the one percent fee on gross premiums is calculated on the gross premiums reported on the statement of surplus lines tax required under AS 21.34.180(b), which has been amended to allow the director to require reporting more often than annually.

Sec. 31. - Sec. 34., Sec. 43. - Sec. 56. Required Coverages or Offers of Coverage.
References to health insurance terms in these sections were changed to be consistent with the new definitions, "health care insurance" in AS 21.12.050 and "health care insurer" in

AS 21.54.900.

Use of the terms "health care insurance plan" and "health care insurer" generally clarifies that the applicability of these sections include MEWAs and, in three provisions, HMOs. This results from the use of the term "health care insurer" which is defined very broadly to include all entities that transact health care insurance. Note that the definition of health care insurance plan" excludes limited benefit policies and supplemental coverages. In the cases where the provision is to apply to these types of policies it is explicitly added.

The changes to these sections were intended to make the sections consistent with each other in terms of applicability and with the newly defined health insurance terms under the federal law.

Note that:

Sec. 43. AS 21.42.345 was modified to conform with the minimum federal standards pursuant to P.L. 104-191 amending the Public Health Service Act (PHSA) to add Sec. 2701(f) (42 U.S.C. 300gg(f)) regarding enrollment periods for dependents. The current provision applies to both individual and group plans while the federal law applies only to group plans. However, for simplicity the changes made to conform to the federal law were made to both individual and group policies.

Sec. 45. - Sec. 46. AS 21.42.347 relating to costs of childbirth was modified to conform with the minimum federal standards pursuant to P.L. 104-191 adding Sec 2751 to PHSA (42 U.S.C. 300gg-51).

Sec. 35. AS 21.36.185. Maintenance of complaint handling records.
Establishes a requirement based on the NAIC Model Unfair Trade Practices Act for an insurer to maintain records regarding the complaints it receives. The record will assist the division in evaluating an insurer's consumer practices.

Sec. 36. AS 21.36.240. Failure to renew.
Clarifies that an insurance policy may only be non-renewed on its annual anniversary. This only applies to personal property and casualty insurance.

Sec. 37. AS 21.36.290. Policy period.
In conjunction with AS 21.36.240, clarifies the annual policy period and assures that rates for personal auto insurance may only be changed once every 6 months, even if the policy is written for a shorter time period.

Sec. 38. AS 21.36.390. Notice to director.
Adds a requirement that insurers and other licensees report producer defalcations, embezzlements, or violations to the director in much the manner as currently is required for reporting claim fraud. Lack of timely reports to the division has resulted in situations

in which harm to the public or other insurers has been exacerbated. Requires licensees as well as insurers to report fraudulent claims.

Sec. 39. AS 21.39.045(b)-- Risk classification: construction industry.
Clarifies that the credit scale recognizing differences in wages paid applies only to the construction industry.

Sec. 40. AS 21.42.130(5). Disapproval of forms.
Clarifies that rates for individual health insurance are not subject to approval consistent with current statutes that do not provide a mechanism or guidelines for such rate review.

Sec. 41. AS 21.42.205. Coordination of benefits.
Requires that benefits provided under health insurance contracts be coordinated. This coordination is applicable only when an individual is covered under more than one health insurance contract.

Sec. 42. AS 21.42.265. Effective date of coverage.
Clarifies that insurance coverage changes required by a law change become effective at renewal unless the law provides an earlier effective date for the changes.

Sec. 57. Sec. 21.53.090. Required regulations.
Under federal law long term care contracts with certain federally defined characteristics may receive favorable tax treatment. Since this creates a separate class of long term care policies and need for additional protections, the amendments to this section expand the director's authority to write specific regulations for this purpose.

Sec. 58. AS 21.54.015. Rate requirements.
Requires that rates for group health insurance contracts not be excessive, inadequate, or unfairly discriminatory to provide a consistent standard for all group health insurers.

Sec. 59.
This section adds several new sections to AS 21.54 to conform with the minimum federal standards for health care insurance in the group market as follows:

Sec. 21.54.100. Unfair discrimination.
This section is added to conform with the minimum federal standards pursuant to P.L. 104-191 adding Sec. 2702 to PHSA (42 U.S.C. 300gg-1) regarding unfair discrimination in the offer of or enrollment under a health care insurance plan.

Sec. 21.54.110. Preexisting condition exclusion.
This section is added to conform with the minimum federal standards pursuant to P.L. 104-191 Sec. 2701(a)-(b) to PHSA (42 U.S.C. 300gg(a)-(b)) relating to preexisting condition exclusions.

Sec. 21.54.120. Creditable coverage.
This section is added to conform with the minimum federal standards pursuant to P.L. 104-191 adding Sec. 2701(c)-(e) to PHSA (42 U.S.C. 300gg(c)-(e)) relating to

creditable coverage. Creditable coverage is used in determining the allowable preexisting condition waiting period or exclusion. Note that the federal law allows the states discretion in determining an allowable break in coverage in determining creditable coverage. AS 21.56 allowed a 90 day break in coverage for small employer groups and this was maintained in this section and as a result would apply to large employers as well.

Sec. 21.54.130. Renewability, termination, and modification of coverage.
This section is added to conform with the minimum federal standards pursuant to P.L. 104-191 adding Sec. 2712 to PHSA (42 U.S.C. 300gg-12) relating to guaranteed renewability, modification and termination of coverage. Subsection (f) of this section was added to allow an insurer to terminate an individual's coverage if the individual has committed fraud or intentional misrepresentation. This is not part of the federal law but was considered an oversight by the NAIC and HCFA.

Sec. 21.54.140. Renewability of coverage for a multiple employer welfare arrangement.
This section is added to conform with the minimum federal standards pursuant to P.L. 104-191 adding Sec. 703 to ERISA (29 U.S.C. 1183) relating to guaranteed renewability for MEWA plans.

Sec. 21.54.150. Mental health benefits.
This section is added to conform with the minimum federal standards relating to mental health benefits parity pursuant to the amendment to P.L. 104-191 adding Sec. 2705 to PHSA (42 U.S.C. 300gg-5).

Sec. 21.54.160. Excepted benefits defined.
This section defines the health plans that are not subject to the minimum federal standards and are termed "excepted benefits" in the federal law. These "excepted benefits" are explicitly defined in P.L. 104-191 adding Sec. 2791(c) to PHSA (42 U.S.C. 300gg-91(c)). These health plans are basically limited benefit and supplemental health insurance plans. The definition of "health care insurance plan" as proposed in this bill excludes "excepted benefits".

Sec. 21.54.170. Determination of size of employer.
This section describes how the size of an employer is to be determined as described in P.L. 104-191 adding Sec. 2791(e)(6) to PHSA (42 U.S.C. 300gg-91(e)).

Article 3. Sec. 21.54.500. Definitions.
This section adds new definitions necessary to conform with the minimum federal standards. The definitions are consistent with the definitions in P.L. 104-191 adding Sec. 2701(b), Sec. 2701(e), Sec. 2705(e) and Sec. 2791 to PHSA (42 U.S.C. 300gg(b), 42 U.S.C. 300gg(e), 42 U.S.C. 300gg-5(e), 42 U.S.C. 300gg-91 respectively)

Sec. 60. - Sec. 68. Comprehensive Health Insurance Association.
These sections amend AS 21.55 relating to the Comprehensive Health Insurance Association. P.L. 104-191 adding Sec. 2744 to PHSA (42 U.S.C. 300gg-44) allows a state to use a qualified high risk pool to guarantee portability of health insurance coverage to federally eligible individuals. The amendments to this section allow a "federally defined

eligible individual" defined in P.L. 104-191 adding Sec. 2741(b) to PHSA (42 U.S.C. 300gg-41(b)) to participate in the CHIA. Use of Alaska's high risk pool (CHIA) would be the least disruptive mechanism allowed under the federal law to reform the individual health insurance market in Alaska and therefore was the selected mechanism. Experience in other states such as Washington, New Jersey, and New York relating to the alternative mechanisms allowed in the federal law has resulted in significant increases in claims and premiums and decreases in the number of individuals insured and the number of insurance companies writing individual health insurance.

Sec. 69. - Sec. 90 Small Employer Health Reinsurance Association.
These sections amend AS 21.56 relating to health insurance coverage for small employers to remove any conflicts with the minimum federal requirements under P.L. 104-191. Certain sections of AS 21.56 were repealed and reenacted under AS 21.54 because under federal law those provisions apply to both large and small employer groups. The sections in AS 21.56 relating to guaranteed issue were amended to conform with the federal minimums for small employer groups pursuant to P.L. 104-191 adding Sec. 2711 to PHSA (42 U.S.C. 300gg-11). To the extent possible the provisions in AS 21.56 were not modified unless they would prevent application of the federal minimums.

Also, several sections are amended to change the term "association" to "reinsurance association" in order to avoid confusion with a "bona fide association" as defined in the federal law.

Sec. 77. AS 21.56.075. Premium report.
This is a new section that requires members of the Small Employer Reinsurance Association to report to the director on an annual basis the total amount of small employer health insurance premiums written in the state. While not required by federal law, this section will significantly improve the ability of the Association to assess Association members for losses.

Sec. 91. AS 21.66.110(a). Premium Tax Payment - Title Insurance.
Allows the director to determine the method of payment of premium taxes to reflect technology changes such as electronic payments and to collect premium taxes quarterly.

Sec. 92. AS 21.66.390(a). Making of rates.
Adds investment income as one of the elements to be considered when evaluating the rates charged by title insurers.

Sec. 93. AS 21.69.310(a). Annual Meeting Location.
Allows the director upon show of good cause to approve a domestic insurer's request to hold its required annual meeting in a city outside of the location of its principal office or place of business.

Sec. 94. AS 21.69.520(a). Borrowed Funds.

Requires director approval for an insurer to borrow funds when a written agreement requires that the money be repaid only out of the insurer's excess surplus and removes permission for an insurer to borrow money in this manner for any purpose of the insurer's business.

Sec. 95. AS 21.75.045(a). Attorney-in-fact License Exemption.
Expands the exception for being licensed as an attorney-in-fact to all reciprocal insurers. The exemption is allowed when the attorney-in-fact is a wholly-owned subsidiary of the reciprocal insurer who only acts for the one reciprocal. Attorneys-in-fact who operate more than one reciprocal insurer must be licensed under this section.

Sec. 96. AS 21.76.020(b). Joint Insurance Arrangement Reporting.
Specifies that the report prepared by a joint insurance arrangement and filed with the legislative budget and audit committee shall also be filed with the director.

Sec. 97. AS 21.76.080(e). Joint Insurance Arrangement Reporting.
Allows for the report filed by the joint insurance arrangement with its board of directors and the director to be an audit based on generally accepted accounting principles rather than requirements established by the director. A report filed with the director is open to public inspection unless specifically precluded by statute.

Sec. 98. AS 21.78.293(b). Receiver's recommendation to the court.
In order to reduce litigation over claims and thereby expedite the closure of a receivership estate (to the benefit of insurance policyholders and other claimants), the superior court shall review and adopt the receiver's report on claims by using the substantial evidence standard. The period of disapproving claims is extended to 120 days.

Sec. 99. AS 21.84.590. Other provisions applicable.
This amendment clarifies that the minimum federal standards apply to Fraternal Benefit Societies.

Sec. 100. - Sec. 102. Health Maintenance Organizations.
These sections amend AS 21.86 relating to HMOs in order to conform with the minimum federal standards pursuant to P.L. 104-191 adding Sec. 2701(g) to PHSA (42 U.S.C. 300gg(g)).

Sec. 103. AS 21.87.140(c)(1). Medical service agreements.
Updates terminology of participant provider contract requirements to reflect managed care compensation arrangements as well as traditional indemnity reimbursement.

Sec. 104. AS 21.87.150(c)(1). Hospital service agreements.
Updates terminology of participant hospital contract requirements to reflect managed care compensation arrangements as well as traditional indemnity reimbursement.

Sec. 105. AS 21.87.180(a). Filing and approval of agreements and contracts.
Conforms form filing requirements for medical and hospital service corporations to similar requirements for other insurers subject to form filing.

Sec. 106. AS 21.87.190(b). Subscription rates, fees, and payments.
Clarifies rate filing requirements. Allows the director discretion to protect medical and hospital service corporations from competitive disadvantage that may arise from disclosing rating formulas when other health insurers are not required to file rates for approval and disclose rating formulas.

Sec. 107. AS 21.87.200. Reserves.
Requires that hospital or medical service corporations have minimum reserve standards and reporting consistent with other health insurers.

Sec. 108. AS 21.87.340. Other provisions applicable.
Amendments in this section clarify that the minimum federal standards apply to Hospital and Medical Service Corporations.

Sec. 109. AS 21.89.020(g) -- Short term auto policy.
Clarifies that the requirements of AS 21.36.210 - 21.36.310 do not apply to seven-day policies.

Sec. 110. AS 21.90.900(29). Definitions for title.
The definition of policy is modified to extend to group certificates issued in Alaska when the group policy is issued and delivered outside of Alaska to ensure consistency in application of state law to all group health care plans covering individuals resident in Alaska. The new minimum federal standards apply to such certificates and without this amendment Alaska may have difficulty asserting regulatory authority over such certificates. Failure to regulate group certificates could result in the federal government determining that Alaska is not substantially enforcing the minimum federal standards resulting in federal regulation of Alaska's health insurance market.

Sec. 111. AS 21.90.900. Definitions for title.
This section adds two new definitions. The term "certified financial statement" is added to clarify its meaning in relation to licensing requirements. This term "medical care" as defined in P.L. 104-191 adding Sec. 2791(a)(2) to PHSA (42 U.S.C. 300gg-91(a)(2)) is added since it is needed in order to define "health care insurance".

Sec. 112. Repeal.
This section repeals the sections in AS 21.56 relating to small employer health insurance that conflict with federal law. As stated above many of the provisions were modified and moved to AS 21.54 since they apply to both large and small groups under the federal law.

AS 21.42.375(d) (mammography) and AS 21.42.395(d) (prostate and cervical cancer

screening) exclude limited and supplemental benefit plans from the applicability of the provisions and since these are excluded by use of the newly defined term "health care insurance plan" these sections were repealed.

Also this section corrects an oversight by repealing Chapter 81 that was superseded by legislation enacted in 1995 (AS 21.09.310).

Sec. 113, Sec. 116, and Sec. 119. Mental health insurance effective dates.
These sections establish the effective date of January 1, 1998 and sunset on September 20, 2001 of the mental health insurance provisions required under the federal law.

Sec. 114. and Sec. 115. Repeal of sunset provisions.
These sections repeal the sunset provisions in AS 21.56 relating to Small Employer Health Insurance and the Dental, Vision and Hearing provision in AS 21.42.385. The repeal of AS 21.56 is necessary since the availability provisions in AS 21.56 are required by federal law which do not sunset.

Sec. 117. and Sec. 118. Effective dates.
Sec. 6, 7, 27-30, and 91 take effect on January 1, 1998. All other sections take effect on July 1, 1997.

EXECUTIVE SUMMARY
KASSENBAUM/KENNEDY BILL

Presented by
Marianne K. Burke, Director
Division of Insurance

Health Insurance Portability and Accountability Act of 1996 (HIPAA, or Kassenbaum/Kennedy)

- signed by the President on August 21, 1996
- most sweeping health care legislation since passage of Employee Retirement Income Security Act (ERISA) in 1974

General Structure of HIPAA:

1) amendments to ERISA. One reason the law is so sweeping is it affects self-funded plans, and helps level the playing field by imposing standards on plans over which the states have no jurisdiction
2) parallel amendments to the Public Health Service Act (PHSA) that affect health carriers
3) amendments to the tax code for long-term care insurance, medical savings accounts and deductibility for the self-employed

Our bill focuses on number 2 - amendments to our insurance code.

Insurance Code amendments fall into three areas:

- **small group market** reforms
- **large group market** reforms
- **individual market** reforms

Essential elements of HIPAA:

Small group market:

1) **guaranteed issue** to
   - **all small employers** (defined as those having an average number of employees during the prior year of 2-50)
   - **all eligible employees**
   - **all products** offered by a carrier in the small group market, not just the standard and basis plans as in current law

2) **guaranteed renewability** of all policies with certain enumerated exceptions

3) **preexisting condition exclusion limitations** - limited to 6/12 (lookback/ exclusion) with credit for prior coverage as long as there has been no gap in coverage greater than 63 days; current Alaska law allows a gap no longer than 90 days

Large Group market:

1) **guaranteed renewability** of all policies with certain enumerated exceptions

2) **preexisting condition exclusion limitations** - limited to 6/12 (lookback/ exclusion) with credit for prior coverage as long as there has been no gap in coverage greater than 63 days

The bill calls for a study of availability in the large group market; no guaranteed issue requirements in this market.

Individual market:

1) **guaranteed issue** to eligible individuals (those with 18 months creditable coverage, most recently in a group plan, with no break in coverage greater than 63 days

2) **guaranteed renewability** of all policies with certain enumerated exceptions

3) **no preexisting condition exclusions** may be imposed **on eligible individuals**

Pregnancy and genetic testing in absence of the condition are not allowed as preexisting conditions in the group market, and are not allowed for eligible individuals in the individual market.

HIPAA creates federal standards in the area of health insurance by essentially creating a floor in certain areas, below which state standards may not fall.

- however, state flexibility exists
- certain state laws are specifically preempted if not in compliance with the federal standards, for example preexisting condition exclusion provisions

With respect to the individual market, the federal standards will not apply if the state enacts what is called an **acceptable alternative mechanism**. There is a four-pronged test for an acceptable alternative mechanism, and the states are given many options as to how to comply.

HIPAA requires that an **acceptable alternative mechanism** meet **four requirements**:

1. It must provide eligible individuals with a **choice** of coverage;

2. It cannot impose any **preexisting condition exclusions** for eligible individuals;

3. The choice must include **at least one policy form** that is:

   (i) comparable to **comprehensive coverage** in the individual market in the state; **or**
   (ii) comparable to the **standard** plan under the state's small group or individual laws;

-AND-

4. The state must be implementing **one of three** things:

   (a) one of **two specified NAIC models laws** on individual market reform;

   (b) a qualified **high risk pool** as defined in the law; or

   (c) (i) a mechanism providing for **risk adjustment, risk spreading**, or a risk spreading mechanism or otherwise provides for some **financial subsidization** of eligible individuals; or

   (ii) a mechanism allowing eligible individuals a **choice of all available** individual health insurance coverage.

OVERVIEW
KASSEBAUM/KENNEDY BILL

Presented by
Marianne K. Burke, Director
Division of Insurance

I. General Points

Overview: P.L. 104-191, commonly called Kassebaum/Kennedy (K/K), creates federal standards for both the individual and group health insurance markets, but it does permit substantial state flexibility for compliance. The law requires insurers to offer coverage to **all small employers** that apply for coverage and **to individuals** meeting certain requirements **(guaranteed issue)**; to guarantee renew coverage in both the group and individual markets **(guaranteed renewal)**; and to **limit the use of preexisting condition exclusions in the group market and eliminate them in the individual market for eligible individuals.** However, the federal law does not limit the premiums that issuers can charge for any type of coverage.

Preemption: The **test for preemption** in all cases EXCEPT for provisions relating to preexisting condition exclusions is: whether the state's standards and requirements would **prevent the application of the federal law.**

The **test for preemption** for provisions affecting **preexisting condition exclusions** is: The federal law DOES "**supersede any provision of State law** which establishes, implements, or continues in effect a standard or requirement applicable to imposition of a preexisting condition exclusion specifically governed by the law (in ERISA section 701 or PHSA section 2701) which **differs** from the standards or requirements in those sections, **UNLESS** the State provision meets one of seven **specific exceptions**.

II. Group Market

K/K requires **guaranteed issue of all products in the small group market.** This is a relatively radical requirement for a number of states. The federal law is also very specific that a **small group is a group of 2 to at least 50.** States may extend the law's guaranteed issue protection to larger groups, and include groups of 1 if they cover the self-employed in the small group rather than the individual market.

The **guaranteed renewability** requirement applies to **groups of all sizes.**

The rules restricting the use of **preexisting conditions exclusions** and prohibiting the use of **health status-related factors** for purposes of issuing and renewing coverage apply to **groups of all sizes.**

NAIC 1992 Small Group Model

Alaska adopted a modified version of the NAIC's 1992 Small Group Model.

The 1992 Small Group Model only requires guaranteed issue of a basic and standard health benefit plan by all health carriers doing business in a state's

small group market. A state with this model will therefore need to expand the guaranteed issue requirement to all products offered by the insurer. K/K requires guaranteed issue of all products in the small group market.

The 1992 Small Group Model requires guaranteed renewability, subject to certain exceptions. In general these exceptions are consistent with the federal law, but need the revisions suggested by the P.L. 104-191 States Implementation Working Group.

The 1992 Small Group Model allows a preexisting condition exclusion of twelve months. This is consistent with K/K, except that the model requires certain revisions to prohibit preexisting condition exclusions based on pregnancy as a preexisting condition and to extend the permissible period for a gap in coverage to 63 days.

Another key issue is the definition of "small employer." The federal law is very specific that there is guaranteed issue for groups of 2 to at least 50, and it sets forth the method of calculating that group. The 1992 Model must be modified as suggested to conform to the federal requirements.

The 1992 Model must also be revised to ensure that its concept of "qualifying previous coverage" and "qualifying existing coverage" are consistent with the federal law's concept of "creditable coverage."

III. Individual Market

We would like to review the possible scenarios for implementing an acceptable alternative mechanism to meet the requirements of K/K for the individual market.

The law requires that an **acceptable alternative mechanism** meet **four requirements**:

1. It must provide eligible individuals with a **choice** of coverage;
2. It cannot impose any **preexisting condition exclusions** for eligible individuals;
3. The choice must include at least one policy form that is:
   (i) comparable to **comprehensive coverage** in the individual market in the state; **or**
   (ii) comparable to the **standard** plan under the state's small group or individual laws;

-AND-

4. The state must be implementing **one of three** things:

   (a) one of the **two NAIC models laws** on individual market reform;
   (b) a qualified **high risk pool** as defined in the law; or
   (c) (i) a mechanism providing for **risk adjustment, risk spreading**, or a risk spreading mechanism or otherwise provides for some **financial subsidization** of eligible individuals; or
   (ii) a mechanism allowing eligible individuals a **choice of all available** individual health insurance coverage.

Under the federal law, an eligible individual:

(1) has had, in the aggregate, at least 18 months of creditable coverage;
(2) the most recent coverage is under a group, governmental, or church plan including a self insured group;
(3) is not eligible for any other coverage, including Medicare, Medicaid, etc.;
(4) has not had coverage terminated for nonpayment of premiums or fraud;
(5) has exhausted a COBRA continuation option if one was available;
(6) has had no gap in coverage exceeding 63 days.

Given these requirements, what are a state's options?

Option 1: Guaranteed issue of all products in the individual market.

States that already have guaranteed issue of all products in the individual market will have to do little to comply with the federal law's requirements. However, even these states must ensure that any state restrictions limiting the individuals eligible for guaranteed issue do not prevent those individuals who are eligible for guaranteed issue under the federal law from obtaining coverage. The state must also ensure that its high risk pool does not impose any preexisting condition exclusions for federally defined eligible individuals.

Option 2: High risk pool.

The federal law defines a qualified high risk pool as one that:

(1) Provides coverage to all eligible individuals.
(2) Does not impose a preexisting condition on an eligible individual;
(3) Provides for premium rates and covered benefits for such coverage consistent with the NAIC's Model Health Plan for Uninsurable Individuals Model Act (i.e., premium rates do not exceed 200 percent of standard risk rates);

States that choose this option will have to make sure that their risk pool meets the requirements above. Other issues raised by the high risk pool:

(1) Can state residency requirements stand?
(2) Must the high risk pool provide a choice of more than one policy? Will one policy with a choice of deductibles suffice?
(3) What is a "comprehensive" policy with respect to a state's individual market?

Option 3: Adopt one of the two NAIC individual market models.

K/K references the two NAIC models addressing individual market reform: (1) the Small Employer and Individual Health Insurance Availability Model Act, as it relates to the individual market ("Availability" Model); and (2) the Individual Health Insurance Portability Model Act ("Portability" Model).

Adoption of one of these models will constitute an acceptable alternative mechanism, provided that the other three criteria are met: a choice of coverage for all federally defined eligible individuals, which includes a choice of a comprehensive policy, and no preexisting condition exclusions for these individuals.

These two models are being reviewed and revised by the NAIC P.L. 104-191 States Implementation Working Group to make the revisions required for compliance with K/K.

General Structure of the Availability Model

In the small group market, the Availability Model requires guaranteed issue of all products, including a standard and basic plan. In the individual market it also requires guaranteed issue of all products, including a standard and basic plan, but sets out two options: a year-round guaranteed issue requirement, or a rolling open enrollment option which guarantees an individual one-month each year in which to obtain a product. It requires adjusted community rating, with variations allowed only for geographic area, family composition, and age.

It requires guaranteed renewability for both small group and individual products, subject to standard exceptions such as fraud or misrepresentation, nonpayment of premiums, etc. In general these exceptions are consistent with the requirements of the federal law, subject to some deviations.

In general the Availability Model s provisions for preexisting condition exclusions, definition of preexisting condition, eligible individual, etc. are similar to the requirements of the federal law. However, it allows a twelve-month preexisting condition exclusion and therefore must be modified to prohibit any exclusions for federally defined eligible individuals. Also, the concept of "crediting" coverage and shortening preexisting condition exclusions accordingly differs somewhat, as do some slight elements of the phrasing of the definitions. Because of the very preemptive language of the federal law for state provisions that address preexisting condition exclusions, some revisions have been made to the language of this model.

General Structure of the Portability Model

The Portability Model addresses only the individual market. It requires guaranteed issue of a basic and a standard plan by all health carriers doing business in the state's individual market. The director establishes by regulation the form and level of coverage of the basic and standard health benefit plans. It permits rating bands, subject to certain requirements.

The Portability Model requires guaranteed renewability of individual health benefit plans.

It allows a twelve-month preexisting condition exclusion and therefore must be modified to prohibit any exclusions for federally defined eligible individuals.

Option 4: Mandatory group conversion policies.

Some states have mandatory group conversion policies. These policies will not apply to individuals covered by self-funded ERISA plans. Therefore, such laws alone will not enable a state to comply with K/K because they will not protect many individuals who are entitled to protection under the federal law. Alaska does not have mandatory group conversion policies.

Option 5: Open enrollment by one or more health insurance issuers.

States that have implemented open enrollment by one or more insurers have in place a broader protection than that afforded by the rolling open enrollment option of the NAIC Availability Model. However, the rolling open enrollment option as set forth in the revised NAIC model is sufficient for compliance with K/K's guaranteed issue requirements because it would allow federally defined eligible individuals to have 63 days to obtain coverage and would not require them to wait until the month of their birthday. Under the NAIC model, other individuals with previous coverage could obtain coverage within 31 days of the termination of the previous coverage. Not available in Alaska.

Option 6: Some combination of the 4 options above.

The federal law permits states to have some combination of permissible mechanism. (Section 2744(a)(2).) The law does not specify whether a state must offer every eligible individual the same choices, or whether it may provide different groups with different choices.

Another point is that some mechanisms already contained in state law will not protect individuals whose previous coverage was in a self-funded ERISA plan. This is a problem with mandatory conversion laws, as noted above.

Option 7: Rely on federal fallback standards instead of implementing an alternative mechanism.

Guaranteed Availability: Federal standards apply if there is No State Alternative Mechanism. (Section 2741(c)). Therefore, in states that do NOT implement an acceptable alternative mechanism under Section 2744, the following standards and exceptions apply:

A. The **health insurance issuer** may **elect** to limit coverage to eligible persons to a **choice** of only **two different policy forms** (Section 2741(c)), both of which must:

(1) be designed for, made generally available to, are actively marketed to, and enroll both eligible and other individuals; **and**

(2) Either:

(a) be the "most popular policy forms:" The forms with the largest and second largest **premium volume** in the state or applicable marketing or service area (as defined in regulation); **or**

(b) be "policy forms with representative coverage:" Be a lower level and a higher level form, each of which contains benefits substantially similar to other individual coverage offered by the issuer AND each of which is covered under some risk spreading mechanism.

(i) Lower level coverage is defined as having an actuarial value of 85--100% of the weighted average;

(ii) Higher level coverage is defined as having an actuarial value of at least 15% greater than lower level coverage and between 100--120% of the weighted average;

(iii) A risk spreading mechanism must provide for risk adjustment, risk spreading, or a risk spreading mechanism (either among issuers or among the policies of an issuer); or must otherwise provide for some financial subsidization for eligible individuals, including through assistance to participating issuers. (Sec. 2744(c)(3)(A).)

(3) For purposes of Section 2741(c), policy forms which have different cost-sharing arrangements or different riders shall be considered different policy forms.

B. Special Rules for Network Plans: (These apply if the state does not implement an alternative mechanism):

(1) A network plan may limit enrollees to those who live, reside or work in the service area;

(2) A network plan may deny coverage based on the plan's enrollment capacity limits, as long as coverage is denied uniformly without regard to health status-related factors;

(3) If coverage is denied based on service capacity, the issuer is suspended from offering new coverage in the service area for 180 days;

C. Exception for Financial Capacity: (This applies if the state does not implement an alternative mechanism.)

(1) Health insurance issuer may deny health insurance coverage in the individual market to an eligible individual if the issuer demonstrates to the director that:

(a) It lacks financial reserves necessary to underwrite additional coverage; AND

(b) Is applying this denial uniformly to all individuals in the state's individual market, consistently with state law and without regard to health status-related factors and without regard to whether individuals are eligible individuals.

(2) If an issuer denies coverage based on financial capacity, it is suspended from offering coverage in the individual market in that service area for the later of: 180 days from the date of denial; or until the issuer demonstrates to the director, if required under state law, that it has sufficient financial reserves to underwrite additional coverage.

Guaranteed Renewability

A. Federal Standards apply REGARDLESS of whether the state is implementing an alternative mechanism for guaranteed issue.

B. All individuals enjoy guaranteed renewability, not just individuals eligible for guaranteed issue.

C. Exceptions to guaranteed renewability requirement:

(1) Nonpayment of premiums;

(2) Fraud or intentional misrepresentation of a material fact by an individual;

(3) Termination of a product: Issuer must provide notice to enrollee 90 days before termination, offer option to purchase any other individual product offered by the issuer, and act uniformly without regard to health status-related factors;

(4) Discontinuance of all individual coverage: Issuer must provide notice to the director and enrollees 180 days before termination, and is prohibited from market reentry for 5 years after date of last discontinuation due to nonrenewal.

(5) Network plans: Issuer may nonrenew if the individual no longer resides, lives, or works in the service area, provided that the issuer nonrenews uniformly, without regard to health status-related factors.

(6) Association membership ceases: Issuer may nonrenew if the individual ceases to be a member of the association through which coverage is obtained, provided that the issuer nonrenews uniformly, without regard to health status-related factors.

(7) Modification of coverage: At the time of coverage renewal, issuer may modify the policy form consistent with state law and provided that modification is effective on uniform basis among all individuals having that policy form.

IV. Other Issues

Mandatory Maternity Coverage

The Newborns' and Mothers' Health Protection Act of 1996 is an amendment to the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191). It applies to health care coverage sold in both the small and large group markets and the individual market.

The Act prohibits group health plans and health insurance issuers from restricting hospital coverage in connection with childbirth to less than 48 hours for a normal vaginal delivery and less than 96 hours for a cesarean section. It also prohibits plans from requiring the provider to obtain authorization for stays of this length. However, these exceptions do not apply to any case in which the decision to discharge the mother earlier than these minimum periods is made "by an attending provider in consultation with the mother."

The law also prohibits a group health plan or health insurance issuer from denying coverage to a mother or child to avoid the law's requirements, or from offering them financial incentives to reduce the length of stay. Nor may group health plans and health insurance issuers penalize attending providers for complying with the law or create financial incentives for providers that are inconsistent with the law.

The law contains three broad exceptions to the preemption of state law addressing hospital stays for childbirth. State law is NOT preempted if: (1) the state law requires coverage for a minimum of 48 hours for normal vaginal delivery and 96 hours for cesarean section; or (2) the state law requires coverage for maternity and pediatric care in accordance with guidelines issued either by the American College of Obstetricians and Gynecologists, or the American Academy of Pediatrics, "or other established professional medical associations"; or (3) the state law requires that, in connection with coverage for maternity care, the decision about the hospital length of stay is left to (or required to be made by) the attending provider in consultation with the mother.

The law also directs the Secretary of the U.S. Department of Health and Human Services to appoint an advisory panel to review studies that the Act requires the Secretary to undertake and to develop a consensus about the appropriateness of the Act's requirements. The advisory panel is to include representation from number of specified entities, including states and entities having expertise in consumer issues.

Because this Act is an amendment to P.L. 104-191 (Kassenbaum-Kennedy), the enforcement provisions of that act also apply to this law. States will enforce the maternity provisions against insurance carriers and entities under state jurisdiction unless the HHS Secretary determines that a state has failed to substantially enforce a provision, in which case the HHS Secretary will enforce the law. The Secretary of the U.S. Department of Labor will enforce the law with respect to ERISA plans.

The Act is effective January 1, 1998.

Mental Health Parity

The Mental Health Parity Act of 1996 is an amendment to the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191). It applies only to health care coverage sold through the large group market (groups of 51 or more).

The law provides that if a group plan does **not impose** an **aggregate lifetime limit** on **medical and surgical benefits**, it may **not impose such a limit on mental health benefits**. If the plan does impose an aggregate lifetime limit, the Act requires the plan to include mental health benefits with medical/surgical benefits in the aggregate limit and not distinguish between the two; or in the alternative, to offer an aggregate limit for mental health benefits that is not less than the aggregate limit for medical/surgical benefits. For plans that categorize among different types of medical and surgical benefits for the purpose of applying limits, the Secretary of the U.S. Department of Health and Human Services (or, for self-funded ERISA plans, the Secretary of the U.S. Department of Labor) is authorized to promulgate regulations for determining the aggregate lifetime limit. The law specifies the method for computing this limit.

The Act imposes **identical rules for annual limits**. If a plan does not include an annual limit on medical and surgical benefits, it may not impose such a limit on mental health benefits. If the plan does impose an annual limit, it must either include mental health benefits in the aggregate and not distinguish between medical/surgical and mental health benefits, or in the alternative, not impose any limit on mental health benefits that is less than the medical/surgical benefits limit. Again, for plans that categorize medical/surgical benefits and apply different limits per category, the HHS Secretary (or Labor Secretary) is required

to promulgate regulations for computing the aggregate annual limit as specified in the Act.

The Act does not require a group health plan to offer any mental health benefit, and does not affect the terms and conditions relating to the scope of any mental health benefit that is provided, except as described above with respect to limits.

The scope of this Act is limited by four of its provisions. First, as noted above, there is an exemption for small employers, defined as those having two to fifty employees. Second, there is an exemption if a group health plan experiences "an increase in the cost under the plan (or for such coverage) of at least 1 percent." The law does not make clear how this provision would be determined or enforced. Third, mental health benefits as defined in the law do not include substance abuse or chemical dependency services. Fourth, there is a sunset provision.

Without additional Congressional action, this law is only in effect from Jan. 1, 1998 through Sept. 30, 2001.

Because this Act is an amendment to P.L. 104-191 (Kassenbaum-Kennedy), the enforcement provisions of that act also apply to this law. States will enforce the mental health parity provisions against insurance carriers and entities under state jurisdiction unless the HHS Secretary determines that a state has failed to substantially enforce a provision, in which case the HHS Secretary will enforce the law. The Secretary of the U.S. Department of Labor will enforce the law with respect to ERISA plans.