

**SB**

**70**

<TARGET><BILL>SB 70</BILL><SUBJECT>SB  
70</SUBJECT><COMM>SFIN27</COMM></TARGET>

# SENATE FINANCE COMMITTEE REPORT

DATE: 3/23/11

FURTHER:

DATE TURNED  
IN TO OFFICE: \_\_\_\_\_

Finance Committee considered SENATE BILL NO. 70

## SB 70-ALASKA HEALTH BENEFIT EXCHANGE

"An Act establishing the Alaska Health Benefit Exchange; and providing for an effective date."

and recommends:

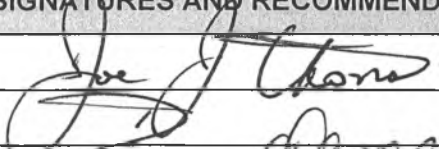
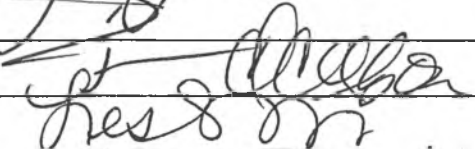


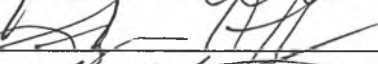

- be replaced with CS SB 70 (FIN) [ Same Title [ ] New Title  
 adopt previous CS \_\_\_\_\_ (\_\_\_\_\_) [ ] Same Title [ ] New Title  
 attached amendment(s)  
 adopt \_\_\_\_\_ Letter of Intent  
 further referral to \_\_\_\_\_ Committee

Dept Abbr.	
ADM	LEG
CED	LAW
COR	LWF
CRT	MVA
EED	DNR
DEC	DPS
DFG	REV
GOV	DOT
DHS	UA

NEW FISCAL NOTE(S)				
Dept.	Fiscal	Indet.	Zero	FN #
DHS	✓			
CFD			✓	
CED	✓			
ADM	✓			

PREVIOUS FISCAL NOTE(S)				
Dept.	Fiscal	Indet.	Zero	FN #

APPROPRIATION - no fiscal note

SIGNATURES AND RECOMMENDATIONS:	PRINTED LAST NAME	DO PASS	DO NOT PASS	NO REC	AMEND
	Thomas	✓			
	EGG OLSON				
	Melvyn	✓		✓	
	ELLIS	✓			
CO-CHAIR: 	Hoffman	✓			
CO-CHAIR: 	Stedman			✓	

# FISCAL NOTE

**STATE OF ALASKA**  
**2012 LEGISLATIVE SESSION**

cost # codes

Bill Version

CSSB070(L&C)

Fiscal Note Number

Publish Date

Identifier (file name) SB070CS(L&C)-DHSS-PAFS-01-18-12

Dept. Affected Health and Social Services

Title Alaska Health Benefit Exchange

Appropriation Public Assistance

Allocation Public Assistance Field Services

Sponsor Sen. French

Requester Senate Finance Committee

OMB Component Number 236

**Expenditures/Revenues**

(Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	FY13 Appropriation Requested	Included in Governor's FY13 Request	Out-Year Cost Estimates				
			FY14	FY15	FY16	FY17	FY18
<b>OPERATING EXPENDITURES</b>	<b>FY13</b>	<b>FY13</b>					
Personal Services	310.5						
Travel							
Services	24.0						
Commodities	1.2						
Capital Outlay	29.7						
Grants, Benefits							
Miscellaneous							
<b>TOTAL OPERATING</b>	<b>365.4</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>

<b>FUND SOURCE</b>		(Thousands of Dollars)					
1002	Federal Receipts	182.7					
1003	GF Match	182.7					
1004	GF						
1005	GF/Prgm (DGF)						
1037	GF/MH (UGF)						
1178	temp code (UGF)						
<b>TOTAL</b>		<b>365.4</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>

<b>POSITIONS</b>							
Full-time							
Part-time	3.0						
Temporary							

<b>CHANGE IN REVENUES</b>							

Estimated SUPPLEMENTAL (FY12) operating costs 0.0 (separate supplemental appropriation required)  
 (discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY13) costs 0.0 (separate capital appropriation required)  
 (discuss reasons and fund source(s) in analysis section)

Why this fiscal note differs from previous version (if initial version, please note as such)

Updated fiscal note to reflect current fiscal year.

Prepared by Ron Kreher, Director  
 Division Public Assistance  
 Approved by Nancy Rolfzen, Assistant Commissioner  
DHSS Finance & Management Services

Phone (907) 465-5835  
 Date/Time 1/18/12 12:00 PM  
 Date 1/18/2012

FISCAL NOTE

STATE OF ALASKA  
2012 LEGISLATIVE SESSION

BILL NO. CSSB070(L&C)

**Analysis**

This legislation establishes a state health insurance exchange for consumers and small businesses in compliance with provisions of the Affordable Care Act. As part of its duties, the exchange will inform individuals about Medicaid, the Child Health Insurance Program (i.e. Denali KidCare), and any other applicable programs. If the exchange determines that the individual is eligible for a program, it must enroll the individual in that program. The legislation also gives the exchange the authority to enter into a contract for the performance of its duties with the Department of Health and Social Services.

Assumptions:

- The legislation will become effective 7/1/2012.
- The Insurance Exchange will contract with the Department of Health and Social Services, Division of Public Assistance (DHSS/DPA) to determine Medicaid and Denali KidCare eligibility for new enrollees.
- The exchange will pass necessary demographic and financial information to DHSS/DPA so that it can establish and maintain Medicaid eligibility for the new enrollees. This information will be passed to DHSS/DPA electronically.
- System enhancements will need to be made to DPA's Eligibility Information System (EIS) to receive data from the exchange and register it in EIS.
- Development and testing of the EIS system enhancements will take 9 months.
- The exchange will begin passing information to DPA's EIS in FY 2013.
- The costs of adding the new Medicaid expansion included in the Affordable Care Act are not included in the estimates.

FY 2013 Administration Costs: \$365.4

Personal Services: Staff needed to develop and test the system enhancements in FY 2013:

\$112.0 for salary and benefits for 1 Analyst/Programmer IV for 9 months  
\$198.5 for salary and benefits for 2 Analyst/Programmers III for 9 months  
\$310.5 - Total

Commodities:

\$ 1.2 (\$0.55 x 3 staff x .75 (9 months)) = \$1.2)

Contractual:

\$ 24.0 costs for phones, office space, etc.

Capital Outlay:

\$ 29.7 one time purchase for personal computers, software, workstations and associated costs for 3 staff  
(\$9.9 x 3 = \$29.7)

# FISCAL NOTE

STATE OF ALASKA  
2012 LEGISLATIVE SESSION

Bill Version SB 70  
Fiscal Note Number \_\_\_\_\_  
( ) Publish Date \_\_\_\_\_

Identifier (file name) SB070-DCCED-INS-12-01-11 Dept. Affected DCCED  
Title Alaska Health Benefit Exchange Appropriation Insurance  
Allocation Insurance  
Sponsor Senator French  
Requester Senate Finance OMB Component Number 354

**Expenditures/Revenues** (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	FY13 Appropriation Requested	Included in Governor's FY13 Request	Out-Year Cost Estimates					
			FY13	FY13	FY14	FY15	FY16	FY17
<b>OPERATING EXPENDITURES</b>								
Personal Services	0.0		0.0	0.0	0.0	0.0	0.0	0.0
Travel	0.0		0.0	0.0	0.0	0.0	0.0	0.0
Services	0.0		0.0	0.0	0.0	0.0	0.0	0.0
Commodities	0.0		0.0	0.0	0.0	0.0	0.0	0.0
Capital Outlay								
Grants, Benefits								
Miscellaneous								
<b>TOTAL OPERATING</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>

FUND SOURCE		(Thousands of Dollars)						
1002	Federal Receipts							
1003	GF Match							
1004	GF							
1005	GF/Prgm (DGF)							
1037	GF/MH (UGF)							
1178	temp code (UGF)							
	<b>TOTAL</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>

POSITIONS								
Full-time								
Part-time								
Temporary								

<b>CHANGE IN REVENUES</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>
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Estimated SUPPLEMENTAL (FY12) operating costs 0.0 (separate supplemental appropriation required;  
(discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY13) costs 0.0 (separate capital appropriation required)  
(discuss reasons and fund source(s) in analysis section)

**Why this fiscal note differs from previous version (if initial version, please note as such)**

Initial version updated to new form for the 2012 Legislative Session

Prepared by Linda S. Hail, Director  
Division Insurance  
Approved by Susan K. Bell, Commissioner  
Commerce, Community, and Economic Development

Phone 907-269-7900  
Date/Time 12/1/11 5:57 PM  
Date 12/30/2011

FISCAL NOTE

STATE OF ALASKA  
2012 LEGISLATIVE SESSION

BILL NO. SB 70

**Analysis**

SB 70 would establish a health benefit exchange in order to facilitate the purchase and sale of individual and small employer health insurance plans in Alaska. The exchange would also provide consumer education and assistance. The exchange would be established as a public corporation within the Department of Commerce, Community and Economic Development, but it would be a separate legal entity.

An exchange board appointed by the Governor would have the responsibility and authority to develop and maintain the exchange which would include developing and maintaining a website for Alaskans to obtain information on insurance plans, to determine eligibility for and enroll eligible Alaskans in Medicaid or Denali Kidcare, to determine cost of coverage after any premium tax credit or cost sharing reduction and many other functions specified in the bill.

The bill does not create any additional duties or role for the Division of Insurance, since the development and maintenance of the exchange is the sole responsibility of the board. Therefore, no fiscal impact on the Division of Insurance is anticipated.

# FISCAL NOTE

**STATE OF ALASKA**  
**2012 LEGISLATIVE SESSION**

Bill Version SB 70  
 Fiscal Note Number \_\_\_\_\_  
 () Publish Date \_\_\_\_\_

Identifier (file name) SB070-DCCED-AHBE-12-08-11 Dept. Affected DCCED  
 Title Alaska Health Benefit Exchange Appropriation Alaska Health Benefit Exchange  
 Allocation Alaska Health Benefit Exchange Op  
 Sponsor Senator French  
 Requester Senate Finance OMB Component Number \_\_\_\_\_

**Expenditures/Revenues** (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	FY13 Appropriation Requested	Included in Governor's FY13 Request	Out-Year Cost Estimates					
			FY13	FY14	FY15	FY16	FY17	FY18
<b>OPERATING EXPENDITURES</b>								
Personal Services	1,280.1		1,280.1	1,280.1	1,280.1	1,280.1	1,280.1	1,280.1
Travel	121.0		30.3	30.3	30.3	30.3	30.3	30.3
Services	273.6		241.0	241.0	241.0	241.0	241.0	241.0
Commodities	30.0		0.0	0.0	0.0	0.0	0.0	0.0
Capital Outlay								
Grants, Benefits	120.0		120.0	120.0	120.0	120.0	120.0	120.0
Miscellaneous								
<b>TOTAL OPERATING</b>	<b>1,824.7</b>	<b>0.0</b>	<b>1,671.4</b>	<b>1,671.4</b>	<b>1,671.4</b>	<b>1,671.4</b>	<b>1,671.4</b>	<b>1,671.4</b>

<b>FUND SOURCE</b>		(Thousands of Dollars)						
1002	Federal Receipts							
1003	GF Match							
1004	GF	1,824.7	1,671.4	1,671.4	1,671.4	1,671.4	1,671.4	1,671.4
1005	GF/Prgm (DGF)							
1037	GF/MH (UGF)							
1178	temp code (UGF)							
	<b>TOTAL</b>	<b>1,824.7</b>	<b>0.0</b>	<b>1,671.4</b>	<b>1,671.4</b>	<b>1,671.4</b>	<b>1,671.4</b>	<b>1,671.4</b>

<b>POSITIONS</b>							
Full-time		12	12	12	12	12	12
Part-time							
Temporary							

<b>CHANGE IN REVENUES</b>							

Estimated SUPPLEMENTAL (FY12) operating costs 0.0 (separate supplemental appropriation required)  
 (discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY13) costs 0.0 (separate capital appropriation required)  
 (discuss reasons and fund source(s) in analysis section)

**Why this fiscal note differs from previous version (if initial version, please note as such)**

This fiscal note has been amended to reflect higher FY13 Personal Services costs due to salary and benefit increases. Travel for years beyond FY13 have been reduced to reflect change from monthly Board meetings to quarterly. One-time support costs have been reduced in years beyond FY13. The fiscal note has been updated to the new form for the 2012 Legislative Session.

Prepared by Jo Ellen Hanrahan, Director  
 Division Administrative Services  
 Approved by Susan K. Bell, Commissioner  
Commerce, Community, and Economic Development

Phone 907-465-2506  
 Date/Time 12/8/11 10:00 AM  
 Date 12/30/2011

FISCAL NOTE

STATE OF ALASKA  
2012 LEGISLATIVE SESSION

BILL NO. SB 70

**Analysis**

SB 70 would establish a health benefit exchange in order to facilitate the purchase and sale of individual and small employer health insurance plans in Alaska. The exchange would also provide consumer education and assistance. The exchange would be established as a public corporation within the Department of Commerce, Community, and Economic Development, but it would be a separate legal entity. An exchange board appointed by the Governor would have the responsibility and authority to develop and maintain the exchange which would include developing and maintaining a website for Alaskans to obtain information on insurance plans, to determine eligibility for and enroll eligible Alaskans in Medicaid or Denali Kidcare, to determine cost of coverage after any premium tax credit or costs sharing reduction and many other functions specified in the bill.

Estimates have been developed for the required resources to meet the core functions to be performed including:

- 1) Personal Services - a staff of 12 including an executive director, accounting staff, web support and program staff.
- 2) Board Costs - first year travel costs based on monthly two day meetings until the exchange is fully operational, followed by quarterly meetings for subsequent years.
- 3) Services - including one-time and on-going work station supplies and equipment, telephone hotlines, phone systems, printing, leased space support contracts and core services costs.
- 4) Commodities - one-time for computers and supplies.
- 5) Grants to the Navigator program.

# FISCAL NOTE

**STATE OF ALASKA** cost # codes  
**2012 LEGISLATIVE SESSION**

Bill Version CSSB070  
 Fiscal Note Number \_\_\_\_\_  
 Publish Date \_\_\_\_\_

Identifier (file name) SB070CS(FIN)-DOA-ETS-01-06-12 Dept. Affected Administration  
 Title Alaska Health Benefit Exchange Appropriation Enterprise Technology Services  
 Allocation Enterprise Technology Services  
 Sponsor Senators French, Davis, Ellis  
 Requester Senate Finance Committee OMB Component Number 2082

**Expenditures/Revenues** (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	FY13 Appropriation Requested	Included in Governor's FY13 Request	Out-Year Cost Estimates				
			FY14	FY15	FY16	FY17	FY18
<b>OPERATING EXPENDITURES</b>	<b>FY13</b>	<b>FY13</b>					
Personal Services							
Travel							
Services	800.0		500.0	500.0	500.0	500.0	500.0
Commodities							
Capital Outlay	2,200.0						
Grants, Benefits							
Miscellaneous							
<b>TOTAL OPERATING</b>	<b>3,000.0</b>	<b>0.0</b>	<b>500.0</b>	<b>500.0</b>	<b>500.0</b>	<b>500.0</b>	<b>500.0</b>

FUND SOURCE		(Thousands of Dollars)					
1002	Federal Receipts						
1003	GF Match						
1004	GF	3,000.0	500.0	500.0	500.0	500.0	500.0
1005	GF/Prgm (DGF)						
1037	GF/MH (UGF)						
1178	temp code (UGF)						
<b>TOTAL</b>		<b>3,000.0</b>	<b>0.0</b>	<b>500.0</b>	<b>500.0</b>	<b>500.0</b>	<b>500.0</b>

POSITIONS							
Full-time							
Part-time							
Temporary							

CHANGE IN REVENUES							

Estimated SUPPLEMENTAL (FY12) operating costs \_\_\_\_\_ (separate supplemental appropriation required;  
 (discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY13) costs \_\_\_\_\_ (separate capital appropriation required)  
 (discuss reasons and fund source(s) in analysis section)

Why this fiscal note differs from previous version (if initial version, please note as such)

Update for session. No change in estimate.

Prepared by Pat Shier  
 Division Enterprise Technology Services  
 Approved by John Cramer  
Deputy Commissioner, Department of Administration

Phone 465-5169  
 Date/Time 01/06/12 @ 8:00 am  
 Date 1/6/2012

FISCAL NOTE

STATE OF ALASKA  
2012 LEGISLATIVE SESSION

BILL NO. CSSB070

**Analysis**

Request for: Platform Build-out for Alaska Health Insurance Exchange

The current available information regarding other state's planning efforts relative to Health Insurance Exchange legislation suggests that costs for a platform build-out vary depending on final platform design. A critical factor will be if the solution implemented is a stand-alone solution or leveraged, in part, on an existing, related solution already in production. As a result, ETS estimates and requests with this fiscal note \$3,000.0 in FY2013 to plan for and build out the platform on which the health insurance exchange will operate. Of the \$3,000.0, ETS anticipates \$800.0 will be needed for purchase of bandwidth services and related costs. ETS is requesting an additional \$500.0 per year over the next six (6) fiscal years for maintenance an operation of the platform solution.

**CS FOR SENATE BILL NO. 70(FIN)**

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SEVENTH LEGISLATURE - SECOND SESSION

**BY THE SENATE FINANCE COMMITTEE**

**Offered:**

**Referred:**

**Sponsor(s): SENATORS FRENCH, Davis, Ellis**

**A BILL**

**FOR AN ACT ENTITLED**

1 **"An Act establishing the Alaska Health Benefit Exchange; and providing for an effective**  
2 **date."**

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

4 \* **Section 1.** The uncodified law of the State of Alaska is amended by adding a new section  
5 to read:

6 INTENT. It is the intent of the legislature in this Act

7 (1) to facilitate the purchase and sale of qualified health plans in the individual  
8 market in this state;

9 (2) to establish a small business health options program exchange to assist  
10 qualified small employers in the state in enrolling employees in qualified health plans offered  
11 in the small group market;

12 (3) to provide consumer education and assist individuals with access to  
13 programs, credits, and cost-sharing reductions;

14 (4) to reduce the number of uninsured Alaskans by creating an organized,

1 transparent, and easy-to-navigate health insurance marketplace that offers a choice of high  
2 value health plans with low administrative costs for individuals and employers; and

3 (5) that the Alaska Health Benefit Exchange Board recommend to the  
4 legislature and the Office of the Governor methods to keep premium costs low and risk pools  
5 strong in the health insurance market place.

6 \* **Sec. 2.** AS 21.54 is amended by adding new sections to read:

7 **Article 2A. Alaska Health Benefit Exchange.**

8 **Sec. 21.54.200. Alaska Health Benefit Exchange.** The Alaska Health Benefit  
9 Exchange is established as a public corporation of the state in the Department of  
10 Commerce, Community, and Economic Development but with separate and  
11 independent legal existence.

12 **Sec. 21.54.210. Alaska Health Benefit Exchange Board.** (a) The Alaska  
13 Health Benefit Exchange Board is established to manage the exchange.

14 (b) The board consists of eight members, including six members appointed by  
15 the governor, the commissioner of health and social services or the commissioner's  
16 designee, serving ex officio, and the director, serving ex officio, without the power to  
17 vote. The members of the board appointed by the governor are

- 18 (1) a representative of small business employers;  
19 (2) a representative of the health care insurance business;  
20 (3) a person with expertise in health plan finance;  
21 (4) a person with expertise in health plan administration;  
22 (5) an actuary or a person with a background in health care actuarial or  
23 economic principles; and  
24 (6) a health care consumer representative.

25 (c) Except for the commissioner or the commissioner's designee and the  
26 director, who serve ex officio, each board member serves for a term of three years  
27 beginning on January 1 and until a successor has been appointed. A member is eligible  
28 for reappointment.

29 (d) The board shall select a member to serve as chair and a member to serve as  
30 vice-chair for a term and with duties and powers necessary to perform their functions.

31 (e) A majority of the board constitutes a quorum for transacting business.

1 (f) If a vacancy occurs, the governor shall make an appointment, effective  
2 immediately, for the balance of the unexpired term.

3 (g) Board members and the executive director hired under (j) of this section  
4 shall comply with the requirements of AS 39.50 (public official financial disclosure)  
5 and shall disclose an affiliation with an insurer, agent, broker, or other representative  
6 of an insurer, a health care provider, or a health care facility.

7 (h) Members of the board are entitled to per diem and transportation costs  
8 under AS 39.20.180.

9 (i) A member of the board of directors of the exchange may not be held civilly  
10 or criminally liable for an act or omission if the act or omission was in good faith and  
11 within the scope of the director's duties.

12 (j) The board shall employ an executive director to administer the exchange.  
13 The executive director shall perform duties as prescribed by the board and may  
14 employ a staff to assist in the performance of the duties of the executive director. The  
15 executive director and staff employed under this subsection are in the partially exempt  
16 service under AS 39.25.120.

17 **Sec. 21.54.220. Duties and powers of the Alaska Health Benefit Exchange;**  
18 **limitation.** (a) The Alaska Health Benefit Exchange Board shall

19 (1) facilitate the purchase and sale of qualified health plans;

20 (2) establish a small business health options program exchange to  
21 assist qualified small employers in the state in enrolling employees in a qualified  
22 health plan;

23 (3) provide for the operation of a toll-free telephone hotline to respond  
24 to requests for assistance;

25 (4) provide for enrollment periods under sec. 1311(c)(6), P.L. 111-148  
26 (Patient Protection and Affordable Care Act), as amended, and regulations adopted  
27 under that Act;

28 (5) maintain an Internet website through which enrollees and  
29 prospective enrollees of qualified health plans may obtain standardized comparative  
30 information on those plans;

31 (6) implement procedures for the certification, recertification, and

1 decertification of qualified health plans according to the determination of the division  
2 consistent with guidelines developed by the United States Secretary of Health and  
3 Human Services under sec. 1311(c), P.L. 111-148 (Patient Protection and Affordable  
4 Care Act), as amended, and regulations adopted under that Act;

5 (7) assign a rating to each qualified health plan offered through the  
6 exchange according to the determination of the division in accordance with the criteria  
7 developed by the United States Secretary of Health and Human Services under sec.  
8 1311(c)(3), P.L. 111-148 (Patient Protection and Affordable Care Act), as amended,  
9 and regulations adopted under that Act;

10 (8) determine the level of coverage of each qualified health plan  
11 according to the determination of the division under regulations issued by the United  
12 States Secretary of Health and Human Services under sec. 1302(d)(2)(A), P.L. 111-  
13 148 (Patient Protection and Affordable Care Act), as amended, and regulations  
14 adopted under that Act;

15 (9) use a standardized format for presenting health benefit options in  
16 the exchange, including the use of the uniform outline of coverage established under  
17 42 U.S.C. 300gg et seq. (sec. 2715, Part A, subpart II, title XXVII, Public Health  
18 Service Act);

19 (10) in accordance with sec. 1413, P.L. 111-148 (Patient Protection  
20 and Affordable Care Act), as amended, and regulations adopted under that Act, inform  
21 individuals of title XIX, Social Security Act eligibility requirements for the Medicaid  
22 program under 42 U.S.C. 1396 - 1396w-2, the Children's Health Insurance Program  
23 under 42 U.S.C. 1397aa - 1397mm (title XXI of the Social Security Act), or any  
24 applicable state or local public program; and, if the exchange determines that any  
25 individual is eligible for a program, enroll that individual in that program;

26 (11) establish and make available by electronic means a calculator to  
27 determine the actual cost of coverage after application of any premium tax credit  
28 under 26 U.S.C. 36B (Internal Revenue Code of 1986), and any cost-sharing reduction  
29 under sec. 1402, P.L. 111-148 (Patient Protection and Affordable Care Act), as  
30 amended, and regulations adopted under that Act;

31 (12) establish a small business health options program exchange

1 through which qualified employers may access coverage for their employees and  
 2 which shall enable a qualified employer to specify a level of coverage so that any of  
 3 its employees may enroll in any qualified health plan offered through the small  
 4 business health options program exchange at the specified level of coverage;

5 (13) subject to sec. 1411, P.L. 111-148 (Patient Protection and  
 6 Affordable Care Act), as amended, and regulations adopted under that Act, grant a  
 7 certification attesting that, for purposes of the individual responsibility penalty under  
 8 26 U.S.C. 5000A (Internal Revenue Code of 1986), an individual is exempt from the  
 9 individual responsibility requirement or from the penalty imposed by that section  
 10 because

11 (A) an affordable qualified health plan covering the individual  
 12 is not available through the exchange or through the individual's employer; or

13 (B) the individual meets the requirements for another  
 14 exemption from the individual responsibility requirement or penalty;

15 (14) provide the following information to the United States Secretary  
 16 of the Treasury:

17 (A) the name and taxpayer identification number of each  
 18 individual issued a certification under (13) of this subsection;

19 (B) the name and taxpayer identification number of each  
 20 individual who was an employee but who was determined to be eligible for the  
 21 premium tax credit under 26 U.S.C. 36B (Internal Revenue Code of 1986)  
 22 because

23 (i) the employer did not provide minimum essential  
 24 coverage; or

25 (ii) the employer provided the minimum essential  
 26 coverage, but it was determined under 26 U.S.C. 36B(c)(2)(C) (Internal  
 27 Revenue Code of 1986), to be unaffordable to the employee or not to  
 28 provide the required minimum actuarial value; and

29 (C) the name and taxpayer identification number of each  
 30 individual who

31 (i) notifies the exchange under sec. 1411(b)(4), P.L.

1 111-148 (Patient Protection and Affordable Care Act), as amended, and  
2 regulations adopted under that Act, that the individual has changed  
3 employers; and

4 (ii) ceases coverage under a qualified health plan during  
5 a plan year and the effective date of that cessation;

6 (15) provide to each employer the name of each employee of the  
7 employer described in (14)(B) of this subsection who ceases coverage under a  
8 qualified health plan during a plan year and the effective date of the cessation;

9 (16) perform duties required of the exchange by the United States  
10 Secretary of Health and Human Services or the United States Secretary of the  
11 Treasury related to determining eligibility for premium tax credits, reduced cost-  
12 sharing, or individual responsibility requirement exemptions;

13 (17) select entities qualified to serve as navigators as determined by  
14 the division in accordance with sec. 1311(i), P.L. 111-148 (Patient Protection and  
15 Affordable Care Act), as amended, and regulations adopted under that Act, and  
16 standards developed by the United States Secretary of Health and Human Services and  
17 award grants to enable navigators to

18 (A) conduct public education activities to raise awareness of  
19 the availability of qualified health plans;

20 (B) distribute fair and impartial information concerning  
21 enrollment in qualified health plans, the availability of premium tax credits  
22 under 26 U.S.C. 36B (Internal Revenue Code of 1986), and the availability of  
23 cost-sharing reductions under sec. 1402, P.L. 111-148 (Patient Protection and  
24 Affordable Care Act), as amended, and regulations adopted under that Act;

25 (C) facilitate enrollment in qualified health plans;

26 (D) provide referrals to the division for consumer assistance for  
27 a person with a grievance, complaint, or question regarding the person's health  
28 benefit plan or coverage, or a determination under that plan or coverage; and

29 (E) provide information in a manner that is culturally and  
30 linguistically appropriate to the needs of the population being served by the  
31 exchange;

1 (18) review the rate of premium growth within the exchange and  
2 outside the exchange as determined by the division and rely on the information  
3 developed by the division on whether to continue limiting qualified employer status to  
4 small employers;

5 (19) rely on policies and procedures developed by the division to  
6 minimize adverse selection among plans sold within the exchange and review policies  
7 within the exchange and outside the exchange to monitor the effect of adverse  
8 selection between the two marketplaces;

9 (20) credit the amount of any free choice voucher to the monthly  
10 premium of the plan in which a qualified employee is enrolled, in accordance with sec.  
11 10108, P.L. 111-148 (Patient Protection and Affordable Care Act), as amended, and  
12 regulations adopted under that Act, and collect the amount credited from the offering  
13 employer;

14 (21) consult with persons having an interest in the activities of the  
15 exchange, including

16 (A) health care insurers;

17 (B) health care consumers who are enrollees in qualified health  
18 plans;

19 (C) individuals and entities with experience in facilitating  
20 enrollment in qualified health plans;

21 (D) representatives of small businesses and self-employed  
22 individuals;

23 (E) the division in the Department of Health and Social  
24 Services responsible for administering Medicaid; and

25 (F) advocates for enrolling hard-to-reach populations;

26 (22) establish one or more advisory groups to consult with the board to  
27 provide expertise on and input into operations of the exchange; the membership of an  
28 advisory group may include health care providers, hospitals, and persons identified in  
29 (21) of this subsection;

30 (23) maintain an accurate accounting of all activities, receipts, and  
31 expenditures;

1 (24) submit an annual accounting report to the United States Secretary  
2 of Health and Human Services, the governor, the director and the legislature; the  
3 report must include the following information described by insurer by benefit plan:

4 (A) the number of covered persons;

5 (B) the number of covered persons receiving free choice  
6 vouchers and the amount of free choice vouchers credited;

7 (C) the number of individuals exempted from individual  
8 responsibility requirements by reason;

9 (D) the number of individuals eligible for premium tax credit;

10 (E) the number of employees who terminated coverage and the  
11 number of individuals obtaining coverage through the exchange who were  
12 covered under an employer health plan in the preceding six months; and

13 (F) other data specified by the director;

14 (25) cooperate with an investigation conducted by the division or the  
15 United States Secretary of Health and Human Services under the Secretary's authority  
16 under P.L. 111-148 (Patient Protection and Affordable Care Act), as amended, and  
17 regulations adopted under that Act, and allow the division or the Secretary, in  
18 coordination with the Inspector General of the United States Department of Health and  
19 Human Services, to

20 (A) investigate the affairs of the exchange;

21 (B) examine the properties and records of the exchange;

22 (C) require periodic reports in relation to the activities  
23 undertaken by the exchange;

24 (26) allow a health care insurer to offer a plan that provides limited  
25 scope dental benefits under 26 U.S.C. 9832(c)(2)(A) (Internal Revenue Code of 1986),  
26 through the exchange, either separately or in conjunction with a qualified health plan,  
27 if the plan provides pediatric dental benefits under sec. 1302(b)(1)(J), P.L. 111-148  
28 (Patient Protection and Affordable Care Act), as amended, and regulations adopted  
29 under that Act;

30 (27) apply for planning and establishment grants made available to the  
31 exchange under sec. 1311, P.L. 111-148 (Patient Protection and Affordable Care Act),

1 as amended, and regulations adopted under that Act;

2 (28) rely on the division's determination relating to the potential for  
3 interstate compacts that would permit the sale and purchase of health care insurance  
4 across state borders and recommend particular compact arrangements for legislative  
5 approval; and

6 (29) submit to the director a plan of operation to ensure the fair,  
7 reasonable, and equitable administration of the exchange; the plan of operation  
8 becomes effective on approval in writing by the director, subject to the following:

9 (A) if the exchange fails to submit a suitable plan under this  
10 paragraph, the director may adopt reasonable regulations necessary or  
11 advisable to carry out the provisions of AS 21.54.200 - AS 21.54.270; the  
12 regulations adopted by the director under this subparagraph must continue in  
13 force until modified by the director or superseded by a plan submitted by the  
14 exchange and approved by the director;

15 (B) the plan of operation must

16 (i) establish procedures for the performance of the  
17 duties and powers of the exchange;

18 (ii) establish procedures for handling assets of the  
19 exchange;

20 (iii) establish the amount and method of reimbursing  
21 members of the board of directors;

22 (iv) establish regular places and times for meetings of  
23 the board of directors;

24 (v) establish procedures for records to be kept of all  
25 financial transactions of the exchange, its agents, and the board of  
26 directors;

27 (vi) contain any additional provisions necessary or  
28 proper for the execution of the powers and duties of the exchange.

29 (b) The exchange may

30 (1) enter into a contract for the performance of the exchange's duties  
31 with the Department of Health and Social Services or another entity that has

1 experience in individual and small group health insurance or benefit administration, or  
 2 other experience relevant to the responsibilities to be assumed by the entity, except  
 3 that the exchange may not contract for the performance of its duties with a health care  
 4 insurer or an affiliate of a health care insurer;

5 (2) enter into information-sharing agreements with federal and state  
 6 agencies and other state exchanges to carry out its duties if the agreements include  
 7 adequate protections with respect to the confidentiality of the information to be shared  
 8 and comply with all state and federal laws and regulations; and

9 (3) apply for and receive grants or donations from federal, state, local  
 10 government, foundation, or private entities; the exchange shall make records of  
 11 application for or receipt of grants or donations under this paragraph available to the  
 12 public on the exchange's Internet website within 30 days after application or receipt.

13 (c) The exchange may not use money intended for the administrative and  
 14 operational expenses of the exchange for staff retreats, promotional giveaways, or  
 15 excessive executive compensation.

16 (d) Neither the exchange nor a health care insurer offering a health benefit  
 17 plan through the exchange may charge an individual a fee or penalty for termination of  
 18 coverage if the individual enrolls in another type of minimum essential coverage  
 19 because

20 (1) the individual has become newly eligible for that coverage; or

21 (2) the individual's employer-sponsored coverage has become  
 22 affordable under the standards of 26 U.S.C. 36B(c)(2)(C) (Internal Revenue Code of  
 23 1986).

24 **Sec. 21.54.230. Health benefit plan certification.** (a) The exchange may  
 25 certify a health benefit plan as a qualified health plan if

26 (1) the plan provides the essential health benefits described in sec.  
 27 1302(a), P.L. 111-148 (Patient Protection and Affordable Care Act), as amended, and  
 28 regulations adopted under that Act, except that the plan is not required to provide  
 29 essential benefits that duplicate the minimum benefits of qualified dental plans if

30 (A) the exchange has determined that at least one qualified  
 31 dental plan is available to supplement the plan's coverage; and

1 (B) the health care insurer makes prominent disclosure at the  
2 time it offers the plan, in a form approved by the exchange, that the plan does  
3 not provide the full range of essential pediatric benefits, and that qualified  
4 dental plans providing those benefits and other dental benefits not covered by  
5 the plan are offered through the exchange;

6 (2) the premium rates and contract language have been approved by  
7 the director;

8 (3) the plan provides at least a bronze level of coverage under  
9 AS 21.54.220(a)(7) unless the plan is certified as a qualified catastrophic plan, meets  
10 the requirements of P.L. 111-148 (Patient Protection and Affordable Care Act), as  
11 amended, and regulations adopted under that Act, for catastrophic plans, and will only  
12 be offered to individuals eligible for catastrophic coverage;

13 (4) the cost-sharing requirements of the plan do not exceed the limits  
14 established under sec. 1302(c)(1), P.L. 111-148 (Patient Protection and Affordable  
15 Care Act), as amended, and regulations adopted under that Act, and, if the plan is  
16 offered through the small business health options program exchange, the deductible  
17 for the plan does not exceed the limits established under sec. 1302(c)(2), P.L. 111-148  
18 (Patient Protection and Affordable Care Act), as amended, and regulations adopted  
19 under that Act;

20 (5) the health care insurer offering the plan

21 (A) is licensed and in good standing to offer health insurance  
22 coverage in the state;

23 (B) offers at least one qualified health plan that provides a  
24 silver level of coverage under AS 21.54.220(a)(7) and at least one plan that  
25 provides a gold level of coverage through each small business health options  
26 program exchange and exchange for individual coverage in which the health  
27 care insurer participates;

28 (C) charges the same premium rate for each qualified health  
29 plan without regard to whether the plan is offered through the exchange and  
30 without regard to whether the plan is offered directly from the health care  
31 insurer or through an insurance producer;

1 (D) does not charge cancellation fees or penalties in violation  
2 of AS 21.54.220(d); and

3 (E) complies with the regulations developed by the United  
4 States Secretary of Health and Human Services under sec. 1311(d), P.L. 111-  
5 148 (Patient Protection and Affordable Care Act), as amended, and regulations  
6 adopted under that Act, and other requirements the exchange establishes;

7 (6) the plan meets the requirements of certification as adopted by  
8 regulation under AS 21.54.250 and by the United States Secretary of Health and  
9 Human Services under sec. 1311(c), P.L. 111-148 (Patient Protection and Affordable  
10 Care Act), as amended, and regulations adopted under that Act, which include  
11 minimum standards in the areas of marketing practices, network adequacy, essential  
12 community providers in underserved areas, accreditation, quality improvement,  
13 uniform enrollment forms, and descriptions of coverage and information on quality  
14 measures for health benefit plan performance; and

15 (7) the exchange determines that making the plan available through the  
16 exchange is in the interest of qualified individuals and qualified employers in this  
17 state.

18 (b) The exchange may not exclude a health benefit plan

19 (1) because the plan is a fee-for-service plan;

20 (2) by imposing premium price controls; or

21 (3) because the plan provides treatments necessary to prevent patients'  
22 deaths that the exchange determines are inappropriate or too costly.

23 (c) The exchange shall require each health care insurer seeking certification of  
24 a plan as a qualified health plan to

25 (1) submit to the exchange a justification for any premium increase  
26 before implementation of that increase; the health care insurer shall prominently post  
27 the justification information on the health care insurer's Internet website; the exchange  
28 shall consider the information submitted, along with the information and the  
29 recommendations provided to the exchange by the director under 42 U.S.C. 300gg-94  
30 (sec. 2794(b), Part C, title XXVII, Public Health Service Act) when determining  
31 whether to allow the health care insurer to make plans available through the exchange;

1 (2) make available to the public in plain language, as defined in sec.  
 2 1311(e)(3)(B), P.L. 111-148 (Patient Protection and Affordable Care Act), as  
 3 amended, and regulations adopted under that Act, and submit to the exchange, the  
 4 United States Secretary of Health and Human Services, and the director accurate and  
 5 timely disclosure of the following:

6 (A) claims payment policies and practices;

7 (B) periodic financial disclosures;

8 (C) data on enrollment;

9 (D) data on disenrollment;

10 (E) data on the number of claims that are denied;

11 (F) data on rating practices;

12 (G) information on cost-sharing and payments with respect to  
 13 any out-of-network coverage;

14 (H) information on enrollee and participant rights under Title I  
 15 of P.L. 111-148 (Patient Protection and Affordable Care Act), as amended, and  
 16 regulations adopted under that Act; and

17 (I) other appropriate information as determined by the United  
 18 States Secretary of Health and Human Services.

19 (3) permit individuals to learn, in a timely manner on the request of the  
 20 individual, the amount of cost-sharing, including deductibles, copayments, and  
 21 coinsurance, under the individual's plan or coverage that the individual would be  
 22 responsible for paying with respect to the furnishing of a specific item or service by a  
 23 participating provider; a minimum, that information must be made available to the  
 24 individual through an Internet website and through other means for individuals  
 25 without access to the Internet.

26 (d) The exchange may not exempt a health care insurer seeking certification of  
 27 a qualified health plan from state licensure or solvency requirements, regardless of the  
 28 type or size of the health care insurer, and shall apply the criteria of this section in a  
 29 manner that ensures equality between or among health care insurers participating in  
 30 the exchange.

31 (e) The provisions of AS 21.54.200 - 21.54.270 that are applicable to qualified

1 health plans also apply, to the extent relevant, to qualified dental plans, except as  
2 modified under (1) - (3) of this subsection or by regulations adopted by the exchange.  
3 Under this subsection,

4 (1) the health care insurer shall be licensed to offer dental coverage,  
5 but need not be licensed to offer other health benefits;

6 (2) the plan must be limited to dental and oral health benefits, without  
7 substantially duplicating the benefits typically offered by a health benefit plan without  
8 dental coverage and must include, at a minimum, the essential pediatric dental benefits  
9 prescribed by the United States Secretary of Health and Human Services under sec.  
10 1302(b)(1)(J), P.L. 111-148 (Patient Protection and Affordable Care Act), as amended,  
11 and regulations adopted under that Act, and other dental benefits as the exchange or  
12 the Secretary may specify by regulation; and

13 (3) the health care insurer may jointly offer a comprehensive plan  
14 through the exchange in which the dental benefits are provided by a health care insurer  
15 through a qualified dental plan and the other benefits are provided by a health care  
16 insurer through a qualified health plan if the plans are priced separately and are also  
17 made available for purchase separately at the same price.

18 **Sec. 21.54.240. Exchange funding; publication of costs of the exchange.** (a)  
19 The exchange may charge assessments or user fees to a health care insurer offering a  
20 health benefit plan or otherwise generate funding necessary to support its operations  
21 provided under AS 21.54.200 - 21.54.270.

22 (b) The exchange shall publish the average costs of licensing, regulatory fees,  
23 and any other payments required by the exchange, and the administrative costs of the  
24 exchange, on its Internet website. That information must include information on  
25 money lost to waste, fraud, and abuse.

26 **Sec. 21.54.250. Regulations.** The division or the exchange may adopt  
27 regulations to implement their respective authority under the provisions of  
28 AS 21.54.200 - 21.54.270. Regulations adopted under this section may not conflict  
29 with or prevent the application of regulations adopted by the United States Secretary  
30 of Health and Human Services under P.L. 111-148 (Patient Protection and Affordable  
31 Care Act), as amended, and regulations adopted under that Act.

1           **Sec. 21.54.260. Relation to other laws.** Provisions of AS 21.54.200 -  
 2 21.54.270, and actions taken by the exchange under AS 21.54.200 - 21.54.270 may  
 3 not be construed to preempt or supersede the authority of the director to regulate the  
 4 business of insurance in the state. Except as expressly provided to the contrary in  
 5 AS 21.54.200 - 21.54.270, all health care insurers offering qualified health plans in the  
 6 state shall comply fully with all applicable health insurance laws of the state and  
 7 regulations adopted and orders issued by the director.

8           **Sec. 21.54.270. Definitions.** In AS 21.54.200 - 21.54.270,

9           (1) "board" means the Alaska Health Benefit Exchange Board  
 10 established AS 21.54.210;

11           (2) "exchange" means the Alaska Health Benefit Exchange established  
 12 under AS 21.54.200;

13           (3) "health benefit plan" has the meaning given in AS 21.54.500,  
 14 except that, notwithstanding AS 21.54.500, it does not include

15                   (A) coverage only for accident or disability income insurance,  
 16 or any combination of accident or disability income insurance;

17                   (B) coverage issued as a supplement to liability insurance;

18                   (C) liability insurance, including general liability insurance and  
 19 automobile liability insurance;

20                   (D) workers' compensation insurance or similar insurance;

21                   (E) automobile medical payment insurance;

22                   (F) credit-only insurance;

23                   (G) coverage for on-site medical clinics;

24                   (H) insurance coverage specified in federal regulations issued  
 25 under the P.L. 104-191 (Health Insurance Portability and Accountability Act of  
 26 1996), under which benefits for health care services are secondary or incidental  
 27 to other insurance benefits;

28                   (I) the following benefits if they are provided under a separate  
 29 policy, certificate, or contract of insurance or are otherwise not an integral part  
 30 of the plan:

31                           (i) limited scope dental or vision benefits;

1 (ii) benefits for long-term care, nursing home care,  
 2 home health care, community-based care, or any combination of long-  
 3 term care, nursing home care, home health care, or community based  
 4 care;

5 (J) limited benefits specified in federal regulations issued under  
 6 P. L. 104-191 (Health Insurance Portability and Accountability Act of 1996);

7 (K) the following benefits if the benefits are provided under a  
 8 separate policy, certificate, or contract of insurance; there is no coordination  
 9 between the provision of the benefits and any exclusion of benefits under any  
 10 group health plan maintained by the same plan sponsor; and the benefits are  
 11 paid with respect to an event without regard to whether benefits are provided  
 12 with respect to an event under any group health plan maintained by the same  
 13 plan sponsor:

14 (i) coverage for only a specified disease or illness; or

15 (ii) hospital indemnity or other fixed indemnity  
 16 insurance;

17 (L) the following benefits if offered as a separate policy,  
 18 certificate, or contract of insurance:

19 (i) Medicare supplemental health insurance as defined  
 20 in 42 U.S.C. 1395ss(g)(1) (sec. 1882(g)(1) ch. 7, Subchapter XVIII,  
 21 Part E, Social Security Act);

22 (ii) coverage supplemental to the coverage provided 10  
 23 U.S.C. 1071 - 1110a (Civilian Health and Medical Program of the  
 24 Uniformed Services (CHAMPUS)); or

25 (iii) similar supplemental coverage provided to  
 26 coverage under a group health plan;

27 (4) "qualified dental plan" means a limited scope dental plan that has  
 28 been certified under AS 21.54.230(e);

29 (5) "qualified employer" means a small employer that elects to make  
 30 its full-time employees and, at the option of the employer, some or all of its part-time  
 31 employees, eligible for one or more qualified health plans offered through the small

1 business health options program exchange if the employer

2 (A) has its principal place of business in this state and elects to  
3 provide coverage through the small business health options program exchange  
4 to all of its eligible employees, wherever employed; or

5 (B) elects to provide coverage through the small business  
6 health options program exchange to all of its eligible employees who are  
7 principally employed in this state;

8 (6) "qualified health plan" means a health benefit plan that has in effect  
9 a certification that the plan meets the criteria for certification described in sec.  
10 1311(c), P.L. 111-148 (Patient Protection and Affordable Care Act), as amended, and  
11 regulations adopted under that Act, and AS 21.54.230;

12 (7) "qualified individual" means an individual, including a minor, who

13 (A) is seeking to enroll in a qualified health plan offered to  
14 individuals through the exchange;

15 (B) resides in this state;

16 (C) at the time of enrollment, is not incarcerated, other than  
17 incarceration pending the disposition of charges; and

18 (D) for the entire period for which enrollment is sought, is and  
19 is reasonably expected to be a citizen or national of the United States or an  
20 alien lawfully present in the United States;

21 (8) "small business health options program exchange" means the small  
22 business health options exchange under AS 21.54.220(a)(12) and sec. 1321, P.L. 111-  
23 148, (Patient Protection and Affordable Care Act), as amended, and regulations  
24 adopted under that Act;

25 (9) "small employer," notwithstanding AS 21.54.500, means an  
26 employer that employed an average of not more than 50 employees during the  
27 preceding calendar year; for purposes of this paragraph,

28 (A) a person treated as a single employer under 26 U.S.C. 414  
29 (b), (c), (m), or (o) (Internal Revenue Code of 1986), shall be treated as a  
30 single employer;

31 (B) an employer and any predecessor employer shall be treated

1 as a single employer;

2 (C) all employees shall be counted, including a part-time  
3 employee and an employee who is not eligible for coverage through the  
4 employer;

5 (D) if an employer was not in existence throughout the  
6 preceding calendar year, the determination of whether that employer is a small  
7 employer shall be based on the average number of employees the employer is  
8 reasonably expected to employ on business days in the current calendar year;  
9 and

10 (E) an employer that makes enrollment in qualified health plans  
11 available to its employees through the small business health options program  
12 exchange and that would cease to be a small employer because of an increase  
13 in the number of its employees, shall continue to be treated as a small  
14 employer for purposes of AS 21.54.200 - 21.54.270 as long as the employer  
15 continuously makes enrollment through the small business health options  
16 program exchange available to its employees.

17 \* **Sec. 3.** AS 39.25.120(c) is amended by adding a new paragraph to read:

18 (22) the executive director and employees of the Alaska Health Benefit  
19 Exchange Board employed under AS 21.54.210(j).

20 \* **Sec. 4.** AS 39.50.200(a)(9) is amended to read:

21 (9) "public official" means

22 (A) a judicial officer;

23 (B) the governor or the lieutenant governor;

24 (C) a person hired or appointed in a department in the  
25 executive branch as

26 (i) the head or deputy head of the department;

27 (ii) the director or deputy director of a division;

28 (iii) a special assistant to the head of the department;

29 (iv) a person serving as the legislative liaison for the  
30 department;

31 (D) an assistant to the governor or the lieutenant governor;

1 (E) the chair or a member of a state commission or board;

2 (F) state investment officers and the state comptroller in the  
3 Department of Revenue;

4 (G) the chief procurement officer appointed under  
5 AS 36.30.010;

6 (H) the executive director of the Alaska Workforce Investment  
7 Board;

8 (I) each appointed or elected municipal officer; [AND]

9 (J) the members of the board of trustees, the executive director,  
10 and the investment officers of the Alaska Permanent Fund Corporation; **and**

11 **(K) the executive director of the Alaska Health Benefit**  
12 **Exchange employed under AS 21.54.210;**

13 \* **Sec. 5.** AS 39.50.200(b) is amended by adding a new paragraph to read:

14 (64) the Alaska Health Benefit Exchange Board (AS 21.54.210).

15 \* **Sec. 6.** The uncodified law of the State of Alaska is amended by adding a new section to  
16 read:

17 TRANSITIONAL PROVISIONS. Notwithstanding AS 21.54.210(c), enacted by sec.  
18 2 of this Act, the initial terms for members of the Alaska Health Benefit Exchange Board  
19 appointed by the governor are as follows:

20 (1) three members shall be appointed to serve for terms ending December 31,  
21 2012;

22 (2) three members shall be appointed to serve for terms ending December 31,  
23 2013.

24 \* **Sec. 7.** The uncodified law of the State of Alaska is amended by adding a new section to  
25 read:

26 TRANSITION: REGULATIONS. The Alaska Health Benefit Exchange Board  
27 established under AS 21.54.200, enacted by sec. 2 of this Act, and the director of insurance  
28 may adopt regulations necessary to implement their respective powers and duties created by  
29 this Act under AS 21.54.250, enacted by sec. 2 of this Act. The regulations take effect under  
30 AS 44.62 (Administrative Procedure Act), but not before the effective date of the statutory  
31 changes.

- 1 \* **Sec. 8.** Section 7 of this Act takes effect immediately under AS 01.10.070(c).
- 2 \* **Sec. 9.** Except as provided in sec. 8 of this Act, this Act takes effect July 1, 2012.

# ALASKA STATE LEGISLATURE



## SENATOR HOLLIS FRENCH

April 1, 2011

Senator Bert Stedman  
Co-Chair, Senate Finance Committee  
State Capitol, Room 516  
Juneau, AK 99801

Senator Stedman,

First, I would like to thank you and the other members of the Senate Finance Committee for your consideration of Senate Bill 70 on Monday, March 28. This letter addresses several questions that came up during that hearing.

### **What language is required to comply with federal law?**

You asked which provisions of SB 70 were mandated by the Patient Protection and Affordable Care Act. What follows is a sectional analysis answering that question.

#### Section 1 of the legislation

The intent language in paragraphs 1 and 2 comes from section 1311(b)(1) of the PPACA.

The language in paragraphs 3-5 is not mandatory.

#### Section 2 of the legislation

Sec. 21.54.200 establishes the Alaska Health Benefit Exchange.

The PPACA leaves the choice of structures for the exchange – governmental agency or nonprofit – up to the states in section 1311(d)(1).

Sec. 21.54.210 establishes the Alaska Health Benefit Exchange board.

The PPACA does not mandate a particular exchange governance structure.

Sec. 21.54.220 of the legislation relates to the duties and powers of the Alaska Health Benefit Exchange.

- (a)(1) is mandated in section 1311 (b)(1)(A)
- (a)(2) is mandated in section 1311(b)(1)(B)
- (a)(3) is mandated in section 1311(d)(4)(C)
- (a)(4) is mandated in section 1311 (c)(6)
- (a)(5) is mandated in section 1311(d)(4)(C)
- (a)(6) is mandated in section 1311(d)(4)(A)
- (a)(7) is mandated in section 1311(d)(4)(D)
- (a)(8) is mandated in section 1302(d)(2)(A)
- (a)(9) is mandated in section 1311(d)(4)E
- (a)(10) is mandated in section 1311(d)(4)(F)
- (a)(11) is mandated in section 1311 (d)(4)(G)
- (a)(12) is mandated in section 1311(b)(1)(B)
- (a)(13) is mandated in section 1311(d)(4)(H)
- (a)(14) is mandated in section 1311(d)(4)(I)
- (a)(15) is mandated in section 1311(d)(4)(J)
- (a)(16) is mandated in section 1412(a)(1)
- (a)(17) is mandated in section 1311(i)
- (a)(18) is mandated in section 1311(e)(2)
- (a)(19) is not mandatory
- (a)(20) is mandated in section 10108(d)(2)
- (a)(21) is mandated in section 1311(d)(6)
- (a)(22) is not mandatory
- (a)(23) is mandated in section 1313(a)

- (a)(24) is mandated in part by section 1313(a)(1).
- (a)(25) is mandated in section 1313(a)(2)
- (a)(26) is mandated in section 1311(d)(2)(B)(ii)
- (a)(27) is not mandatory
- (a)(28) is not mandatory
- (a)(29) is not mandatory
- (b)(1) is not mandatory
- (b)(2) is not mandatory
- (b)(3) is not mandatory
- (c) is mandated in section 1311(d)(5)
- (d) is mandated in section 1312(d)(4)

Section 21.54.230 relates to Health Benefit Plan Certification.

- (a)(1) is mandated by section 1302(b)(1)(J), 1302 (b)(4)(F) and 1311(d)(2)(ii)
- (a)(2) is not mandatory
- (a)(3) is mandated in section 1303(e), 1311(c)(3), and 1311(d)(2)
- (a)(4) is mandated in section 1302(c)(1) and section 1302(c)(2)
- (a)(5) is mandated in section 1301(a)(1)
- (a)(6) is mandated in section 1311(c)(1)
- (a)(7) is mandated in section 1311(e)(1)(B)
- (b) is mandated in section 1311(e)(1)(B)(i through iii)
- (c)(1) is mandated in section 1311(e)(2)
- (c)(2) is mandated in 1311(e)(3)(A) and (B)
- (c)(3) is mandated in 1311(e)(3)(C)
- (d) is not mandatory
- (e) is mandated in section 1302(b)(1)(J) and 1311(d)(2)(B)(ii)

Section 21.54.240 relates to exchange funding

(a) is mandated in section 1311(d)(5)(A)

(b) is mandated in section 1311(d)(7)

Section 21.54.250 relates to regulations; it is not mandatory

Section 21.54.260 relates to an exchange's relation to other laws; it is mandated by 1321(d)

Section 21.54.270 relates to definitions of terms used in this legislation

### Section 3 of the legislation

The PPACA does not mandate the classification of employees in the partial exempt service

### Section 4 of the legislation

The PPACA does not mandate that an Exchange's Executive Director is defined as a public official

### Section 5 of the legislation

The PPACA does not mandate the exchange governance structure.

### Section 6 of the legislation

The PPACA does not mandate the exchange governance structure, or the transitional provisions in this section given the bill's selection of board governance.

### Section 7 of the legislation

The PPACA does not require states to grant regulatory authority.

### Section 8-10 of the legislation relate to effective dates

The PPACA requires HHS to make a determination on Jan 1, 2013 regarding a state's exchange implementation status. Sec. 10 of the legislation fully implements the exchange starting on July 1, 2012, to ensure 6 months of operation prior to this federal determination, but the specific July 1, 2012 effective date is not mandated by the PPACA.

## **IHS Recipients**

Senator Olson asked how this legislation would affect Indian Health Service (IHS) recipients. As mentioned during the March 28 hearing, health reform considers IHS coverage as benefits which satisfy the requirement to have insurance, so no penalty will be assessed if a beneficiary doesn't carry private insurance coverage. However, participation in the exchange – whether to acquire private health coverage, or get connected with other public programs, like Medicaid – will be an option for IHS beneficiaries.

If an IHS recipient chooses to purchase health insurance through the exchange, the individual is entitled to free medical services - without cost sharing or copayment requirements - if the recipient's household income falls below 300% of the poverty line. While the poverty line is adjusted annually, this year, for a family of four in Alaska, that level of income is \$83,000.

During the committee meeting the exchange's enrollment periods were discussed, and it was put on the record that most Alaskans can buy or switch health insurance policies once per year. For IHS recipients, monthly open enrollment periods allow beneficiaries to more readily access health insurance policies, to supplement medical services provided by the Indian Health Service.

In closing, health programs operated by the Indian Health Service, Indian tribes, tribal organizations and Urban Indian organizations are the payer of last resort for services provided through those programs, when private coverage is also carried by an individual. The effect of this provision in the Affordable Care Act will bring needed funds into the IHS system when beneficiaries carry additional coverage, helping to finance health benefits provided to program recipients, while giving added flexibility for IHS beneficiaries.

## **Uncompensated Care in Alaska**

Senator Thomas asked about the quantity of uncompensated care delivered in Alaska each year, to individuals who cannot pay for the care they receive. According to Families USA, total uncompensated health care delivered in Alaska to the uninsured amounted to \$174.7 million during 2010. This is up from \$124.8 million in 2005, demonstrating that our problem has been growing.

The dollar amounts are calculated based on the average payout for the uncompensated medical services provided, if private insurance had paid the bill.

Families USA is a national nonprofit, non-partisan organization dedicated to the achievement of high-quality, affordable health care for all Americans. For more information, the report can be accessed at this address:

[http://www.familiesusa.org/assets/pdfs/Paying\\_a\\_Premium\\_rev\\_July\\_13731e.pdf](http://www.familiesusa.org/assets/pdfs/Paying_a_Premium_rev_July_13731e.pdf)

### **Dental Coverage**

Senator McGuire asked about dental benefits under the Alaska Health Benefit Exchange.

In general, children's oral health benefits will be required as part of an essential health benefit package.

For adults, exchanges have to allow stand-alone dental plans within the exchange. However, these dental policies don't have to meet the actuarial levels as defined for health benefit plans.

To help consumers understand what they can expect from a health plan they select, exchange policies will be ranked by 'actuarial value' within the exchange. Actuarial value is defined as the percentage of total health costs, on average, that a policy will cover for any individual, taking into account all cost sharing provisions under the policy. For the most basic plans, the actuarial value must be greater than 60%, or otherwise the policy will be considered 'catastrophic' coverage. Dental benefits won't be categorized or judged by these standards.

The legislation doesn't currently require dental coverage for adults as a mandated health benefit. States do have an option of mandating benefits beyond the federal essential benefit package, but if they choose to do so, the state will be responsible for the cost of the additional benefit.

### **Opting Out of Health Reform**

Senator McGuire asked about the federal requirement to have health coverage. While the question seemed more philosophical rather than logistical, I'd like to provide additional details about the Exchange's role in the 'opt-out' process.

The requirement that all Americans acquire some form of health coverage, with few exceptions, was passed by Congress in the Affordable Care Act. Starting in 2014, financial penalties will be assessed if individuals don't meet that requirement. Senate Bill 70 doesn't change this provision. However, the exchange does have an important role relating to a few 'opt-out' provisions, provided for under federal law.

The penalty for not having health insurance won't be levied if a person is part of a religion opposed to acceptance of benefits from a health insurance policy. Incarcerated individuals and individuals/families that earn less than the threshold where an income tax return must be filed will be exempted. Finally, anyone who will have to pay more than 8% of income for health insurance – after taking into account employer contributions and tax credits to make coverage affordable – will be exempt from the requirement to have health coverage. The health exchange will be charged with administering these exemptions in Alaska.

Those covered by Medicaid, S-CHIP programs, Medicare, TRICARE, or employer provided health insurance will be considered 'insured' for the purposes of the Affordable Care Act, as well, in addition to IHS beneficiaries, as described above.

### **Regional Exchanges**

Senator Hoffman asked during the March 28 hearing about regional health insurance exchanges, and whether they were considered when crafting the legislation. The Affordable Care Act specifically allows for the creation of regional health exchanges, under Sec. 1311(f)(1).

The act requires member states of any regional exchange to consent to such an arrangement, and would require all member states to pass enabling legislation.

A regional exchange, while potentially lowering costs, has added complexities when compared to a state based exchange. In addition to finding partner states who can agree on terms and conditions with Alaska, member states would have to come up with a regional structure that still honors state consumer protection laws, state dispute resolution practices, state mandated benefits, and state insurance oversight, all responsibilities that individual states continue to hold under the Affordable Care Act.

In short, a regional exchange was ruled out by my office during initial drafting of Senate Bill 70 as we felt it required action from the executive branch, which wasn't occurring at the time.

Thank you for consideration of the legislation, and don't hesitate to contact my office if additional questions come to mind.

Sincerely,



Senator Hollis French



## **Senator Hollis French**

### **Sponsor Statement**

### **SB 70 – Alaska Health Benefit Exchange**

Competition improves quality, lowers cost and gives consumers a meaningful choice. The Alaska Health Benefit Exchange will make private health insurance companies more responsive to health care consumers in Alaska.

Buying health insurance can be difficult and complicated. This legislation helps consumers identify and enroll in a health insurance policy that will serve them well, regardless of what their future holds.

The Exchange will promote competition among plans by providing information to consumers on a leveled playing field. Today, individuals shopping for airline tickets can log onto the internet and in minutes view competing itineraries, sorted by route, schedule, carrier and price. In this same way, the web based portal created by this bill will allow health insurance consumers to compare carriers, cost-sharing, benefit design, and premium costs of different plans, all in a manner of minutes.

The legislation helps make health coverage affordable for Alaskans. The exchange will determine eligibility for health insurance tax credits, cost-sharing assistance, and medical assistance programs like Medicaid. Through the Small Business Health Options Program (SHOP), the exchange will connect small businesses with tax incentives and an insurance pooling mechanism, which can stabilize premiums and make coverage more affordable. Finally, the exchange establishes the mechanism to exempt people from the requirement to have health coverage, if affordable insurance products aren't available.

An exchange can open the door to innovative ways that keep health care costs down. For years, the idea of buying and selling health insurance across state lines has been cited as a competitive response to small insurance pools. This legislation will ask the Exchange board to consider interstate compacts, and if one makes sense for Alaskans, legislation can be proposed to make it happen.

Forty-nine other states are working towards the establishment of an exchange, and while other elements of health reform are controversial, the exchange idea is championed by Governors of both parties - even by those who are suing the federal government to stop reform.

“State exchanges are good from a conservative standpoint because they involve consumer choice and markets,” said former US Senate Majority Leader Bill Frist, a Tennessee Republican, in an Associated Press article (1/22/11). “Each state can develop the exchange that best meets the needs of their people.”

Finally, this legislation is Alaska’s chance to create a health insurance exchange on our own terms. By 2014, the state is required to have a consumer-centered exchange that makes buying health insurance easier for individuals and small businesses. If we don’t act now, the federal government will create and impose an exchange on us.

Please join me in supporting an Alaskan-based solution which puts Alaskans first.

# Alaska State Legislature



Senator Hollis French

## SB 70 – Explanation of Changes

The following changes were made in the Senate Labor and Commerce Committee:

- On page 2 of the CS, the legislation reworks the Exchange board. It replaces the original board of 13 voting members with a board of 7 voting members.

Members of the board include:

- o HSS Commissioner, or their designee
- o A representative of small employers
- o A representative of the health care insurance business
- o A member with expertise in health plan financing
- o A member with expertise in health plan administration
- o A health care actuary, or someone with similar economic experience
- o A consumer representative

In addition, the director of the Division of Insurance acts as a non-voting member.

- On Page 3 of the CS, new subsection (i) confirms that board members won't be civilly or criminally liable for an act or omission, if it was within the scope of the board member's duties and was done in good faith
- On Page 3 lines 18-20 *of the original draft*, (a)1 and (a)2 had some overlap. The new CS on page 3 only retains a(2), and as a result, renumbers (a)1 through (a)22.
- Page 3 line 31 – Page 4 line 4 require the Division of Insurance to implement procedures relating to health plan certification, recertification and decertification. Before, this was a responsibility of the Exchange board.
- Page 4 lines 5-9 require the Division of Insurance to rate each qualified health plan. Before, this was a responsibility of the Exchange board.
- Page 4 lines 10-14 require the Division of Insurance to determine the level of each qualifying plan. Before, this was a responsibility of the Exchange board.

- Page 6 lines 13-17 places the Navigator grant program under the Division of Insurance. Before, this program was a responsibility of the Exchange board.
- On page 6 line 26-28, the legislation directs complaints about health benefit plans to the Division of Insurance, and not the federal government like the old draft.
- Page 7 lines 1-4 require the Division of Insurance to review the rate of premium growth inside and outside the exchange, and to provide recommendations whether to expand the size of employers who can use the exchange. Before, this was a responsibility of the Exchange board.
- Page 7 lines 5-8 requires the Division of Insurance to develop policies and procedures to minimize adverse selection within the exchange, and between plans sold inside and outside the exchange. Before, this was a responsibility of the Exchange board.
- Page 7 lines 26-29 gives the board the authority to establish advisory groups to provide expertise and input about exchange operations. It doesn't specify the makeup of these advisory groups.
- Page 8 lines 1 – 13 establishes a new annual accounting report. The report reviews new enrollment, changes in enrollment, tax credits, and individual responsibility exemptions, broken down by insurer by benefit plan where applicable.
- Page 8 lines 14-23 now requires the exchange to cooperate with an investigation by the Division of Insurance. The legislation still requires cooperation with federal investigations.
- Page 9 lines 2-5 states that the exchange will rely on the Division of Insurance's determination relating to the potential for interstate compacts. The division will recommend particular compact arrangements for legislative approval.
- Page 9 lines 6-28 requires the exchange board to establish a plan of operation, which is reviewed and approved by the director of the Division of Insurance. If a suitable plan isn't developed, this new subsection allows for the director to adopt reasonable regulations to carry out the responsibilities of the exchange.
- Page 10, lines 10-12 requires public disclosure of grants or donations applied for or received by the exchange within 30 days of the application or receipt of funds, whichever is applicable.
- Page 14 lines 18-21 have been changed to clarify that user fees from health care insurers offering health benefit plans will be relied upon to finance the exchange.

- Page 14 lines 26-31 have been changed to give the Division of Insurance authority to adopt regulations to implement their authority under the legislation.
- Page 19 lines 26-31 have been changed in the section relating to transition regulations. The change gives the director of the Division of Insurance the ability to adopt regulations, but makes it clear that any regulations won't be in effect until the effective date of statutory changes.
- Page 20 line 1 has been modified to make the transitional provisions related to board terms effective on July 1, 2011. Before, the bill gave those transitional provisions an immediate effective date.

For more information about these changes, contact Andy Moderow in Senator French's office at 907-465-3892.

## Section by Section Summary of SB 70

3/23/11- Corresponds with version \l

Below is a description of key components, section by section, in Senate Bill 70.

**Section 1** of the legislation, found on page 1 through page 2 line 5, provides intent language for this legislation. It highlights the importance of **connecting individuals and small businesses with quality health insurance policies, to reduce the number of uninsured Alaskans.**

**Section 2** of the legislation, found on page 2 line 6 through page 18 line 14, establishes the Alaska Health Benefit Exchange.

**Section 21.54.200** (page 2 lines 8-11) sets up the health benefit exchange as a public corporation of the state, much like the permanent fund corporation.

**Section 21.51.210** (Page 2 line 12 through Page 3 line 16) establishes the board which will manage the Alaska Health Benefit Exchange. The board consists of 8 members, with 7 voting members. The Commissioner of Health and Social Services, or their designee, will serve on the committee ex officio, and the Director of the Division of Insurance will hold a non-voting seat.

The remaining language in this section lays out disclosure requirements, procedures in case of a vacancy, and other technical aspects of the board. In addition, it authorizes the board to hire an Executive Director, who can hire staff to implement this legislation.

**Section 21.54.220** (Page 3 line 17 to Page 10 line 21) outlines the powers and duties of the Alaska Health Benefit exchange.

(a)1 outlines the primary duty of the exchange, which is to **facilitate the purchase and sale of qualified health plans.** (Definitions of qualified individuals, employers and plans can be found on pages 15 and 16 of this bill.)

(a)2 and (a)12 both establish the **Small Business Health Options Program** (known as SHOP), which connects employees of small business with health coverage in a new 'pool.' In addition, SHOP connects small businesses that offer health coverage to employees with tax credits.

(a)3 provides for a **telephone call center to assist individuals.**

(a)4 requires that 'enrollment periods' are held annually to facilitate the changing of health insurance policies. These **open enrollment periods encourage competition** and allow individuals to move from one plan to another while reducing the potential for 'adverse selection.'

(a)5 provides for the **creation of an internet marketplace** to connect individuals with health insurance coverage.

(a)6 provides for certification and decertification of health plans sold through the exchange.

(a)7 and (a)8 requires the exchange to **compare health plans on metrics of quality and price.**

(a)9 requires the exchange to use a **standardized format of presenting health benefit options** in the exchange, to assist consumers with comparing products.

(a)10 requires the exchange to **determine potential eligibility for state or local medical assistance programs, such as Medicaid and Denali KidCare.** If qualified, **the exchange will assist with the enrollment process.**

(a)11 establishes a **tax credit calculator** to help individuals know the cost of health coverage, after assistance is applied.

(a)13 requires that **the exchange exempts Alaskans from the requirement to retain health insurance if certain criteria is met.** As an example, these exemptions will occur when an affordable insurance policy isn't available to an individual, after tax credits are applied.

(a)(14)(A) shares information about individuals exempted from the health insurance requirement. (a)(14)(B) shares information about employees who aren't offered affordable health coverage through employment. (a)(14)(C) shares information about employees who cease to have employer coverage due to a change in employment.

(a)15 notifies an employer when an employee receives premium assistance from the government, either because the employer doesn't offer a plan, or offers a plan which doesn't meet minimum standards or is unaffordable.

(a)16 explicitly states that the exchange will assist consumers by determining **eligibility for premium tax credits, reduced-cost sharing, or exemptions from the insurance mandate.**

(a)17 sets up the framework for **Navigator Grants.** These grants can be pursued by most organizations or trade groups for the purposes of helping the exchange fulfill its goals. **Navigator duties include enrollment assistance, information sharing, and assistance with dispute resolution.**

(a)18 requires the Division of Insurance to consider the rate of premium growth within and outside the exchange, in an effort to **evaluate the effect and benefit of incorporating larger employers within SHOP exchange.**

(a)19 asks the Division of Insurance to develop policy and procedures that **minimize adverse selection**, both inside the exchange and between plans sold within and outside the exchange.

(a)20 requires the exchange to provide credit for any **'free choice voucher' that an employer provides an employee for the purpose of covering premium costs**.

(a)21 requires the exchange to **consult with stakeholders**.

(a)22 allows the exchange to establish one or more advisory groups, to provide input into exchange operations.

(a)23 **outlines accounting requirements**, and (a)24 requires an annual accounting report to be submitted to federal and state stakeholders. (a)25 allows for cooperation with any investigation or audit by the Division of Insurance or Secretary of Health and Human Services.

(a)26 allows a health insurer to offer a limited dental plan as part of a qualified health plan, so long as pediatric dental benefits are included.

(a)27 requires the exchange to apply for planning and establishment grants for the Exchange. **Grants of up to \$1 million have been awarded to each of 48 states to date for planning.**

(a)28 requests that the Division of Insurance offer recommendations about **potential interstate compacts that would permit the sale and purchase of health insurance across state lines**.

(a)29 requires that the Exchange board establish a plan of operation, and submit it to the director of the Division of Insurance for approval.

Proposed subsection (b)1, found on page 9 line 29, allows the exchange to contract out some of the responsibilities outlined in this legislation.

Proposed subsection (b)2 allows the exchange to share information with federal and state agencies, provided that confidentiality protections consistent with state and federal laws are upheld.

Proposed subsection (b)3 allows the exchange to receive grants to finance operations, and it requires prompt disclosure of any financial contributions.

Proposed subsection (c) prohibits certain expenses to keep costs down for consumers.

Subsection (d) ensures individuals won't be penalized if they change coverage because they are newly eligible for that coverage, or if employer sponsored coverage becomes affordable.

**Proposed Section 21.54.230** of the legislation, found on page 10 line 22 through page 14 line 15, relates to health plan certification.

Subsection (a) outlines requirements of a qualified health plan, and the insurers offering such plans.

(a)(1) allows flexibility for an insurer to include or not include adult dental benefits, so long as one supplemental dental plan is included within the exchange.

(a)(2) requires that premium rates and plan language are approved.

(a)(3) requires plans to meet certain **quality guidelines in terms of the actuarial value** to a consumer, except in instances where catastrophic plans are sufficient to protect an individual from financial hardship.

(a)(4) meets **cost sharing and deductible assistance requirements** which protect consumers.

(a)(5) and (a)(6) require that an insurer in the exchange offer plans which meet certain quality metrics, and that they charge the **same rates for similar policies inside and outside the exchange**.

(a)(7) requires the exchange to determine that making the plan available through the exchange is **in the interest of employers and individuals**.

Subsection (b) specifies that an exchange cannot exclude a plan because it is fee-for-service, through price controls, or because a plan pays for lifesaving treatments.

Subsection (c)(1) **requires an insurer to justify any premium increase** prior to implementing the premium increase. This justification must be shared with the public, and the exchange will consider these premium increases when determining whether to certify plans.

Subsection (c)2 and (c)3 requires insurers to **provide the public with fiscal, claim, rating, and enrollment data**, in instances when disclosure is consistent with privacy laws. It requires insurers to release cost data, including cost sharing paid by the consumer, for a specific item or service under a health insurance policy.

Subsection (d) makes it clear that state insurance laws regarding solvency and licensing are still applicable to plans within the exchange, and that insurers are treated equally.

Subsection (e) relates to dental benefits under the law, and the flexibility of plans under reform in this area.

**Proposed section 21.54.240**, found on page 14 lines 16-23, relates to exchange funding. It requires the exchange to finance itself after being established, and requires this funding to come from insurers who offer health benefit plans through the exchange. The cost of this financing must be disclosed on the exchange website.

**Proposed section 21.54.250**, found on page 14 lines 24-29, allows the exchange board and Division of Insurance to adopt regulations.

**Proposed section 21.54.260**, found on page 14 line 30 to page 15 line 5, requires insurers to honor state health insurance laws as established.

**Section 21.54.270**, found on page 15 line 6 through page 18 line 14, provide definitions of some terms used in this act.

**Section 3 of the legislation**, found on page 18 lines 15-17, adds employees of the exchange to the list of partially exempt service.

**Section 4 of the legislation**, on page 18 line 18 through page 19 line 10, defines the Executive Director of the exchange as a public official.

**Section 5 of the legislation**, on page 19 lines 11-12, adds the Alaska Health Benefit Exchange Board to the list of state commissions or boards.

**Section 6 of the legislation**, on page 19 lines 13-21, outlines transitional provisions relating to board terms.

**Section 7 of the legislation**, on page 19 lines 22-29, gives the ability to draft regulations to the Exchange board and Division of Insurance, under the Administrative Procedure Act, though regulations won't take effect until the effective date of statutory changes.

**Sections 8 of the legislation**, on page 19 lines 30-31, provides for a July 1, 2011 effective date for the exchange board, the duties of the board, and the board's ability to make regulations.

**Section 9 of the legislation**, on page 20 line 1, make certain transitional provisions effective immediately.

**Section 10 of the legislation**, on page 20 line 2, makes the remainder of the act effective on July 1, 2012. This is when health plan certification would begin under the legislation.

*adopted 02/03/12  
changes effective Dates*

27-LS0286E  
Bailey  
2/1/12

**CS FOR SENATE BILL NO. 70(FIN)**

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SEVENTH LEGISLATURE - SECOND SESSION

BY THE SENATE FINANCE COMMITTEE

**Offered:**  
**Referred:**

**Sponsor(s): SENATORS FRENCH, Davis, Ellis**

**A BILL**

**FOR AN ACT ENTITLED**

1 **"An Act establishing the Alaska Health Benefit Exchange; and providing for an effective**  
2 **date."**

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

4 \* **Section 1.** The uncodified law of the State of Alaska is amended by adding a new section  
5 to read:

6 INTENT. It is the intent of the legislature in this Act

7 (1) to facilitate the purchase and sale of qualified health plans in the individual  
8 market in this state;

9 (2) to establish a small business health options program exchange to assist  
10 qualified small employers in the state in enrolling employees in qualified health plans offered  
11 in the small group market;

12 (3) to provide consumer education and assist individuals with access to  
13 programs, credits, and cost-sharing reductions;

14 (4) to reduce the number of uninsured Alaskans by creating an organized,

1 transparent, and easy-to-navigate health insurance marketplace that offers a choice of high  
2 value health plans with low administrative costs for individuals and employers; and

3 (5) that the Alaska Health Benefit Exchange Board recommend to the  
4 legislature and the Office of the Governor methods to keep premium costs low and risk pools  
5 strong in the health insurance market place.

6 \* **Sec. 2.** AS 21.54 is amended by adding new sections to read:

7 **Article 2A. Alaska Health Benefit Exchange.**

8 **Sec. 21.54.200. Alaska Health Benefit Exchange.** The Alaska Health Benefit  
9 Exchange is established as a public corporation of the state in the Department of  
10 Commerce, Community, and Economic Development but with separate and  
11 independent legal existence.

12 **Sec. 21.54.210. Alaska Health Benefit Exchange Board.** (a) The Alaska  
13 Health Benefit Exchange Board is established to manage the exchange.

14 (b) The board consists of eight members, including six members appointed by  
15 the governor, the commissioner of health and social services or the commissioner's  
16 designee, serving ex officio, and the director, serving ex officio, without the power to  
17 vote. The members of the board appointed by the governor are

18 (1) a representative of small business employers;

19 (2) a representative of the health care insurance business;

20 (3) a person with expertise in health plan finance;

21 (4) a person with expertise in health plan administration;

22 (5) an actuary or a person with a background in health care actuarial or  
23 economic principles; and

24 (6) a health care consumer representative.

25 (c) Except for the commissioner or the commissioner's designee and the  
26 director, who serve ex officio, each board member serves for a term of three years  
27 beginning on January 1 and until a successor has been appointed. A member is eligible  
28 for reappointment.

29 (d) The board shall select a member to serve as chair and a member to serve as  
30 vice-chair for a term and with duties and powers necessary to perform their functions.

31 (e) A majority of the board constitutes a quorum for transacting business.

1 (f) If a vacancy occurs, the governor shall make an appointment, effective  
2 immediately, for the balance of the unexpired term.

3 (g) Board members and the executive director hired under (j) of this section  
4 shall comply with the requirements of AS 39.50 (public official financial disclosure)  
5 and shall disclose an affiliation with an insurer, agent, broker, or other representative  
6 of an insurer, a health care provider, or a health care facility.

7 (h) Members of the board are entitled to per diem and transportation costs  
8 under AS 39.20.180.

9 (i) A member of the board of directors of the exchange may not be held civilly  
10 or criminally liable for an act or omission if the act or omission was in good faith and  
11 within the scope of the director's duties.

12 (j) The board shall employ an executive director to administer the exchange.  
13 The executive director shall perform duties as prescribed by the board and may  
14 employ a staff to assist in the performance of the duties of the executive director. The  
15 executive director and staff employed under this subsection are in the partially exempt  
16 service under AS 39.25.120.

17 **Sec. 21.54.220. Duties and powers of the Alaska Health Benefit Exchange;**  
18 **limitation.** (a) The Alaska Health Benefit Exchange Board shall

19 (1) facilitate the purchase and sale of qualified health plans;

20 (2) establish a small business health options program exchange to  
21 assist qualified small employers in the state in enrolling employees in a qualified  
22 health plan;

23 (3) provide for the operation of a toll-free telephone hotline to respond  
24 to requests for assistance;

25 (4) provide for enrollment periods under sec. 1311(c)(6), P.L. 111-148  
26 (Patient Protection and Affordable Care Act), as amended, and regulations adopted  
27 under that Act;

28 (5) maintain an Internet website through which enrollees and  
29 prospective enrollees of qualified health plans may obtain standardized comparative  
30 information on those plans;

31 (6) implement procedures for the certification, recertification, and

1 decertification of qualified health plans according to the determination of the division  
2 consistent with guidelines developed by the United States Secretary of Health and  
3 Human Services under sec. 1311(c), P.L. 111-148 (Patient Protection and Affordable  
4 Care Act), as amended, and regulations adopted under that Act;

5 (7) assign a rating to each qualified health plan offered through the  
6 exchange according to the determination of the division in accordance with the criteria  
7 developed by the United States Secretary of Health and Human Services under sec.  
8 1311(c)(3), P.L. 111-148 (Patient Protection and Affordable Care Act), as amended,  
9 and regulations adopted under that Act;

10 (8) determine the level of coverage of each qualified health plan  
11 according to the determination of the division under regulations issued by the United  
12 States Secretary of Health and Human Services under sec. 1302(d)(2)(A), P.L. 111-  
13 148 (Patient Protection and Affordable Care Act), as amended, and regulations  
14 adopted under that Act;

15 (9) use a standardized format for presenting health benefit options in  
16 the exchange, including the use of the uniform outline of coverage established under  
17 42 U.S.C. 300gg et seq. (sec. 2715, Part A, subpart II, title XXVII, Public Health  
18 Service Act);

19 (10) in accordance with sec. 1413, P.L. 111-148 (Patient Protection  
20 and Affordable Care Act), as amended, and regulations adopted under that Act, inform  
21 individuals of title XIX, Social Security Act eligibility requirements for the Medicaid  
22 program under 42 U.S.C. 1396 - 1396w-2, the Children's Health Insurance Program  
23 under 42 U.S.C. 1397aa - 1397mm (title XXI of the Social Security Act), or any  
24 applicable state or local public program; and, if the exchange determines that any  
25 individual is eligible for a program, enroll that individual in that program;

26 (11) establish and make available by electronic means a calculator to  
27 determine the actual cost of coverage after application of any premium tax credit  
28 under 26 U.S.C. 36B (Internal Revenue Code of 1986), and any cost-sharing reduction  
29 under sec. 1402, P.L. 111-148 (Patient Protection and Affordable Care Act), as  
30 amended, and regulations adopted under that Act;

31 (12) establish a small business health options program exchange

1 through which qualified employers may access coverage for their employees and  
2 which shall enable a qualified employer to specify a level of coverage so that any of  
3 its employees may enroll in any qualified health plan offered through the small  
4 business health options program exchange at the specified level of coverage;

5 (13) subject to sec. 1411, P.L. 111-148 (Patient Protection and  
6 Affordable Care Act), as amended, and regulations adopted under that Act, grant a  
7 certification attesting that, for purposes of the individual responsibility penalty under  
8 26 U.S.C. 5000A (Internal Revenue Code of 1986), an individual is exempt from the  
9 individual responsibility requirement or from the penalty imposed by that section  
10 because

11 (A) an affordable qualified health plan covering the individual  
12 is not available through the exchange or through the individual's employer; or

13 (B) the individual meets the requirements for another  
14 exemption from the individual responsibility requirement or penalty;

15 (14) provide the following information to the United States Secretary  
16 of the Treasury:

17 (A) the name and taxpayer identification number of each  
18 individual issued a certification under (13) of this subsection;

19 (B) the name and taxpayer identification number of each  
20 individual who was an employee but who was determined to be eligible for the  
21 premium tax credit under 26 U.S.C. 36B (Internal Revenue Code of 1986)  
22 because

23 (i) the employer did not provide minimum essential  
24 coverage; or

25 (ii) the employer provided the minimum essential  
26 coverage, but it was determined under 26 U.S.C. 36B(c)(2)(C) (Internal  
27 Revenue Code of 1986), to be unaffordable to the employee or not to  
28 provide the required minimum actuarial value; and

29 (C) the name and taxpayer identification number of each  
30 individual who

31 (i) notifies the exchange under sec. 1411(b)(4), P.L.

1 111-148 (Patient Protection and Affordable Care Act), as amended, and  
2 regulations adopted under that Act, that the individual has changed  
3 employers; and

4 (ii) ceases coverage under a qualified health plan during  
5 a plan year and the effective date of that cessation;

6 (15) provide to each employer the name of each employee of the  
7 employer described in (14)(B) of this subsection who ceases coverage under a  
8 qualified health plan during a plan year and the effective date of the cessation;

9 (16) perform duties required of the exchange by the United States  
10 Secretary of Health and Human Services or the United States Secretary of the  
11 Treasury related to determining eligibility for premium tax credits, reduced cost-  
12 sharing, or individual responsibility requirement exemptions;

13 (17) select entities qualified to serve as navigators as determined by  
14 the division in accordance with sec. 1311(i), P.L. 111-148 (Patient Protection and  
15 Affordable Care Act), as amended, and regulations adopted under that Act, and  
16 standards developed by the United States Secretary of Health and Human Services and  
17 award grants to enable navigators to

18 (A) conduct public education activities to raise awareness of  
19 the availability of qualified health plans;

20 (B) distribute fair and impartial information concerning  
21 enrollment in qualified health plans, the availability of premium tax credits  
22 under 26 U.S.C. 36B (Internal Revenue Code of 1986), and the availability of  
23 cost-sharing reductions under sec. 1402, P.L. 111-148 (Patient Protection and  
24 Affordable Care Act), as amended, and regulations adopted under that Act;

25 (C) facilitate enrollment in qualified health plans;

26 (D) provide referrals to the division for consumer assistance for  
27 a person with a grievance, complaint, or question regarding the person's health  
28 benefit plan or coverage, or a determination under that plan or coverage; and

29 (E) provide information in a manner that is culturally and  
30 linguistically appropriate to the needs of the population being served by the  
31 exchange;

1 (18) review the rate of premium growth within the exchange and  
2 outside the exchange as determined by the division and rely on the information  
3 developed by the division on whether to continue limiting qualified employer status to  
4 small employers;

5 (19) rely on policies and procedures developed by the division to  
6 minimize adverse selection among plans sold within the exchange and review policies  
7 within the exchange and outside the exchange to monitor the effect of adverse  
8 selection between the two marketplaces;

9 (20) credit the amount of any free choice voucher to the monthly  
10 premium of the plan in which a qualified employee is enrolled, in accordance with sec.  
11 10108, P.L. 111-148 (Patient Protection and Affordable Care Act), as amended, and  
12 regulations adopted under that Act, and collect the amount credited from the offering  
13 employer;

14 (21) consult with persons having an interest in the activities of the  
15 exchange, including

16 (A) health care insurers;

17 (B) health care consumers who are enrollees in qualified health  
18 plans;

19 (C) individuals and entities with experience in facilitating  
20 enrollment in qualified health plans;

21 (D) representatives of small businesses and self-employed  
22 individuals;

23 (E) the division in the Department of Health and Social  
24 Services responsible for administering Medicaid; and

25 (F) advocates for enrolling hard-to-reach populations;

26 (22) establish one or more advisory groups to consult with the board to  
27 provide expertise on and input into operations of the exchange; the membership of an  
28 advisory group may include health care providers, hospitals, and persons identified in  
29 (21) of this subsection;

30 (23) maintain an accurate accounting of all activities, receipts, and  
31 expenditures;

1 (24) submit an annual accounting report to the United States Secretary  
2 of Health and Human Services, the governor, the director and the legislature; the  
3 report must include the following information described by insurer by benefit plan:

4 (A) the number of covered persons;

5 (B) the number of covered persons receiving free choice  
6 vouchers and the amount of free choice vouchers credited;

7 (C) the number of individuals exempted from individual  
8 responsibility requirements by reason;

9 (D) the number of individuals eligible for premium tax credit;

10 (E) the number of employees who terminated coverage and the  
11 number of individuals obtaining coverage through the exchange who were  
12 covered under an employer health plan in the preceding six months; and

13 (F) other data specified by the director;

14 (25) cooperate with an investigation conducted by the division or the  
15 United States Secretary of Health and Human Services under the Secretary's authority  
16 under P.L. 111-148 (Patient Protection and Affordable Care Act), as amended, and  
17 regulations adopted under that Act, and allow the division or the Secretary, in  
18 coordination with the Inspector General of the United States Department of Health and  
19 Human Services, to

20 (A) investigate the affairs of the exchange;

21 (B) examine the properties and records of the exchange;

22 (C) require periodic reports in relation to the activities  
23 undertaken by the exchange;

24 (26) allow a health care insurer to offer a plan that provides limited  
25 scope dental benefits under 26 U.S.C. 9832(c)(2)(A) (Internal Revenue Code of 1986),  
26 through the exchange, either separately or in conjunction with a qualified health plan,  
27 if the plan provides pediatric dental benefits under sec. 1302(b)(1)(J), P.L. 111-148  
28 (Patient Protection and Affordable Care Act), as amended, and regulations adopted  
29 under that Act;

30 (27) apply for planning and establishment grants made available to the  
31 exchange under sec. 1311, P.L. 111-148 (Patient Protection and Affordable Care Act),

1 as amended, and regulations adopted under that Act;

2 (28) rely on the division's determination relating to the potential for  
3 interstate compacts that would permit the sale and purchase of health care insurance  
4 across state borders and recommend particular compact arrangements for legislative  
5 approval; and

6 (29) submit to the director a plan of operation to ensure the fair,  
7 reasonable, and equitable administration of the exchange; the plan of operation  
8 becomes effective on approval in writing by the director, subject to the following:

9 (A) if the exchange fails to submit a suitable plan under this  
10 paragraph, the director may adopt reasonable regulations necessary or  
11 advisable to carry out the provisions of AS 21.54.200 - AS 21.54.270; the  
12 regulations adopted by the director under this subparagraph must continue in  
13 force until modified by the director or superseded by a plan submitted by the  
14 exchange and approved by the director;

15 (B) the plan of operation must

16 (i) establish procedures for the performance of the  
17 duties and powers of the exchange;

18 (ii) establish procedures for handling assets of the  
19 exchange;

20 (iii) establish the amount and method of reimbursing  
21 members of the board of directors;

22 (iv) establish regular places and times for meetings of  
23 the board of directors;

24 (v) establish procedures for records to be kept of all  
25 financial transactions of the exchange, its agents, and the board of  
26 directors;

27 (vi) contain any additional provisions necessary or  
28 proper for the execution of the powers and duties of the exchange.

29 (b) The exchange may

30 (1) enter into a contract for the performance of the exchange's duties  
31 with the Department of Health and Social Services or another entity that has

1 experience in individual and small group health insurance or benefit administration, or  
2 other experience relevant to the responsibilities to be assumed by the entity, except  
3 that the exchange may not contract for the performance of its duties with a health care  
4 insurer or an affiliate of a health care insurer;

5 (2) enter into information-sharing agreements with federal and state  
6 agencies and other state exchanges to carry out its duties if the agreements include  
7 adequate protections with respect to the confidentiality of the information to be shared  
8 and comply with all state and federal laws and regulations; and

9 (3) apply for and receive grants or donations from federal, state, local  
10 government, foundation, or private entities; the exchange shall make records of  
11 application for or receipt of grants or donations under this paragraph available to the  
12 public on the exchange's Internet website within 30 days after application or receipt.

13 (c) The exchange may not use money intended for the administrative and  
14 operational expenses of the exchange for staff retreats, promotional giveaways, or  
15 excessive executive compensation.

16 (d) Neither the exchange nor a health care insurer offering a health benefit  
17 plan through the exchange may charge an individual a fee or penalty for termination of  
18 coverage if the individual enrolls in another type of minimum essential coverage  
19 because

20 (1) the individual has become newly eligible for that coverage; or

21 (2) the individual's employer-sponsored coverage has become  
22 affordable under the standards of 26 U.S.C. 36B(c)(2)(C) (Internal Revenue Code of  
23 1986).

24 **Sec. 21.54.230. Health benefit plan certification.** (a) The exchange may  
25 certify a health benefit plan as a qualified health plan if

26 (1) the plan provides the essential health benefits described in sec.  
27 1302(a), P.L. 111-148 (Patient Protection and Affordable Care Act), as amended, and  
28 regulations adopted under that Act, except that the plan is not required to provide  
29 essential benefits that duplicate the minimum benefits of qualified dental plans if

30 (A) the exchange has determined that at least one qualified  
31 dental plan is available to supplement the plan's coverage; and

1 (B) the health care insurer makes prominent disclosure at the  
 2 time it offers the plan, in a form approved by the exchange, that the plan does  
 3 not provide the full range of essential pediatric benefits, and that qualified  
 4 dental plans providing those benefits and other dental benefits not covered by  
 5 the plan are offered through the exchange;

6 (2) the premium rates and contract language have been approved by  
 7 the director;

8 (3) the plan provides at least a bronze level of coverage under  
 9 AS 21.54.220(a)(7) unless the plan is certified as a qualified catastrophic plan, meets  
 10 the requirements of P.L. 111-148 (Patient Protection and Affordable Care Act), as  
 11 amended, and regulations adopted under that Act, for catastrophic plans, and will only  
 12 be offered to individuals eligible for catastrophic coverage;

13 (4) the cost-sharing requirements of the plan do not exceed the limits  
 14 established under sec. 1302(c)(1), P.L. 111-148 (Patient Protection and Affordable  
 15 Care Act), as amended, and regulations adopted under that Act, and, if the plan is  
 16 offered through the small business health options program exchange, the deductible  
 17 for the plan does not exceed the limits established under sec. 1302(c)(2), P.L. 111-148  
 18 (Patient Protection and Affordable Care Act), as amended, and regulations adopted  
 19 under that Act;

20 (5) the health care insurer offering the plan

21 (A) is licensed and in good standing to offer health insurance  
 22 coverage in the state;

23 (B) offers at least one qualified health plan that provides a  
 24 silver level of coverage under AS 21.54.220(a)(7) and at least one plan that  
 25 provides a gold level of coverage through each small business health options  
 26 program exchange and exchange for individual coverage in which the health  
 27 care insurer participates;

28 (C) charges the same premium rate for each qualified health  
 29 plan without regard to whether the plan is offered through the exchange and  
 30 without regard to whether the plan is offered directly from the health care  
 31 insurer or through an insurance producer;

1 (D) does not charge cancellation fees or penalties in violation  
2 of AS 21.54.220(d); and

3 (E) complies with the regulations developed by the United  
4 States Secretary of Health and Human Services under sec. 1311(d), P.L. 111-  
5 148 (Patient Protection and Affordable Care Act), as amended, and regulations  
6 adopted under that Act, and other requirements the exchange establishes;

7 (6) the plan meets the requirements of certification as adopted by  
8 regulation under AS 21.54.250 and by the United States Secretary of Health and  
9 Human Services under sec. 1311(c), P.L. 111-148 (Patient Protection and Affordable  
10 Care Act), as amended, and regulations adopted under that Act, which include  
11 minimum standards in the areas of marketing practices, network adequacy, essential  
12 community providers in underserved areas, accreditation, quality improvement,  
13 uniform enrollment forms, and descriptions of coverage and information on quality  
14 measures for health benefit plan performance; and

15 (7) the exchange determines that making the plan available through the  
16 exchange is in the interest of qualified individuals and qualified employers in this  
17 state.

18 (b) The exchange may not exclude a health benefit plan

19 (1) because the plan is a fee-for-service plan;

20 (2) by imposing premium price controls; or

21 (3) because the plan provides treatments necessary to prevent patients'  
22 deaths that the exchange determines are inappropriate or too costly.

23 (c) The exchange shall require each health care insurer seeking certification of  
24 a plan as a qualified health plan to

25 (1) submit to the exchange a justification for any premium increase  
26 before implementation of that increase; the health care insurer shall prominently post  
27 the justification information on the health care insurer's Internet website; the exchange  
28 shall consider the information submitted, along with the information and the  
29 recommendations provided to the exchange by the director under 42 U.S.C. 300gg-94  
30 (sec. 2794(b), Part C, title XXVII, Public Health Service Act) when determining  
31 whether to allow the health care insurer to make plans available through the exchange;

1 (2) make available to the public in plain language, as defined in sec.  
2 1311(e)(3)(B), P.L. 111-148 (Patient Protection and Affordable Care Act), as  
3 amended, and regulations adopted under that Act, and submit to the exchange, the  
4 United States Secretary of Health and Human Services, and the director accurate and  
5 timely disclosure of the following:

6 (A) claims payment policies and practices;

7 (B) periodic financial disclosures;

8 (C) data on enrollment;

9 (D) data on disenrollment;

10 (E) data on the number of claims that are denied;

11 (F) data on rating practices;

12 (G) information on cost-sharing and payments with respect to  
13 any out-of-network coverage;

14 (H) information on enrollee and participant rights under Title I  
15 of P.L. 111-148 (Patient Protection and Affordable Care Act), as amended, and  
16 regulations adopted under that Act; and

17 (I) other appropriate information as determined by the United  
18 States Secretary of Health and Human Services.

19 (3) permit individuals to learn, in a timely manner on the request of the  
20 individual, the amount of cost-sharing, including deductibles, copayments, and  
21 coinsurance, under the individual's plan or coverage that the individual would be  
22 responsible for paying with respect to the furnishing of a specific item or service by a  
23 participating provider; a minimum, that information must be made available to the  
24 individual through an Internet website and through other means for individuals  
25 without access to the Internet.

26 (d) The exchange may not exempt a health care insurer seeking certification of  
27 a qualified health plan from state licensure or solvency requirements, regardless of the  
28 type or size of the health care insurer, and shall apply the criteria of this section in a  
29 manner that ensures equality between or among health care insurers participating in  
30 the exchange.

31 (e) The provisions of AS 21.54.200 - 21.54.270 that are applicable to qualified

1 health plans also apply, to the extent relevant, to qualified dental plans, except as  
2 modified under (1) - (3) of this subsection or by regulations adopted by the exchange.  
3 Under this subsection,

4 (1) the health care insurer shall be licensed to offer dental coverage,  
5 but need not be licensed to offer other health benefits;

6 (2) the plan must be limited to dental and oral health benefits, without  
7 substantially duplicating the benefits typically offered by a health benefit plan without  
8 dental coverage and must include, at a minimum, the essential pediatric dental benefits  
9 prescribed by the United States Secretary of Health and Human Services under sec.  
10 1302(b)(1)(J), P.L. 111-148 (Patient Protection and Affordable Care Act), as amended,  
11 and regulations adopted under that Act, and other dental benefits as the exchange or  
12 the Secretary may specify by regulation; and

13 (3) the health care insurer may jointly offer a comprehensive plan  
14 through the exchange in which the dental benefits are provided by a health care insurer  
15 through a qualified dental plan and the other benefits are provided by a health care  
16 insurer through a qualified health plan if the plans are priced separately and are also  
17 made available for purchase separately at the same price.

18 **Sec. 21.54.240. Exchange funding; publication of costs of the exchange.** (a)

19 The exchange may charge assessments or user fees to a health care insurer offering a  
20 health benefit plan or otherwise generate funding necessary to support its operations  
21 provided under AS 21.54.200 - 21.54.270.

22 (b) The exchange shall publish the average costs of licensing, regulatory fees,  
23 and any other payments required by the exchange, and the administrative costs of the  
24 exchange, on its Internet website. That information must include information on  
25 money lost to waste, fraud, and abuse.

26 **Sec. 21.54.250. Regulations.** The division or the exchange may adopt  
27 regulations to implement their respective authority under the provisions of  
28 AS 21.54.200 - 21.54.270. Regulations adopted under this section may not conflict  
29 with or prevent the application of regulations adopted by the United States Secretary  
30 of Health and Human Services under P.L. 111-148 (Patient Protection and Affordable  
31 Care Act), as amended, and regulations adopted under that Act.

1           **Sec. 21.54.260. Relation to other laws.** Provisions of AS 21.54.200 -  
2 21.54.270, and actions taken by the exchange under AS 21.54.200 - 21.54.270 may  
3 not be construed to preempt or supersede the authority of the director to regulate the  
4 business of insurance in the state. Except as expressly provided to the contrary in  
5 AS 21.54.200 - 21.54.270, all health care insurers offering qualified health plans in the  
6 state shall comply fully with all applicable health insurance laws of the state and  
7 regulations adopted and orders issued by the director.

8           **Sec. 21.54.270. Definitions.** In AS 21.54.200 - 21.54.270,

9           (1) "board" means the Alaska Health Benefit Exchange Board  
10 established AS 21.54.210;

11           (2) "exchange" means the Alaska Health Benefit Exchange established  
12 under AS 21.54.200;

13           (3) "health benefit plan" has the meaning given in AS 21.54.500,  
14 except that, notwithstanding AS 21.54.500, it does not include

15                   (A) coverage only for accident or disability income insurance,  
16 or any combination of accident or disability income insurance;

17                   (B) coverage issued as a supplement to liability insurance;

18                   (C) liability insurance, including general liability insurance and  
19 automobile liability insurance;

20                   (D) workers' compensation insurance or similar insurance;

21                   (E) automobile medical payment insurance;

22                   (F) credit-only insurance;

23                   (G) coverage for on-site medical clinics;

24                   (H) insurance coverage specified in federal regulations issued  
25 under the P.L. 104-191 (Health Insurance Portability and Accountability Act of  
26 1996), under which benefits for health care services are secondary or incidental  
27 to other insurance benefits;

28                   (I) the following benefits if they are provided under a separate  
29 policy, certificate, or contract of insurance or are otherwise not an integral part  
30 of the plan:

31                           (i) limited scope dental or vision benefits;

1 (ii) benefits for long-term care, nursing home care,  
2 home health care, community-based care, or any combination of long-  
3 term care, nursing home care, home health care, or community based  
4 care;

5 (J) limited benefits specified in federal regulations issued under  
6 P. L. 104-191 (Health Insurance Portability and Accountability Act of 1996);

7 (K) the following benefits if the benefits are provided under a  
8 separate policy, certificate, or contract of insurance; there is no coordination  
9 between the provision of the benefits and any exclusion of benefits under any  
10 group health plan maintained by the same plan sponsor; and the benefits are  
11 paid with respect to an event without regard to whether benefits are provided  
12 with respect to an event under any group health plan maintained by the same  
13 plan sponsor:

14 (i) coverage for only a specified disease or illness; or

15 (ii) hospital indemnity or other fixed indemnity  
16 insurance;

17 (L) the following benefits if offered as a separate policy,  
18 certificate, or contract of insurance:

19 (i) Medicare supplemental health insurance as defined  
20 in 42 U.S.C. 1395ss(g)(1) (sec. 1882(g)(1) ch. 7, Subchapter XVIII,  
21 Part E, Social Security Act);

22 (ii) coverage supplemental to the coverage provided 10  
23 U.S.C. 1071 - 1110a (Civilian Health and Medical Program of the  
24 Uniformed Services (CHAMPUS)); or

25 (iii) similar supplemental coverage provided to  
26 coverage under a group health plan;

27 (4) "qualified dental plan" means a limited scope dental plan that has  
28 been certified under AS 21.54.230(e);

29 (5) "qualified employer" means a small employer that elects to make  
30 its full-time employees and, at the option of the employer, some or all of its part-time  
31 employees, eligible for one or more qualified health plans offered through the small

1 business health options program exchange if the employer

2 (A) has its principal place of business in this state and elects to  
3 provide coverage through the small business health options program exchange  
4 to all of its eligible employees, wherever employed; or

5 (B) elects to provide coverage through the small business  
6 health options program exchange to all of its eligible employees who are  
7 principally employed in this state;

8 (6) "qualified health plan" means a health benefit plan that has in effect  
9 a certification that the plan meets the criteria for certification described in sec.  
10 1311(c), P.L. 111-148 (Patient Protection and Affordable Care Act), as amended, and  
11 regulations adopted under that Act, and AS 21.54.230;

12 (7) "qualified individual" means an individual, including a minor, who

13 (A) is seeking to enroll in a qualified health plan offered to  
14 individuals through the exchange;

15 (B) resides in this state;

16 (C) at the time of enrollment, is not incarcerated, other than  
17 incarceration pending the disposition of charges; and

18 (D) for the entire period for which enrollment is sought, is and  
19 is reasonably expected to be a citizen or national of the United States or an  
20 alien lawfully present in the United States;

21 (8) "small business health options program exchange" means the small  
22 business health options exchange under AS 21.54.220(a)(12) and sec. 1321, P.L. 111-  
23 148, (Patient Protection and Affordable Care Act), as amended, and regulations  
24 adopted under that Act;

25 (9) "small employer," notwithstanding AS 21.54.500, means an  
26 employer that employed an average of not more than 50 employees during the  
27 preceding calendar year; for purposes of this paragraph,

28 (A) a person treated as a single employer under 26 U.S.C. 414  
29 (b), (c), (m), or (o) (Internal Revenue Code of 1986), shall be treated as a  
30 single employer;

31 (B) an employer and any predecessor employer shall be treated

1 as a single employer;

2 (C) all employees shall be counted, including a part-time  
3 employee and an employee who is not eligible for coverage through the  
4 employer;

5 (D) if an employer was not in existence throughout the  
6 preceding calendar year, the determination of whether that employer is a small  
7 employer shall be based on the average number of employees the employer is  
8 reasonably expected to employ on business days in the current calendar year;  
9 and

10 (E) an employer that makes enrollment in qualified health plans  
11 available to its employees through the small business health options program  
12 exchange and that would cease to be a small employer because of an increase  
13 in the number of its employees, shall continue to be treated as a small  
14 employer for purposes of AS 21.54.200 - 21.54.270 as long as the employer  
15 continuously makes enrollment through the small business health options  
16 program exchange available to its employees.

17 \* **Sec. 3.** AS 39.25.120(c) is amended by adding a new paragraph to read:

18 (22) the executive director and employees of the Alaska Health Benefit  
19 Exchange Board employed under AS 21.54.210(j).

20 \* **Sec. 4.** AS 39.50.200(a)(9) is amended to read:

21 (9) "public official" means

22 (A) a judicial officer;

23 (B) the governor or the lieutenant governor;

24 (C) a person hired or appointed in a department in the  
25 executive branch as

26 (i) the head or deputy head of the department;

27 (ii) the director or deputy director of a division;

28 (iii) a special assistant to the head of the department;

29 (iv) a person serving as the legislative liaison for the  
30 department;

31 (D) an assistant to the governor or the lieutenant governor;

1 (E) the chair or a member of a state commission or board;

2 (F) state investment officers and the state comptroller in the  
3 Department of Revenue;

4 (G) the chief procurement officer appointed under  
5 AS 36.30.010;

6 (H) the executive director of the Alaska Workforce Investment  
7 Board;

8 (I) each appointed or elected municipal officer; [AND]

9 (J) the members of the board of trustees, the executive director,  
10 and the investment officers of the Alaska Permanent Fund Corporation; **and**

11 **(K) the executive director of the Alaska Health Benefit**  
12 **Exchange employed under AS 21.54.210;**

13 \* **Sec. 5.** AS 39.50.200(b) is amended by adding a new paragraph to read:

14 (64) the Alaska Health Benefit Exchange Board (AS 21.54.210).

15 \* **Sec. 6.** The uncodified law of the State of Alaska is amended by adding a new section to  
16 read:

17 TRANSITIONAL PROVISIONS. Notwithstanding AS 21.54.210(c), enacted by sec.  
18 2 of this Act, the initial terms for members of the Alaska Health Benefit Exchange Board  
19 appointed by the governor are as follows:

20 (1) three members shall be appointed to serve for terms ending December 31,  
21 2012;

22 (2) three members shall be appointed to serve for terms ending December 31,  
23 2013.

24 \* **Sec. 7.** The uncodified law of the State of Alaska is amended by adding a new section to  
25 read:

26 TRANSITION: REGULATIONS. The Alaska Health Benefit Exchange Board  
27 established under AS 21.54.200, enacted by sec. 2 of this Act, and the director of insurance  
28 may adopt regulations necessary to implement their respective powers and duties created by  
29 this Act under AS 21.54.250, enacted by sec. 2 of this Act. The regulations take effect under  
30 AS 44.62 (Administrative Procedure Act), but not before the effective date of the statutory  
31 changes.

- 1 \* **Sec. 8.** Section 7 of this Act takes effect immediately under AS 01.10.070(c).
- 2 \* **Sec. 9.** Except as provided in sec. 8 of this Act, this Act takes effect July 1, 2012.

## SB 70 Comments and Issues

1. Based on the successful experience of other small employer exchanges, it is vital that the Exchange collect all premiums from employers in the employer exchange and pay those to the insurers. Today the small employer writes one check to the insurer each month. It is simple. In the exchange, employees of employers will be able to pick their plan. This creates a complexity whereby the employer would have to write separate checks each month to different insurers. This is a complex new burden small employers will not want. The Connecticut and New York exchanges have proven they can administratively handle this task on behalf of employers and "keep it simple" administratively.

Here is suggested language:

- (i) Provide consolidated billing and premium payment by employers including detailed information to employers on health plans and costs chosen by their employees;*
- (ii) Establish an electronic interface and facilitate the flow of funds between insurers, employers, and employees, including subsidies and the use of "free choice vouchers;"*
- (iii) Provide plan enrollment information to employers.*

2. Utah has established a mechanism whereby employers can contribute an amount on behalf of part-time and seasonal employees to the exchange, without setting up an employer insurance program. They say this is popular with employers. This way an employee can get contributions from multiple employers. Employers might be willing to make a fixed contribution, whereas they are not willing to obligate themselves to full coverage that they see as unaffordable for part-time or seasonal employees. However, overall the entire health system and all participants are better off if employers make even a small or modest contribution to employee health coverage.

Example from the Utah Exchange:

*What is premium aggregation? Premium aggregation is a mechanism to pay insurance premiums with contributions from multiple sources. The unique feature of the Exchange allows employees aggregate the defined contribution from your employer, your premium contribution, and contributions from other sources, such as second employer, a spouse's employer, state assistance programs, etc.*

3. Will the Alaska Exchange be starting with the current definition of small group and limiting small employers to 50 employees or fewer? Or will you allow larger firms to buy insurance in the exchange, 51-100 or greater? One option is to allow the exchange to get up and running smoothly with employers with 50 or fewer employees (the present small group market definition) and to expand later after the exchange is past the startup phase. A related issue is whether self-employed can purchase from the small employer exchange (12 states currently allow this in their small group market).

4. We recommend based on lessons learned in other states with insurance pools and exchanges that insurance brokers/agents be used for the small employer exchange. Insurance agents are experienced, sell many products to small employers and are trusted advisors to small employers. While some have argued that exchanges could lower their costs by eliminating broker costs, this would create the unintended consequence of brokers steering all the low-risk employers to outside markets and undermining the stability of the exchange.

5. Given the Exchange is an independent agency and considerable funds will be flowing through the Exchange, an independent financial audit is a good idea.

6. Many experts have written on the topic of adverse selection and believe this is the Achilles' heel of insurance pools and exchanges, and why many have historically failed.

*(1) One option is to have the Board study, review options and recommend measures to prevent or counter adverse selection.*

*(2) A second option is provided by the bill before the Montana Legislature that would create a level playing field between the insurance market outside the health insurance exchange and with the exchange pool.*

**Health plan design requirements inside the exchange—outside the exchange.**

*(1) Each health insurance issuer wishing to participate in the exchange may offer up to three different plan designs in each of the following benefit categories: platinum, gold, silver, and bronze (as defined in the federal act) in individual health insurance market and in the small employer group health insurance market.*

*2) All issuers participating in the exchange must offer at least one gold plan and one silver plan, both inside and outside the exchange, unless the issuer does not operate outside the exchange.*

*(3) If the issuer offers a bronze plan or a plan with an actuarial value of 60% or less to individuals or small employer groups outside the exchange, it must also offer at least one substantially similar “qualified” bronze plan option inside the exchange.*

*(4)*

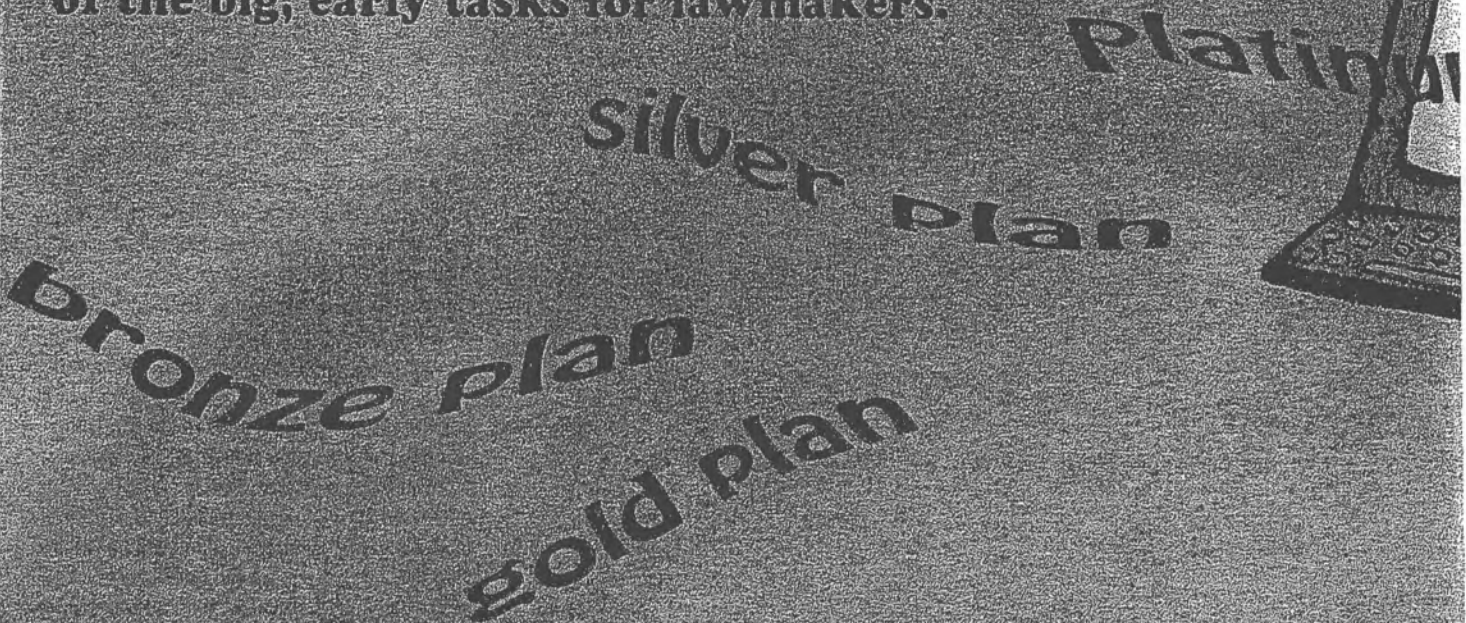
*(a) All health insurance issuers that participate in the exchange and offer individual or small employer group preferred provider organization (PPO) health plans, other plans with incentives for using particular networks of providers, or managed care plans outside the exchange, must also offer such network-based plans inside the exchange.*

*(b) Health insurer issuers must comply with the network adequacy rules promulgated under chapter 36, Part 2, or the network adequacy rules for PPOs that the commissioner shall adopt pursuant to 33-22-1707 for plans issued both inside and outside the exchange.*

*(c) Health insurance issuers must use the same network of providers for their health plans offered inside and outside the exchange.*

# Facing the Future

Setting up health insurance exchanges is one of the big, early tasks for lawmakers.



BY RACHEL BRAND

**A**da May Roberts worried each year about renewing her health insurance. She feared being told the price had doubled or the insurance company would not renew her policy.

So every fall, the Massachusetts innkeeper spent hours with insurance salespeople, reading the fine print and filling out medical forms. Then she prayed she'd be covered.

All that changed three years ago. On the

*Rachel Brand is a freelance writer in Denver and a frequent contributor to State Legislatures.*

first day the Massachusetts Health Connector opened, Roberts typed her name, birthday and zip code into a website. In five minutes, she had a list of 22 plans—rated gold, silver or bronze. It took her only 10 minutes to buy health insurance. Since then, her rates have dropped \$300 a month, and she never fears being kicked off.

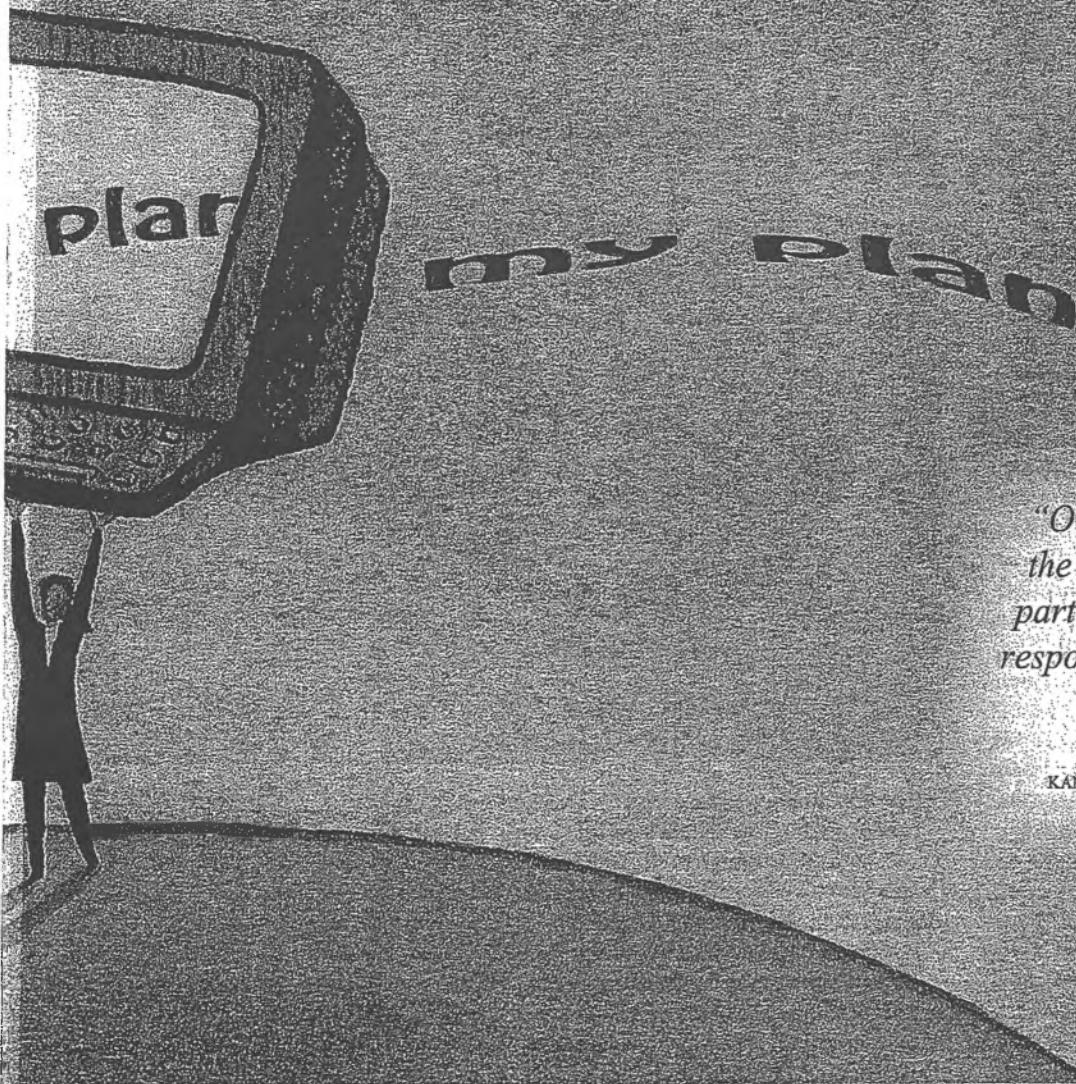
"I'm happy, happy, happy," says the 59-year-old. "The weight of uncertainty has been lifted. Massachusetts got it right."

Welcome to the future of health insurance. In three years, as many as 16 million people will buy innum through such online

trading posts, and the number will swell to 31 million by 2020. Insurers won't be able to deny folks coverage because they are in poor health, and plans will be easy to compare.

But state lawmakers have lots to do before that day comes. They must decide whether to offer an exchange, who will run it, and how it will work with insurers.

Then they must launch the exchange into a fiscal environment that is anything but inviting. The overall cost of getting exchanges up and running is expected to be \$4.4 billion nationwide, although some federal funds will offset the cost.



*"Over time, we'll build the expectation that it's part of people's personal responsibility to buy health insurance."*

SANDY PRAEGER  
KANSAS INSURANCE COMMISSIONER

#### IT'S THE LAW

A core tenet of federal health care reform passed in March is this: The federal government wants more people to have health insurance.

So in 2014, the government will help 19 million people become insured for the first time. Some will qualify for subsidies, others for an expanded Medicaid program. This help is specifically for people who are unemployed, self-employed or work for companies that don't offer coverage.

At the same time, it will be against the law not to have health insurance, except in some

specific cases. People who flout the law will pay a penalty that varies by income.

Nobody knows how many people will use the carrots or respond to the sticks.

"Over time, we'll build the expectation that it's part of people's personal responsibility to buy health insurance," says Kansas Insurance Commissioner Sandy Praeger.

Regardless, exchanges will play a role. "If you are going to move into a world in which people buy insurance on their own," says Jon Kingsdale, former commissioner of the Massachusetts Connector, "you need a vehicle to make it relatively easy for them to do so."

#### ONLINE MARKETPLACE

Exchanges are designed to make it easy to shop for and buy insurance. They're often compared to airline ticket websites such as Expedia.com. But exchanges go further.

Imagine if Expedia.com gave shoppers information on the quality of flights—their on-time frequency, customer service ratings and the quality of the food. Exchanges will provide such qualitative information about health plans.

They also will not sell plans that fail to meet minimum quality standards and benefit packages set out by the federal government.

*"If you have not already begun to implement, you are behind. A lot of folks are waiting on the political winds, but I would hope your legislative leaders would dig in and get started."*

UTAH HOUSE SPEAKER DAVE CLARK

They'll make it easy for consumers to shop by grouping health plans into tiers—bronze, silver, gold and platinum—based on how much of the cost customers take on. Health care reform also requires insurers to justify annual price increases to the exchange board.

Finally, exchanges will be the portal through which people determine if they are eligible for Medicaid, federal subsidies or other programs, such as CHIP, the Children's Health Insurance Program. That's a daunting information technology challenge in the next three years for the existing state IT infrastructure.

"But this is an opportunity to take highly fragmented, at times very inefficient and cumbersome eligibility systems, and bring them into the 21st century," says Kingsdale.

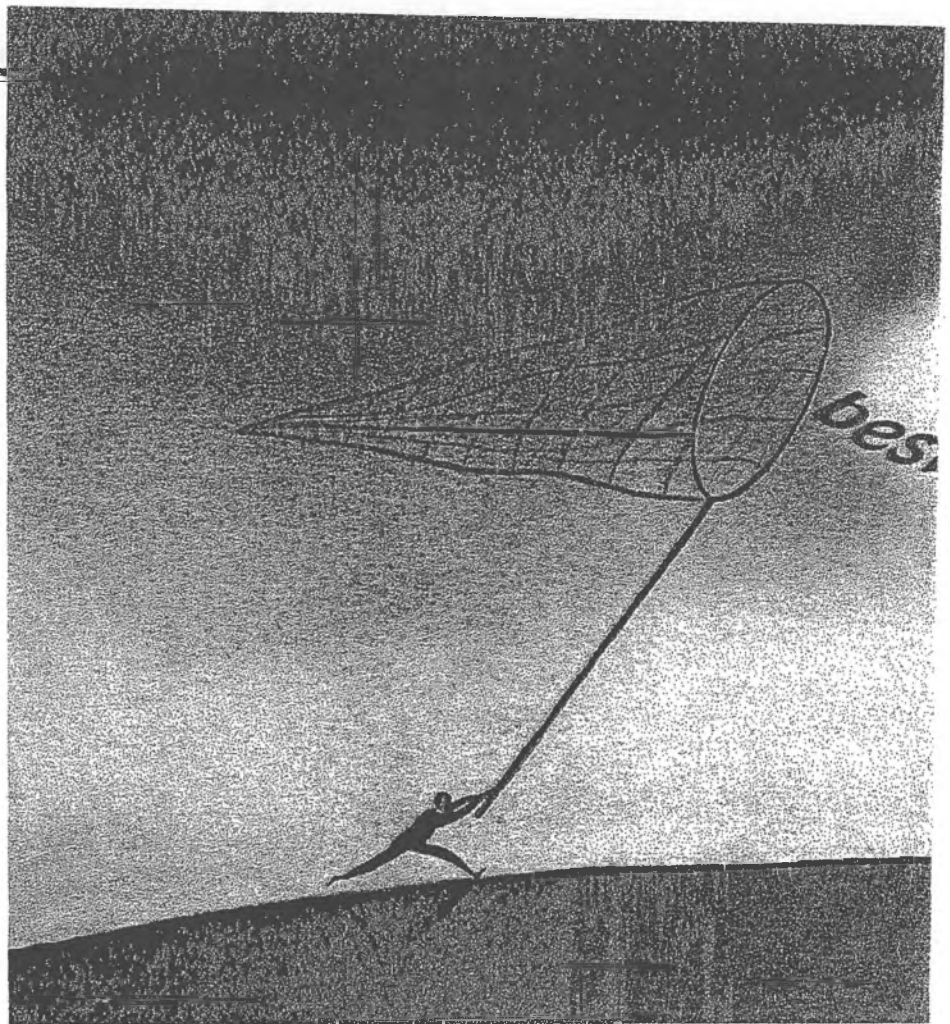
#### THE CLOCK IS TICKING

The timeline to set up exchanges is short—just three years. So state leaders considering exchanges—the alternative is to allow their citizens to use a federally established exchange—should pass authorizing legislation in 2011, experts say.

"If you have not already begun to implement, you are behind," says Utah House Speaker Dave Clark. "A lot of folks are waiting on the political winds, but I would hope your legislative leaders would dig in and get started."



HOUSE SPEAKER  
DAVE CLARK  
UTAH



Here are some key dates.

In September, many state leaders sent letters to the U.S. Department of Health and Human Services asking for \$1 million to fund planning for exchanges.

Within months, the federal government is expected to announce details of much larger developmental grants, possibly tens of millions of dollars, to pay for information systems and other exchange-related infrastructure.

By January 2013, states will have to show the U.S. Department of Health and Human Services they have a "functioning" exchange. If not, state residents will be steered to a federally established exchange.

Exchanges open in January 2014.

"By 2013, states should be well along with having a designated organization and the administrative systems in place," says Richard Curtis, president of the Institute for Health Policy Solutions. He noted that even if exchanges are ready to go then, they will have to wait until complementary parts of health reform go into effect in 2014.

#### WHO'S LEADING?

Right now, only Massachusetts and Utah have functioning exchanges. Both will need changes to fit federal law.

Other states are taking first steps. This fall, Colorado legislators are holding public meetings on the exchanges. In Iowa and Kansas, executive agency heads are working through early implementation issues.

California lawmakers in September passed legislation to authorize work on the exchange, lay down guiding principles and set up a governing structure. At press time, Governor Arnold Schwarzenegger had not signed the bills.

All this preamble is needed, because once they dig in to writing legislation, lawmakers must make some important, potentially controversial, decisions.

First, who will be in charge of the exchange? The options include a state agency, an independent governmental entity or a non-profit.

Governance is crucial because an exchange

Plan for me

*"We want people with knowledge of the health care marketplace to be on the board because the exchange is, in effect, selling insurance."*

CALIFORNIA SENATOR ELAINE ALQUIST

behaves like a business, selling insurance, and a government—determining eligibility. It's e-commerce meets social services.

"Who runs it will determine the direction and flavor," says Kingsdale.

Existing state agencies might flavor the exchange with their own spices. Massachusetts' exchange is run in an independent agency governed by a nine-member board. California's proposed exchange would be run by an independent agency governed by a five-person board of health insurance experts, appointed by the governor's office and the



SENATOR  
ELAINE ALQUIST  
CALIFORNIA

Legislature. To avoid conflicts of interest, there would be no doctors or insurers on the board.

"We want people with knowledge of the health care marketplace to be on the board because the exchange is, in effect, selling insurance," says California Senator Elaine Alquist.

"We chose a small board because we want it to be able to reach consensus quickly and easily. Additionally, because the exchange will be competing in the private insurance market, it will need to make decisions quickly," she says, "but it is still important to have public hearings and to be accessible and accountable to the public."

Utah, by contrast, runs its exchange through the state Office of Consumer Health Services. Other states, such as Kansas and Colorado, are looking at using existing state agencies.

Colorado Senator Betty Boyd says she's "not sure I see another department being created in these fiscal times."

#### PICK AND CHOOSE?

One of the most controversial decisions legislators will need to make is whether an exchange can pick or, in legislative language, "selectively contract," with health plans.

Go back to the Expedia.com example. Imagine if it could pick a handful of airlines to work with and lock out the rest in the interest of negotiating a better deal for consumers.

Some say that would promote competition, others say the opposite.

Although federal law says exchanges can't dictate price to health insurers, states can go beyond minimum federal requirements on health plans in the best interest of consumers, says Curtis of the Institute for Health Policy Solutions.

"An exchange can say, 'Look, here are our criteria, and we want to see your competitive bids across the board,'" Curtis says. "This introduces two levels of competition, both to



SENATOR  
BETTY BOYD  
COLORADO

get into the exchange and among plans within the exchange."

California's legislation would let the exchange selectively contract with health plans, a provision California health plans strongly oppose.

"The governor's signature on these bills would harm Californians' access to health insurance," John Graham of the Pacific Research Institute wrote in a recent newspaper article. "Limited choice means higher costs."

California policy experts took this approach because they think it will allow them to get the best value for consumers.

"As a bulk purchaser, the exchange will have significant market clout in the individual market, and it should seek to get a good deal on price and on improving quality," says California's Alquist. "Part of the way we do this is by picking plans on the basis of value and quality compared to their competitors."

Kingsdale, who consulted on California's legislation, points out that "while there are no guarantees in life, using discretion in the service of bringing down price and creating value is a good thing."

Other legislators feel selective contracting could stymie market competition, or even shut down some plans.

Selective contracting "becomes a real problem if a state decides the only way individuals and small groups can purchase is through this state exchange," says Praeger of Kansas. "Then the ability to deny some plans access might put them out of business."

Utah's Clark says his state doesn't plan to allow selective contracting. "The [reform] legislation requires the insurance companies to justify premium increases. We have not found the need to interject ourselves into that."

#### BALANCING THE MARKETS

Finally, legislators must set up exchanges in ways that don't attract all only sicker patients, while healthier people buy insurance

*"I believe that if a plan doesn't want to sell on the exchange, then they can't sell insurance in Iowa."*

IOWA SENATOR JACK HATCH



ing subsidies or government-paid health care must buy through the exchange, while wealthier people won't have to. (There's no requirement that individuals buy insurance through the exchange, just that they buy insurance.)

Iowa Senator Jack Hatch says his state may force all plans that sell individual and small group insurance to go through Iowa's exchange. "I believe that if a plan doesn't want to sell on the exchange, then they can't sell insurance in Iowa."

Since California's proposed plan will not take all comers, the legislation set up rules to protect the exchange. Any plan that sells in the exchange must sell all product categories—platinum to bronze—and sell the same products outside it. No carrier, for example, will be able to sell a catastrophic plan outside the exchange only.

**IT'S COMPLICATED**

If setting up a health insurance exchange sounds complex, that's because it is. Each answer leads to more questions.

"It's like Jell-O," says Praeger. "You push down somewhere, and it pops up somewhere else."

Fortunately, legislators can tap the expertise of colleagues in Massachusetts and Utah.

The National Association of Insurance Commissioners is working closely with the U.S. Department of Health and Human Services on exchange issues. The insurance commissioners organization and the National Academy of Social Insurance, a nonprofit devoted to the role of social insurance in promoting economic security, are each writing model legislation.

"Building this thing will be a mammoth task," says Iowa's Hatch. "But remember, it doesn't have to answer every question. It just has to provide a pathway for a consumer to make a decision about health insurance."

**CHECK OUT** an interview with the former head of the Massachusetts health insurance exchange and find more information on how states are implementing health care reform at [www.ncsl.org/magazine](http://www.ncsl.org/magazine).

on the open market. In insurance language, that's called "adverse selection," or a death spiral.

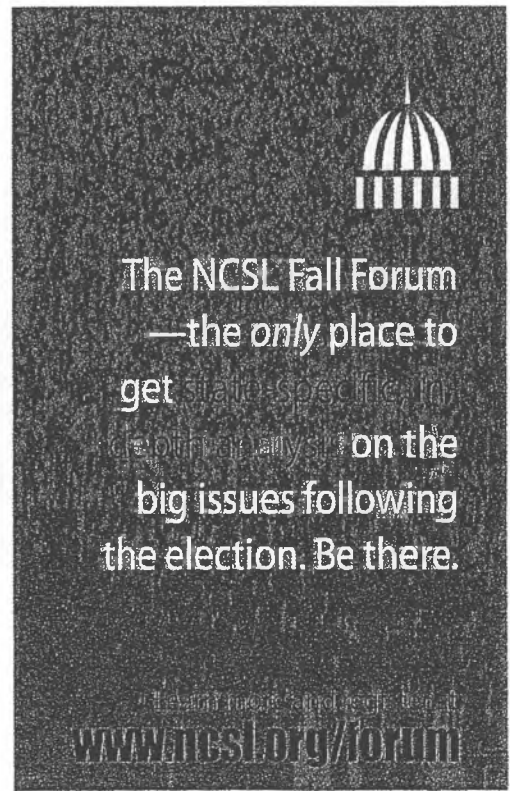
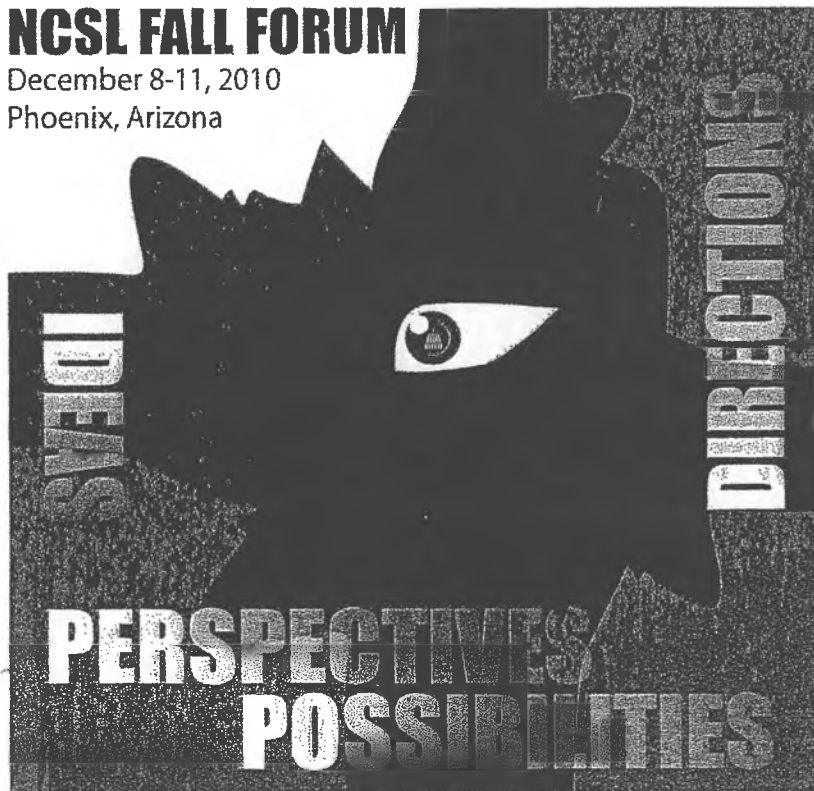
"This is a big issue," says Joan Henneberry, Colorado's Medicaid director. "It has to do with making sure the rules of engagement are the same in both markets.

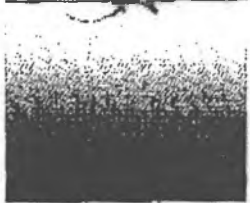
"If you require all sorts of bells and whistles inside the exchange and nothing outside, you could have a market outside offering plans that are a lot less expensive with lighter benefits," she says. "The risk is all the people who really need insurance are going to buy it inside the exchange."

The risk of adverse selection is also built into the exchange by design. People receive-

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February 8, 2011

Senator Dennis Egan  
Chair, Senate Labor & Commerce Committee  
Beltz 105  
Juneau, Alaska 99801

Re: SB 70, Alaska Health Benefit Exchanges

Dear Senator Egan and Members of the Senate Labor & Commerce Committee:

My name is Mark Regan. I am Legal Director of the Disability Law Center of Alaska, which is the State-designated organization for protection and advocacy of Alaskans with disabilities. I would like to make three points this afternoon in support of the Labor & Commerce Committee's moving forward with Senate Bill 70, the bill that would establish a health benefit exchange that would help people find coverage in the individual and small group insurance markets.

The first point is that it is hard for people with disabilities who have chronic conditions to find private insurance in the individual and small group health insurance markets, and an Exchange can help them find the coverage they need on the same general terms as everyone else who needs to find individual or small-group health insurance.

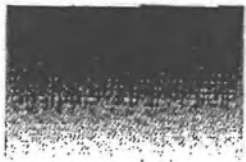
The second point is there is nothing about an Exchange that requires the State of Alaska to enforce an individual mandate requiring citizens to have private health insurance coverage. SB 70 is a version of the National Association of Insurance Commissioners' model Act, which reflects federal requirements, but if the individual mandate in federal law survives the court challenges to it, enforcing the mandate will be a federal responsibility, not a State one.

Third, and finally, I want tentatively to suggest that even if the individual mandate is found unconstitutional by the U.S. Supreme Court, there is still likely to be a binding federal requirement that there be Exchanges in every State, whether operated by the State of Alaska or by a nonprofit entity set up by the federal government; and that it probably would be best for Alaskans with disabilities if the State does the operating.

An Alaska Health Benefit Exchange is a good way for people to find health insurance

First, an Exchange would make sure Alaskans with disabilities are in the same system as other people who need help finding affordable private coverage in the individual and small group health insurance markets. According to the Kaiser Commission's 2008-2009 data, 128,000 Alaskans were uninsured in that year, 19% of the total population, which is two percentage points higher than the country as a whole. Alaskans with disabilities sometimes have special trouble getting coverage because they have chronic conditions

MEMBER OF THE  
NATIONAL  
DISABILITY  
RIGHTS  
NETWORK



that would lead insurance companies either to reject them outright – through a “pre-existing condition exclusion” – or lead private insurance companies to price the coverage that would be available at a level people simply can’t afford. But the high cost of coverage can be a problem for everyone. Even if you don’t have a chronic condition, it can still be hard to afford coverage without assistance from someone, typically an employer, as anyone who has tried to pay the full cost of insurance under COBRA will remember. The existing individual and small group insurance market is a limited one and it is hard for people to find coverage through it.

An Exchange, like the Exchange contemplated in SB 70, is likely to be helpful in several important ways. People can use it to search for insurance policies that they otherwise wouldn’t know about. Insurance companies can compete in terms of price and networks of doctors and other providers of medical services. Because there will be a lot of people participating – we hope – the average cost of coverage should be lower than it would be in a high-risk pool like the pools the State is now operating. Furthermore, the federal government will be assisting people of low- to- moderate incomes with subsidies for premium and cost-sharing payments they need to make, and those subsidies will be available mainly for coverage people would purchase through an Exchange. Again according to Kaiser Commission 2008-2009 data, 90,900 uninsured Alaskan adults had family incomes below 400% of the poverty income guidelines and so, other things being equal, would have been eligible for subsidies under the Act. So an Exchange would be available for people with disabilities on the same terms as everyone else, and the subsidies low-to-moderate income families might need would be available there too.

An Alaska Health Benefit Exchange would not be enforcing a federal health insurance mandate

Second, an Exchange would not be in the business of enforcing any federal requirement that people have insurance coverage. Note that the list of the Board’s duties in section 2 of SB 70, proposed AS 21.54.220(a), does not include enforcing a penalty against anyone for not having health insurance coverage. In fact, it’s the other way around, instead of penalizing people, the Board’s duties include helping people demonstrate that they would be exempt from any penalty of this sort [proposed AS 21.54.220(a){14} and {15}], and administering a system through which federal subsidies would be made available so people could afford coverage [proposed AS 21.54.220(a){17}]. If the individual mandate survives the court challenge to it, the responsibility for enforcing the mandate rests with the federal government, not the State.

That is because the federal health care overhaul’s minimum coverage provision is a federal, not a State, requirement. Under the new federal law, employers and other providers of health care make enrollment reports to HHS, not to a State. [PPACA, § 1502(a); see 26 U.S.C. § 6055.] A person who appears not to have enrolled gets a “notice of nonenrollment,” but this comes from the Treasury, not from a State. [PPACA, § 1502(c).] The “shared responsibility payment” penalty is a payment to the

Testimony in Support of SB 70

February 8, 2011

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federal government to be included with a person's federal tax return. [PPACA, § 1501; see 26 U.S.C. § 5000A(b)(2).] The Secretary of HHS, not a State, serves notice of the penalty. [§ 5000A(g)(1).] The procedure for collecting the penalty, and for defending against collection, is the same general procedure as federal tax procedure. [Id..] The restrictions on criminal prosecution and on liens and levies are restrictions on federal tax enforcement procedures, not on state activities. [§§ 5000A(g)(2)(A) and (B).] Whether or not someone gets a hardship exemption is to be determined by HHS, not by a State. [§ 5000A(e)(5).] There is simply no occasion on which the Alaska Health Benefit Exchange would ever directly impose or collect a penalty on someone who fails to meet the federal minimum coverage provision.

Nor would moving forward with an Exchange force the State of Alaska to drop any argument that the federal individual insurance mandate is unconstitutional. In fact, just about every State which is a plaintiff in the Florida v. U.S. lawsuit has taken steps towards investigating how an Exchange would work – getting Federal planning grants for doing this and considering legislation on the subject – and one State which is challenging the individual mandate, Utah, already has an Exchange statute on its books. (Part of the Utah statute setting up an Exchange on this subject is at Utah Code, § 63M-1-2504, and the website's URL is <http://www.exchange.utah.gov/>.) In fact, Utah not only has an Exchange statute on its books, but it has a "health care freedom act" that says that no citizen of Utah should be required to purchase health insurance. [Utah Code, § 63M-1-2505.5.] If Utah can move forward with an Exchange under those circumstances, so can Alaska.

#### An Alaska Health Benefit Exchange in state law would keep Alaskans in charge

Finally, there is a question about what federal law is likely to require States to do – or, more accurately, what Federal law is likely to require to be done in every State by someone, State or nonprofit – once the litigation about the individual mandate is over. In the Florida v. U.S. case, the plaintiffs (including the State of Alaska) raised a direct challenge to the federal Act's Exchange provisions, saying that those provisions commandeered State government into enforcing federal law. Judge Vinson actually rejected that challenge, saying States had an option under the Act: set up an Exchange that satisfies federal standards, or watch and wait while the federal government sets up an Exchange through a public nonprofit agency of its own.

Now, it is possible that if the challenge to the individual mandate succeeds at the U.S. Supreme Court, it will be clear that the Act's current standards for Exchanges would have to be modified. Maybe the whole idea of an individual and small group market where there would be "guaranteed issue" – they can't turn you down because you have a pre-existing condition – and "community rating" – they can't charge you more money simply because you have a chronic health condition – would have to be rethought. The reason for this is that the individual mandate prompts relatively healthy people to participate in the system, and unless relatively healthy people participate in the system along with

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people with disabilities and chronic conditions, the average cost of a policy within that system would go way up. So if the mandate is unconstitutional, there would need to be a discussion of other ways to get people to participate in the system. No one can be sure exactly what Congress would decide to do if the U.S. Supreme Court were to throw out the individual mandate.

But the idea of many people participating in the individual and small group health insurance market, and finding out information about which policies would be best for them, and getting subsidies to help them afford insurance, is such a good one that Congress will likely try to encourage this even if the individual mandate disappears. Before the health insurance overhaul passed Congress, there were several suggestions about how to encourage people to participate in the market without actually penalizing them for not doing it. For example, there was a suggestion that people could choose not to have health insurance – but they'd have to promise that they wouldn't ask for any federal subsidies if they did decide to buy insurance, and they'd have to deal with pre-existing condition exclusions if it turned out that they needed insurance after all. It's not clear which of those different suggestions Congress might adopt. But it is quite possible that there would be an Exchange requirement in federal law, no matter what, with the same option for States that is in federal law now – a State could operate an Exchange, or, if the State decided not to operate an Exchange, the federal government would operate one through a nonprofit.

If those turn out to be the circumstances, I'd suggest that Alaskans' preference will be to have the State operate an Alaska Health Benefit Exchange, where the people running the system would be State people who likely would have good ideas about what is best for Alaskans. The alternative would be a federally sponsored nonprofit agency. So, if you want there to be an opportunity for Alaskan control over the Alaskan part of this problem, you should move forward with SB 70.

Thank you very much, again, for the opportunity to testify on this important issue.

Sincerely,



Mark Regan  
Legal Director

February 8, 2011

RE: Hearing by (S) L&C Tuesday, February 8, 2011, 1:30 pm

Doris Robbins  
1281 Overhill Dr.  
Fairbanks AK 99709-6753  
(907) 374-0597 - Cell: 907-687-2174

I support SB 70: *Alaska Health Benefit Exchange*

I understand that this hearing is regarding whether Alaskans will have an opportunity to set up a health benefit exchange which should provide clear options and some competition for health coverage or expenditures. The exchange would make clear information available to Alaskans of what their health care dollars buy.

Currently, Alaskans are not sure of what they are getting for their health dollars. The rules are murky and you never know when an insurer will end coverage or an unexpected medical bill will put you in financial jeopardy. This legislation should shine a light on what you are paying for, and set up options that will allow most Alaskans to know what they are getting without bait and switch tactics.

The exchange will act as a one-stop-shop for Alaskans to make choices that suit their needs and pocketbook. In addition, stipulations should be laid out clearly to show what is acceptable by us of insurance companies who want to do business in our state, as well as eventually providing competition across state lines. There should be no hidden fees, and all the rules on display to indicate what your health expenditures are buying for you.

In addition, while the governor has turned down federal cash for set-up costs, that was not "earmark" money. The available federal money has been taken by 48 other states, some suing against and some accepting the new federal health law. With the cooperation of our governor we can have the exchange start-up costs without dipping into the general fund. This is Alaska's deal and not connected to the federal health care law.

Do we act now to make changes or continue wading in our present expensive health care muddy water? If we do nothing the climate for paying for health care in Alaska will continue deteriorating as it slowly bankrupts us all whether we currently have coverage or not.

If we begin setting our own standards, we will bring more possibilities for all businesses to provide economical coverage for their employees, or allow individuals to get more for their independent health care dollars.

Please take the first step by sending SB 70 on to the next committee to get the conversation rolling. Then it is up to all Alaskans to speak out for an improved climate for medical coverage in this state.

Doris Robbins, speaking in my own behalf  
Member of the Retired Public Employees of Alaska (RPEA)



**SMALL BUSINESS  
MAJORITY**

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February 8, 2011

Dear Senators:

Alaska's small businesses are being crushed under high healthcare costs, forcing both business owners and workers to pay a heavy price. SB 70, legislation establishing the Alaska Health Benefit Exchange, is under consideration in the Senate Labor and Commerce Committee. It will go a long way toward lowering costs and improving access for small business owners. Alaska can and should take the lead in establishing this marketplace now so small employers can get the relief they need in the form of lower costs and more choice. With fewer dollars going to insurance companies and more kept in the pockets of small business owners, they will be able to invest in their businesses and hire new employees, helping Alaska's economy grow.

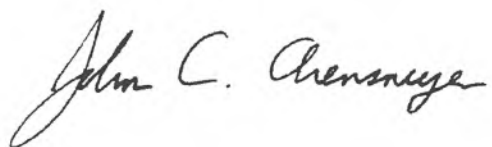
In the ongoing effort to ease this burden on small businesses, we urge you to stand up for Alaska's small business community and work to finalize this crucial legislation. Small employer exchanges have been established in Utah, Connecticut, New York City and Massachusetts. They have been supported by members of both parties and are proven to benefit small business owners and their employees. The idea of a small employer exchange has been around for a long time, and has broad support among business groups and members of Congress from both political parties.

A survey of Alaska small businesses we conducted found that only 21% pay for health insurance for their employees. Of those, 79% said they were struggling to do so. Moreover, nearly one-third (32%) of fishermen who are self-employed, a vital part of Alaska's economy, are uninsured. While insurance rates for small employers continue to climb, an exchange will help change this.

A well-run exchange will be the primary vehicle for making healthcare affordable and accessible for small businesses and their employees, as well as the state's self-employed entrepreneurs. It will allow small businesses to band together to purchase insurance, giving them the type of clout that large businesses enjoy when negotiating for coverage. Your leadership on this issue will guarantee the exchange is created the right way so small businesses receive the myriad benefits that a strong, robust exchange will provide. As important job creators in Alaska, small businesses need your quick action now more than ever.

Attached are some specific comments and issues based on our research of other successful exchanges.

Sincerely,

A handwritten signature in black ink that reads "John C. Arensmeyer". The signature is written in a cursive style with a large, sweeping initial "J".

John Arensmeyer  
Founder & CEO

## Health care overhaul debate now shifts to states

By RICARDO ALONSO-ZALDIVAR

(01/22/11 11:15:06)

True or false: States suing to overturn core requirements of President Barack Obama's health care overhaul are refusing to carry out the law. If you said "true," you'd be wrong.

Republican state legislators and governors are working on how to deliver coverage to more than 30 million people now uninsured, as the law calls for, even as GOP attorneys general lead the legal battle to overturn the law's mandate that most Americans have health insurance.

The result? Perhaps the first practical opportunity for the two political parties to work together on an issue that divide them in Washington.

"I can be philosophically opposed and recognize that we can't be asleep at the switch," said Alabama state Rep. Greg Wren, a Republican playing a national role.

"I for one have no interest in ceding any regulatory or statutory authority to the federal government in this area and allowing our state to default while we pursue the litigation side," said Wren, co-chairman of a National Conference of State Legislatures task force on the health care remake.

The debate in the nation's capital seems headed for a stalemate this year because Senate Democrats have the votes to thwart House Republicans' efforts to repeal the law. Denying the Obama administration money to carry out the law isn't a sure strategy either; most of the money was woven tightly into the legislation Congress passed last year.

"We will see a lot of small battles in Congress, but the real center of gravity will shift to the states," said Mike Leavitt, former Republican governor of Utah and health secretary under President George W. Bush. "Bipartisanship is more vibrant in the states than it is in Washington. That doesn't mean it's plentiful, but at least it's alive."

States have to be ready to take on major responsibilities when the coverage expansion gets going in 2014. If not, the federal government will come in and run things.

States must set up and operate health insurance markets where an estimated 24 million people eventually will buy private coverage, most with the aid of federal subsidies. Also, states must open their Medicaid programs to a broader segment of low-income people.

The Medicaid expansion worries state officials. They're already struggling with the costs of the program, draining money from other services from education to law enforcement. Special added Medicaid payments that Washington funneled to the states in the economic downturn will end this year, worsening the crunch.

About 16 million newly eligible people eventually would get Medicaid under the law, and potentially several million more who are eligible today but not signed up could enroll as well. The law says the

federal government will pick up the full cost of those newly eligible for the first few years, but doesn't deal directly with covering the other group.

If state officials are unsure about the Medicaid expansion, they're intrigued about what they might be able to do with the new insurance markets, known as exchanges.

Consumers will be able to go online and pick a private plan from a range of coverage levels and options. Comparison shopping will be easier because benefits will be standardized.

Nearly every state has applied for an initial round of federal planning grants to explore how to design the markets.

"State exchanges are good from a conservative standpoint because they involve consumer choice and markets," said former Senate Majority Leader Bill Frist, a Tennessee Republican.

"What I would like to see is more flexibility given to states in the regulations that define how the legislation works," said Frist. "Each state can develop the exchange that best meets the needs of their people." Two models already exist: Utah's, which is light on regulation, and Massachusetts', where the state government is more directly involved.

Frist, a heart transplant surgeon, has teamed with Democrat Tom Daschle of South Dakota, also a former Senate leader, to try to change the health care debate by stepping back from the repeal fight and using the law as a foundation that can be improved. They expect to direct many of their recommendations to the states.

In New Jersey, Democratic Assemblyman Herb Conaway is hoping to be able to work with Republican Gov. Chris Christie to design their state's exchange. Conaway, a primary care doctor, heads the health committee and is the Democratic counterpart to Alabama's Wren in national planning efforts by state legislators.

"There will be tangible benefits that come to states for taking on these problems," said Conaway. "Done right, there is a benefit that comes to them from getting their people insured. An insured population uses resources more wisely, instead of going to the emergency room and getting treatment that costs four times as much."

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Online:

National Conference of State Legislatures: <http://tinyurl.com/6ca2rad>

White House background on the health law: <http://tinyurl.com/2dv65w5>

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*From the Houston Chronicle – January 23, 2011*



## **Let Texas control health insurance**

**By STATE REP. JOHN ZERWAS  
HOUSTON CHRONICLE**

While it is no secret that I oppose the federal health care reform bill, if we don't act now to create the Texas Health Insurance Connector, our state could be forced to cede regulatory control of a significant chunk of its health insurance market to the federal government. The desire to avoid such oversight has generated broad support for the connector, which I am proposing in House Bill 636. In addition to members of both political parties, a variety of groups that don't usually agree on issues have come forward to support keeping Texas in charge of its health insurance market through the passage of HB 636. Those groups include the Texas Association of Business, Texas Hospital Association, Texas Medical Association, Texas Restaurant Association and two Texas health insurance industry groups.

Why must we do this? Among the provisions of the federal health care reforms is a requirement that an organized health insurance market known as an American Health Benefit Exchange be established in every state to provide coverage for U.S. citizens or legal immigrants who do not have access to affordable employer-based coverage. Each state must demonstrate by 2013 that it will have the structure in place to operate its exchange or the federal government will establish and manage it for that state. The Texas Health Insurance Connector, a simplified health insurance market, would serve as our state's exchange.

Although I support the efforts by Texas Attorney General Greg Abbott and others to have the health care bill ruled unconstitutional, the connector proposal is more about what's best for Texas and less about what the federal government has passed. It's about ensuring that Texas maintains regulatory oversight over what could end up being a large segment of its health insurance market.

The exchange concept did not originate with Obamacare. The idea was first proposed in the 1970s, and the model is being used in such politically opposite

states as Utah and Massachusetts. Because of the federal government's 2013 deadline, our current legislative session may provide us the only opportunity to take action to keep the federal government out of our health-insurance market.

As proposed, the Texas connector will provide managed competition among health insurers with standard coverage available in five categories, making it easier to compare policies, providing uniform rules for pricing, and offering consumers the ability to select a policy that meets their coverage and budget needs. Through the connector, comparing and selecting health coverage could become as easy as shopping for your travel arrangements on one of the Internet-based travel services.

The connector would supplement the state's existing health-insurance market, not replace it. Since policies regulated by the state would continue to be sold outside of the connector market, the state could maintain consistent regulatory oversight both inside and outside the connector, thereby avoiding dual regulatory rules that would result from a federally managed exchange. Consistent regulations are critical to helping the state avoid adverse selection issues and limiting confusion among consumers.

To offer coverage within the connector, health plans must be accredited on clinical-quality measures while meeting other criteria regarding marketing rules, standard formats for presenting benefit options and network adequacy. Policies sold within the exchange will be required to offer a minimum level of essential benefits that cover hospitalization, medical and surgical care, emergency services, ambulatory patient care, maternity and newborn care, treatment for mental health and substance abuse disorders, prescription drugs, rehabilitation services and devices, laboratory services, pediatric care and prevention and wellness services.

Something must be done to rein in the cost of health insurance, and the goal of HB 636 is to bring the cost of coverage down by promoting competition and ensuring that Texas families and Texas employers have the right to choose their own coverage.

I believe the connector concept is one that's worth exploring, especially if it keeps Texans in charge of our state's health insurance market.

I invite you to join me in protecting our state's interest in managing how we select our health care.

*Zerwas, a Republican from Richmond, represents Texas House District 28.*