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

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

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

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

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

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

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

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

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

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

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

- 24 (1) utilization review of health care services, including review of the medical
25 necessity of hospital and physician services;
- 26 (2) case management;
- 27 (3) selective contracting with hospitals, physicians, and other health care
28 providers;
- 29 (4) reasonable benefit differentials applicable to providers that participate or do
30 not participate in arrangements using restricted network provisions; and
- 31 (5) other managed care provisions.

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

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

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

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

18 ARTICLE 2. SMALL EMPLOYER HEALTH INSURANCE PLANS.

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

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

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

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

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

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

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

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

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

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

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

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

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

1 employers;

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

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

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

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

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

19 (7) a small employer insurer shall

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

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

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

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

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

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

7 (2) the provisions of the health benefit plan

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

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

11 (C) relating to any preexisting condition provision.

12 (c) A small employer insurer shall

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

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

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

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

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

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

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

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

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

6 (1) nonpayment of the required premiums;

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

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

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

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

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

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

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

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

25 or

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

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

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

1 that established service area.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 geographic service area;

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

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

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

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

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

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

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

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

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

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

22 (d) A small employer insurer

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

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

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

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

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

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

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

8 Sec. 21.55.250. DEFINITIONS. In this chapter,

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

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

18 (3) "agent" has the meaning given in AS 21.90.000;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2 (A) the individual

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

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

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

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

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

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

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

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

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

28 (A) Medicare or Medicaid;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- 11 (1) AS 21.03
- 12 (2) AS 21.06
- 13 (3) AS 21.09, except AS 21.09.090
- 14 (4) AS 21.18.010
- 15 (5) AS 21.18.030
- 16 (6) AS 21.18.040
- 17 (7) AS 21.18.120
- 18 (8) AS 21.21.321
- 19 (9) AS 21.36
- 20 (10) AS 21.42.345 - 21.42.365, and 21.42.375
- 21 (11) AS 21.51.120
- 22 (12) AS 21.53
- 23 (13) AS 21.54.020
- 24 (14) AS 21.55
- 25 (15) AS 21.69.400
- 26 (16) [(15)] AS 21.69.520
- 27 (17) [(16)] AS 21.69.600, 21.69.620, and 21.69.630
- 28 (18) [(17)] AS 21.78
- 29 (19) [(18)] AS 21.89.040
- 30 (20) [(19)] AS 21.89.060
- 31 (21) [(20)] AS 21.90.

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

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

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

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

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

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

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

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

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

Final

CS FOR SENATE BILL NO. 242 (FINANCE)
IN THE LEGISLATURE OF THE STATE OF ALASKA
SEVENTEENTH LEGISLATURE - SECOND SESSION

BY THE SENATE FINANCE COMMITTEE

Offered:
Referred:

Sponsor(s): SENATORS COLLINS, Menard, Pearce

A BILL
FOR AN ACT ENTITLED

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

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

- 4 * Section 1. PURPOSE. (a) The purpose of this Act is to
- 5 (1) promote the availability of health insurance coverage to small employers regardless
- 6 of their health status or claims experience;
- 7 (2) prevent abusive rating practices;
- 8 (3) require disclosure of rating practices to purchasers;
- 9 (4) establish rules regarding renewability of coverage;
- 10 (5) establish limitations on the use of preexisting condition exclusions;
- 11 (6) provide for development of "basic" and "standard" health benefit plans to be offered
- 12 to all small employers;
- 13 (7) provide for establishment of a reinsurance program; and
- 14 (8) improve the overall fairness and efficiency of the small group health insurance

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1 market.

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

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

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

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

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

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

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

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

24 CHAPTER 55. SMALL EMPLOYER HEALTH INSURANCE.

25 ARTICLE 1. SMALL EMPLOYER HEALTH REINSURANCE ASSOCIATION.

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

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

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

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

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

19 Sec. 21.55.030. GENERAL POWERS. The association may

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

22 (2) sue or be sued;

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

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

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

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

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

1 members' risks by the association;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 calendar year;

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

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

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

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

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

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

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

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

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

- 20 (1) three members who are representatives of participating insurers;
- 21 (2) one member who represents small employers;
- 22 (3) one member who represents employees of small employers; and
- 23 (4) one member who represents health care providers; and
- 24 (5) one member who represents agents or brokers.

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

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

3 (2) case management;

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

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

8 (5) other managed care provisions.

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

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

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

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

26 ARTICLE 2. SMALL EMPLOYER HEALTH INSURANCE PLANS.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

27 (7) a small employer insurer shall

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

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

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

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

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

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

15 (2) the provisions of the health benefit plan

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

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

19 (C) relating to any preexisting condition provision.

20 (c) A small employer insurer shall

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

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

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

1 disclosure, except

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

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

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

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

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

14 (1) nonpayment of the required premiums;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 preceding the effective date of coverage;

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

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

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

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

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

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

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

1 provided in (3) of this section;

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

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

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

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

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

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

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

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

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

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

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

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

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

30 (d) A small employer insurer

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

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

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

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

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

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

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

16 Sec. 21.55.250. DEFINITIONS. In this chapter,

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

10 (A) the individual

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

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

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

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

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

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

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

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

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

5 (A) Medicare or Medicaid;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- 25 (1) AS 21.03
26 (2) AS 21.06
27 (3) AS 21.09, except AS 21.09.090
28 (4) AS 21.18.010
29 (5) AS 21.18.030
30 (6) AS 21.18.040
31 (7) AS 21.18.120

- 1 (8) AS 21.21.321
- 2 (9) AS 21.36
- 3 (10) AS 21.42.345 - 21.42.365, and 21.42.375
- 4 (11) AS 21.51.120
- 5 (12) AS 21.53
- 6 (13) AS 21.54.020
- 7 (14) AS 21.55
- 8 ~~(15)~~ AS 21.69.400
- 9 ~~(16)~~ [(15)] AS 21.69.520
- 10 ~~(17)~~ [(16)] AS 21.69.600, 21.69.620, and 21.69.630
- 11 ~~(18)~~ [(17)] AS 21.78
- 12 ~~(19)~~ [(18)] AS 21.89.040
- 13 ~~(20)~~ [(19)] AS 21.89.060
- 14 ~~(21)~~ [(20)] AS 21.90.

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

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

- 22 (1) AS 21.03
- 23 (2) AS 21.06
- 24 (3) AS 21.09, except AS 21.09.090
- 25 (4) AS 21.18.010
- 26 (5) AS 21.18.030
- 27 (6) AS 21.18.040
- 28 (7) AS 21.18.120
- 29 (8) AS 21.21.321
- 30 (9) AS 21.36
- 31 (10) AS 21.42.345 - 21.42.365, and 21.42.375

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

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

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

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

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

1 submitted by the association and approved by the director.

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

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

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

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

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

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

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

#3

7-LS0847J.2
Ford
05/04/92

5-6-92
FD moved
Failed

AMENDMENT

OFFERED IN THE SENATE
TO: CSSB 242(HES)

BY SENATOR DUNCAN

Page 23, line 6, after "exceed":

Insert "the lower of
(1)"

Page 23, line 8:

Delete "(1)"
Insert "(A)"

Page 23, line 14:

Delete "(2)"
Insert "(B)"

Page 23, line 15 following "manual":

Insert "; and

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



Official Business

Alaska State Legislature

Senate

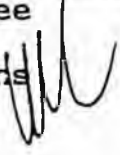
P.O. BOX V
State Capitol
Juneau, Alaska 99811

MEMORANDUM

May 5, 1992

SUBJECT: CSSB 242 (HES)

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

FROM: Senator Virginia Collins 

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

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

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

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

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

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

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

Senate Finance Committee
May 5, 1992
Page 2

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

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

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

* * * * *

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

STATE OF ALASKA

DEPARTMENT OF COMMERCE &
ECONOMIC DEVELOPMENT

DIVISION OF INSURANCE

WALTER J. HICKEL, GOVERNOR

P.O. BOX D
JUNEAU, ALASKA 99811-0800
PHONE: (907) 465-2315

May 5, 1992

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

Dear Senator Pourchot:

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

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

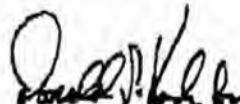
Amendment #1. We have no problem with the revision to the sunset provision from three to five years.

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

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

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

Very truly yours.


David J. Walsh
Director

NFIB Alaska

National Federation of
Independent Business

POSITION PAPER

OF

NATIONAL FEDERATION OF INDEPENDENT BUSINESS
NFIB/ALASKA

TO

SENATE FINANCE COMMITTEE

MAY 2, 1992

IN
SUPPORT
OF

SB 242 - HEALTH INSURANCE FOR SMALL EMPLOYERS

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



The Guardian of
Small Business

Chairman, members of the Committee, my name is Resa Jerrel, and I am the State Director for the National Federation of Independent Business - NFIB/Alaska. I am happy to be here today in support of SB 242.

BACKGROUND

NFIB/Alaska is comprised of 4,730 small and independent business owners. The legislative agenda of NFIB/Alaska is determined by our ballot. The ballot is our annual poll of our members on a series of issues deemed critical to small business. A majority vote, of the members in response to the poll, sets our policy and position on legislative issues.

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

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

Yes 72.2% No 17% Undecided 10.8%

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

Yes 50.2% No 19.3% Undecided 30.5%

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

Yes 90% No 5.2% Undecided 4.8%

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

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

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

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

SMALL BUSINESS MARKET REFORM

Small business owners desire to build on the existing health care system. SB 242 is a voluntary health insurance program to provide more accessibility, renewability, predictability and stability for small businesses. It is a viable means of providing health insurance to the uninsured population in Alaska.

State mandates cumulatively can raise the cost of health insurance for small businesses. SB 242 has a provision that state mandates do not apply to health benefit plans provided to small employers. This will allow the insurance industry to design and market affordable health insurance policies. A lower cost plan would have great appeal to firms that currently do not offer health insurance coverage. Small businesses are willing to provide health insurance to employees, as long as the cost is not prohibitive.

It also, requires the small employer insurers to disclose information relating to premium rates and health benefit plans.

It requires insurers to describe in detail their rating practices and renewal underwriting practices. Providing this information will help small business owners to be better informed. The Congressional Budget Office believes that "giving consumers the information they need to make more informed decisions might enhance both the quality and cost-effectiveness of care."

SUGGESTIONS

NFIB/Alaska appreciates the Sponsor's effort to encompass firms with 3 - 25 employees. Unfortunately, this still leaves the one person firm or the "mom and pop" firms out in the cold. NFIB/Alaska realizes that there are problems in covering these smaller firms, but we urge the committee to explore ways to include this group of business owners.

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

POSITION PAPER

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

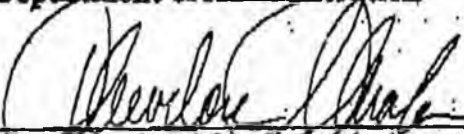
With resolution of the issue noted below, the administration can support this legislation.

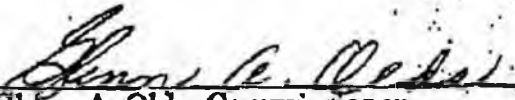
One of the more challenging issues facing this country and Alaska is the ever-increasing number of people unable to afford or even find health care insurance. This bill would address small employers who have been unable to purchase health care coverage for employees, especially when one employee has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

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

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


 Nancy Bear Userra, Commissioner
 Department of Administration


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


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

Date: 4/27/92

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Official Business

Alaska State Legislature

Senate

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

M E M O R A N D U M

April 22, 1992

SUBJECT: Sectional Analysis of CSSB 242 (HES)
TO: Members, Senate Finance Committee
FROM: Senator Virginia Collins *VC*

What follows is a sectional analysis of the above described bill. As a preliminary matter, please note that a sectional analysis of a bill should not be considered an authoritative interpretation of the bill and the bill itself is the best statement of its contents.

Section 1 - Purpose.

Section 2 - Adds a new section to AS 21.36 (Trade Practices and Frauds) that prohibits violations of the fair marketing standards established under Sec. 21.55.180.

Section 3 - Excludes AS 21.55 (Small Employer Health Insurance chapter) from the unfair discrimination provision of the Trade Practices and Fraud law (AS 21.36.090).

Section 4 -

Sec. 21.55.010 - Creates the Small Employer Health Reinsurance Association as a nonprofit incorporated legal entity and requires membership of all insurers offering health benefit plans in the state.

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

Sec. 21.55.030 - General powers of the association.

Sec. 21.55.040 - Requires the association to submit a plan of operation to the director of the division of insurance. Requires members to comply with the plan and requires the plan to establish certain procedures.

Sec. 21.55.050 - Establishes specific provisions that apply to reinsurance provided by a member to employees or dependents of

employees of a small employer. Establishes a methodology for determining premium rates to be charged for reinsuring small employers and individuals covered under this section. Requires the association to report to the director of the division of insurance the association's net loss for the previous calendar year. Requires association to establish a formula by which to make assessments against reinsuring insurers. Sets provisions for determining assessments.

Sec. 21.55.060 - Establishes, in the association, the Health Benefit Plan Committee composed of members representing specific groups. Specifies what the committee must do and allows the committee to recommend certain cost containment features.

Sec. 21.55.070 - Requires the board to issue a report every two years on the effectiveness of the association.

Sec. 21.55.080 - Exempts the association from the Administrative Procedure Act (AS 44.62).

Sec. 21.55.090 - Exempts the association from payment of taxes, except for real or personal property taxes.

Sec. 21.55.100 - Provides immunity from civil actions filed against a member of the association for a negligent act on behalf of the association.

Sec. 21.55.110 - Establishes when an individual or health group benefit plan is subject to AS 21.55 and provides that other laws requiring coverage, reimbursement, utilization, or consideration of a specific health care practitioner do not apply to a health benefit plan provided to a small employer. Treats certain insurers as one insurer for purposes of applying the restrictions on health benefit plans issued under AS 21.55.

Sec. 21.55.120 - Establishes provisions restricting the premium rate for a health benefit plan. Requires small employer insurers to disclose certain information relating to premium rates and health benefit plans. Requires small employer insurers to describe in detail their rating practices and renewal underwriting practices, file an actuarial certification with the director of the division of insurance, and make certain information available to the director upon request. Allows the director to adopt regulations relating to rating practices.

Sec. 21.55.130 - Requires renewability of health benefit plans and provides under what conditions a plan would not be renewable. Prohibits certain small employer insurers who do not renew a health benefit plan from writing a new business in the state for five years. Specifies when provisions apply to an insurer operating in an established geographic service area.

Sec. 21.55.140 - Except as provided under Sec. 21.55.160, requires small employer insurers to offer a basic health benefit plan and a standard health benefit plan. Requires insurers to file health benefit plans with the director of the division of insurance. Allows the director to disapprove those plans that do not comply with AS 21.55.

Sec. 21.55.150 - Requires health benefit plans for a small employer to contain certain provisions.

Sec. 21.55.160 - Exempts a small employer insurer from providing coverage under certain conditions.

Sec. 21.55.170 - Provides when a small employer insurer may cease to do business in the small employer market.

Sec. 21.55.180 - Establishes fair marketing standards for small employer insurers.

Sec. 21.55.250 - Definitions.

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

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

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

Section 8 - Transition section in regards to association's plan of operation, a small employer insurer's basic and standard health benefit plans, an insurer's filing net insurance premium earned from certain health insurance plans, and when the Health Benefit Plan Committee shall submit health benefit plans.

Section 9 - Effective date.

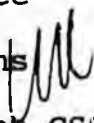
Alaska State Legislature

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

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

Senator Virginia Collins

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

From: Senator Virginia Collins 

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

Date: April 16, 1992

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

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

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

Thank you for your consideration of this request.





ALASKA STATE MEDICAL ASSOCIATION

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

MAY 20 1991

May 15, 1991

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

Senate Bill 242

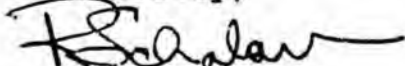
Dear Senator Collins:

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

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

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

Sincerely,



Ray Schalow
Executive Director

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



May 14, 1991

Senator Virginia Collins
Pouch V State Capital
Juneau, Alaska 99811

Dear Senator Collins:

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

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

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

With Regards,

George Krusz
President



Aetna Health Plans
1301 4th Avenue, Suite 1600
Century Square
P.O. Box 91032
Seattle, WA 98111-9132
Fax: (206) 467-2887

James E. Hickey
Manager
(206) 467-2802

April 27, 1992

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

Dear Senator Collins:

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

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

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

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

Sincerely,

Jim Hickey
Manager
Aetna Health Plans



ALASKA STATE MEDICAL ASSOCIATION

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

April 27, 1992


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

Dear Senator Collins,

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

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

Sincerely yours,


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

ENTERPRISE

Small Insurers Seek to Block Plan to Widen Coverage

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

By EUGENE CARLSON

Staff Reporter of THE WALL STREET JOURNAL

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

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

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

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

lawmakers to President Bush.

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

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

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

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

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

Besides pressing his case with Ohio

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

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

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

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

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

and Senate leaders from both parties.

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

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

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

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

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

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

April 7, 1992

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

Dear Senator Sturgulewski:

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

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

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

Sincerely,

Tom E. Roy
President

Commentary

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

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

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

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

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

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

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

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

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

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



Is it spring yet?

Photo by Steve McCutcheon

Mental Health Trust lands: Will the settlement work?

By Sen. Jim Duncan

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Less

DEC Commis

Three years after the Valdez oil spill, the cleanup has been learned, says the Environmental Conservation Commission.

"Today we have learned important strategies, respect sound contingencies, the Spill Technical Group in Juneau recovered the nation's first oil spill response organization to assure prevention of, and hazardous substances.

The spill also demonstrated the importance of public participation in the restoration process, prepared people and communities in many ways must be restored.

Sandor said the spill. "There is optimism among all parties remaining clear. And with the government's, re-underway."

Sandor noted to settle litigation over 68.7 million light crude oil on March 16, 1991, more than six times the cost of the Exxon Valdez.

This January lawsuits were filed in court, with the state and the Exxon Valdez settlement in less than \$900 million to the environmental concentration of litigation.

The council is a public community restoration plan. "Under the settlement, funding is the next decade in a way perpetuity."

Under both federal and state laws, the Exxon Valdez settlement is the toughest in the world.

"We are working with the federal government to regulate the Oil Pollution State Emergency and the Long-term committee to develop hazard response plans, prepare the state to respond to any substance."

Community advisory councils have been established since the public involvement program. Sandor



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

By Tim Bradner
Alaska Journal of Commerce

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

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

One bill is Senate Bill 242,

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

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

ployees," Collins said.

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

A second proposal is Senate Bill 74, sponsored by Sen. Jalmar Kerttula of Palmer, which would form a non-profit state Comprehensive Health Insurance Association to ex-

tend coverage to high-risk individuals. Twenty-four states have adopted similar programs, Kerttula said. Insurers selling in the Alaska market would be required to join the association, coverage to those considered high-risk could not be denied, and a cap would be placed on premiums.

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

Continued on Page 2

Required insurance pools should cover risks

Continued from Page 1
 require no task force.

"Our studies show that 35,000 of the 90,000 uninsured are in families with income levels 250 percent or above the poverty line. If insurance can be made available at a reasonable cost, they should be able to pay for it themselves," Duncan said.

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

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

Key points of her proposal:

- Guaranteed availability: All small

employer groups would be able to obtain private health insurance regardless of the health risks they represent.

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

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

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

- Premium pricing limits: Insurance companies would be required to limit how much their rates could vary for groups similar in geography, demographic composition and plan design. A carrier's premiums for similar

groups could not vary by more than 25 percent from the carrier's midpoint rate, as well as a 15 percent limit of how much a carrier's rates could vary by industry. Finally, increases would be held to no more than 15 percent above a carrier's trend, the year-to-year increase in the lowest new business rate.

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

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

To establish premiums, the five members of the association that have the largest numbers of individuals

under plans with similar benefits will submit rate proposals for risk coverage equivalent to that under the state plan. Premiums for the state plan could not exceed 125 percent of the average of those five proposals.

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

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

Kerttula said that, in theory, premiums would cover the majority of claims paid by the pool. In practice, premiums are generally insufficient because of the premium cap and the poor health of the uninsured. "A 1968 (federal) Government Accounting Office study concluded that for every \$1 received in premiums by the current operating pools, \$1.60 is paid out in claims. This bill takes the approach taken in most states with pools, to assess the pool members the excess costs in proportion to their share of the state health insurance market." And while high-risk pools in other states usually lose money—and losses can at times be large—the cost has generally been in the range of one percent of the total amount of premiums collected from all health insurance policies sold in those states, Kerttula said.

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

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

The Health Resources and Access Task Force was told that in 1980 Alaska's 10 top community hospitals had to pass \$17 million in uncollectible charity cases onto patients who had insurance and could pay. That was the cost of medical services and insurance.

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ALASKA STATE

HOSPITAL & NURSING HOME

ASSOCIATION

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

Re: Support SB 242
Health Insurance Small
Employers

Dear Senator Sturgulewski:

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

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

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

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

Sincerely,

Harlan R. Knudson
President/CEO

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

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

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

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

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

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

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

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

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

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

POSITION PAPER
SB 242
Page 2

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

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

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

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

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

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

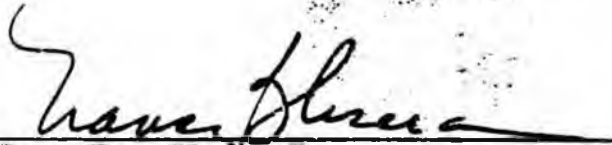
AS 21.55.140 provides no standard of review of forms for the director to follow. Without such standards, the director will not be in a position to disapprove use of forms.

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

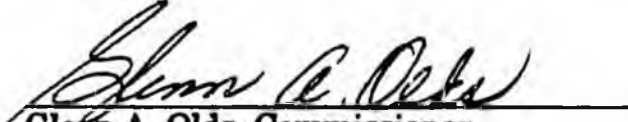
AS 21.55.180 should apply fair marketing standards to all persons, not just small employer insurers. Subsection (c) and (d) should address entities such as managing general agents and third-party administrators. Subsection (f) should apply to all persons.

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

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


Nancy Bear Useya, Commissioner
Department of Administration

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


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

Date: 4-13-92

NFIB Alaska

National Federation of
Independent Business

April 7, 1992

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

RE: SB 242: Health Insurance for small employers.

Dear Senator Collins:

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

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

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

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

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

1991

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

Yes 72.2% No 17% Undecided 10.8%

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



The Guardian of
Small Business

Page: 2

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

Yes 50.2% No 19.3% Undecided 30.5%

1989

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

Yes 8% No 87% Undecided 5%

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

Sincerely,



Resa Jerrel
State Director

Enclosure

cc: Senate Health, Education and
Social Services Committee

THOMAS A. TURNER, CLU

MAR 13 1992

INSURANCE AND EMPLOYEE BENEFITS

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

March 10, 1992

Re: SB 242

Dear Senator Collins:

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

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

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

Sincerely,



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

cc: Senator J. Kerttula



Southern Alaska Life Underwriters Association
P.O. Box 10-3956
Anchorage, Alaska 99510

MAR 17 1992

March 5, 1992

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

Dear Chris and Nanci,

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

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

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

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

Sincerely,

Jeff Duzenbery
President

(907) 258-5065 work
(907) 248-1336 home

Alaska State Legislature

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

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

Senator Virginia Collins

CSSB 242 (HES)

Small Employer Health Insurance Reform

CSSB 242 (HES) promotes the availability of health insurance coverage for small employers and reforms the small employer health insurance market. Without requiring additional state expenditures, it provides:

- * **Guaranteed availability** - All small employer groups would be able to obtain private health insurance regardless of the health risk they represent (see Sec. 21.55.140(a)).
- * **Coverage of whole groups** - Coverage must be available to entire groups. Neither an employer nor an insurer could exclude individuals having high medical risks from the group's coverage (see Sec. 21.55.150(6)).
- * **Renewability of coverage** - Individuals in employer groups and employer groups themselves would be assured at the time of renewal that their coverage would not be canceled because of deteriorating health (see Sec. 21.55.130).
- * **Continuity of coverage** - Once a person is covered and has satisfied a plan's preexisting condition requirements, he or she would not have to meet those requirements again when changing jobs or when the employer changes carriers (see Sec. 21.55.150(2)).
- * **Premium pricing limits** - The bill limits how much insurance companies could vary their rates for groups similar in geography, demography, and plan design. It also limits increases in rates (see Sec. 21.55.120).

Based on model legislation drafted by the National Association of Insurance Commissioners, CSSB 242 (HES) would improve the overall fairness and efficiency of the small employer health insurance market. It enjoys support from the National Federation of Independent Business, the Alaska State Chamber of Commerce, the Alaska State Hospital and Nursing Home Association, and other organizations.



UNINSURED ALASKA POPULATION

Total Uninsured Population <i>(Excluding Native Population)</i>	76,627	
Uninsured earning less than 300% of poverty level	61.47%	(47,106)
Uninsured earning more than 300% of poverty level:	38.53%	(29,521)
Uninsured Children Under Age 19 <i>(300% of Federal Poverty Level and below)</i>	15,694	(20.48%)
less than 100% of poverty level:	4,284 children	
100 - 200% of poverty level	4,898 children	
200 - 300% of poverty level	6,522 children	
Uninsured Small Business Family Members	16,025	(20.91%)
• Firms with 25 employees		
• Include full-time/full-year workers		
• Does not include full time/part-year workers		
Medically Uninsurable <i>(i.e. "high risk" individuals)</i>	4,000	(5.22%)

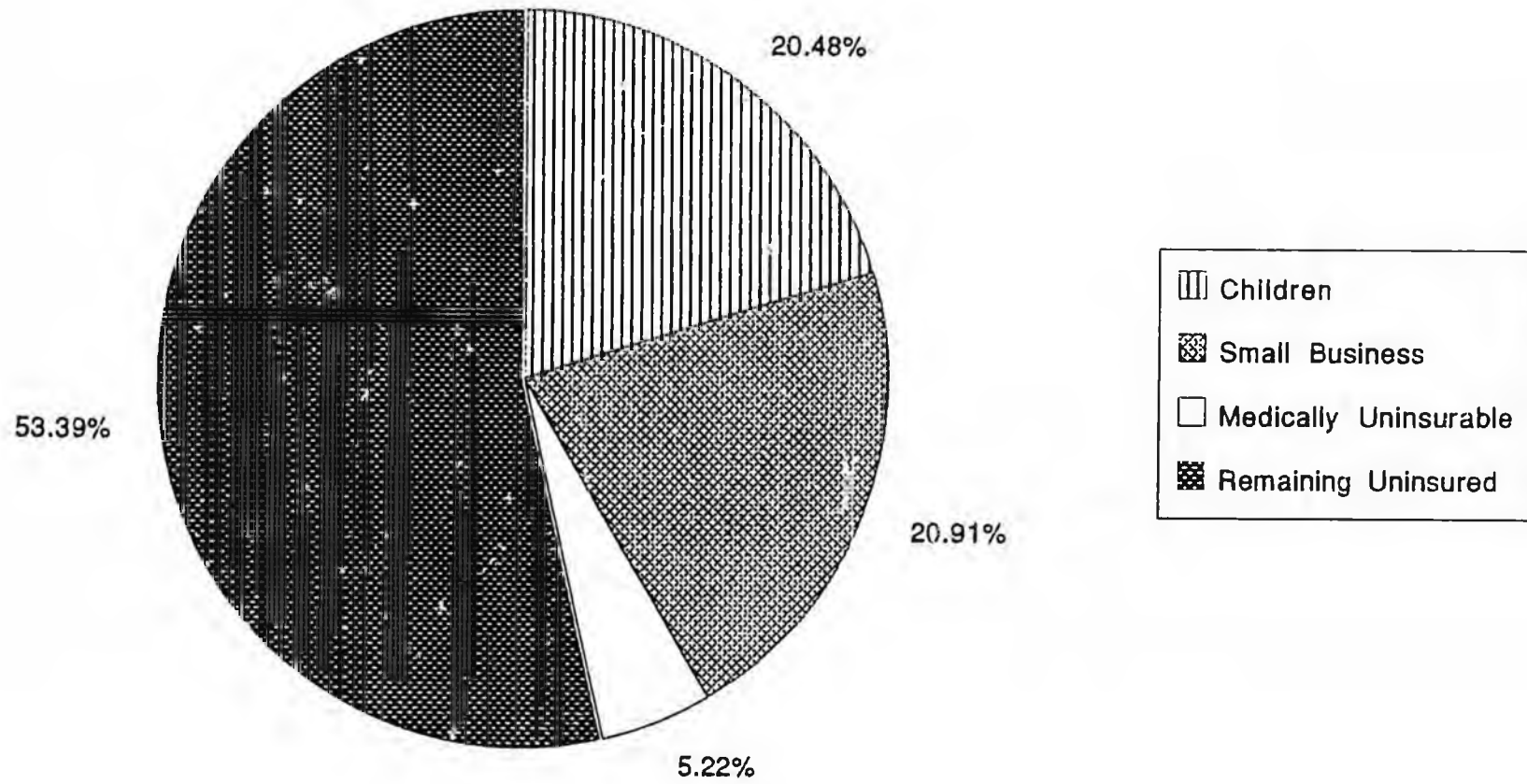
Above figures represent potential size of enrollee participant group for coverage provided under the terms of SB 74, SB 242 and SB 290. Actual enrollment will depend on specific benefit levels offered, participant premium/contribution levels, and participant cost-sharing provisions.

1992 Poverty Guidelines for Alaska

<i>Size of family unit</i>	<i>Poverty Guideline (100%)</i>
1	\$8,500
2	\$11,480
3	\$14,460
4	\$17,440
5 and above	extra \$2,980 per member

Data Sources: Health Systems Research, Inc. February 7, 1992 report; Aema estimate.

UNINSURED ALASKAN POPULATION



SMALL EMPLOYER MARKET REFORMS

	<u>NAIC</u>	<u>CSSB 242 (HES)</u>
<u>Availability</u>	Guaranteed issue	Guaranteed issue
<u>Group Size</u>	1-25	3-25
<u>Case Characteristics</u>	Geography, age, sex, size of employer, and other objective criteria but does not include claim experience, health status or duration of coverage	Geography, age, sex, size of employer, and other objective criteria but does not include claim experience, health status or duration of coverage
<u>Rating Restrictions</u>	Within a class of business, the rates for similar groups may not vary from the index rate by more than 25%. The index rate for any insurer's class of business may not exceed another class of business by more than 20%.	An insurer's rates for similar groups may not vary from applicable index rate by more than 35%.
<u>Transitional Period</u>	3 years	3 years
<u>Renewal Rating</u>	Trend plus 15% plus changes in case characteristics	Trend plus 15% plus changes in case characteristics
<u>Renewability</u>	Guaranteed renewable except "for cause"	Guaranteed renewable except "for cause"
<u>Whole Groups</u>	Must take whole group	Must take whole group
<u>Continuity of Coverage</u>	Plans must credit the time a person was covered under a previous employer-based plan if the coverage was continuous	Plans must credit the time a person was covered under a previous employer-based plan if the coverage was continuous

	<u>NAIC</u>	<u>CSSB 242 (HES)</u>
<u>Reinsurance</u>	Prospective with opt out. Insurers elect whether to participate in the reinsurance mechanism.	Mandatory prospective. Insurers <u>must</u> participate in the reinsurance mechanism.
<u>Reinsurance Price</u>	150% for whole groups 500% for individuals	150% for whole groups 500% for individuals
<u>Cost Sharing</u>	First \$5000 of claims and 10% of next \$50,000 in claims	First \$5000 of claims
<u>Assessments</u>	5% of the premium of small employer market	5% of the premium of small employer market
<u>Minimum Participation Requirements</u>	Consideration of dual participation required	Not included
<u>Class of Business Rating</u>	Included	Not included
<u>Industry Rating</u>	Maximum 15% above lowest rate factor associated with any industry classifications.	A rate factor may not vary by more than 15% from arithmetic average of highest and lowest rate factors associated with all industry classifications.
<u>Reinsurance Board</u>	Eight members, with Insurance Director as ex-officio member. Director appoints. Members to include representatives of small employers and insurers, with at least 5 representatives of reinsuring carriers.	Nine members, selected by participating members, approved by Director. At least two-thirds of members shall be small employer insurers. At least one member shall be insurer principally in small employer market; one principally in large employer market; one to represent HSO, HSC, or MSO; one to represent HMO; one to represent other benefit arrangement.

	<u>NAIC</u>	<u>CSSB 242 (HES)</u>
<u>Health Benefit Plan Committee</u>	Appointed either by Governor or Director. Includes representatives of insurers, small employers and employees, and health care providers.	Appointed by Director. Same representatives as NAIC model, but also includes representative of agents and brokers.
<u>Cost Shifting</u>	No reference	Shifting program costs to other insureds, or to state <u>not</u> allowed.
<u>Reporting</u>	No reference	Annual report to Director, Legislature required first 5 years; thereafter every 2 years
<u>Insurers With Restricted Charters, i.e., Fraternal Benefits Organizations</u>	Not Included	Guarantees issue only to those permitted by charter.

CSSB 242 (HES)

Small Employer Health Insurance Reform

Highlights

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