

**ALASKA LEGISLATURE COMMITTEE FILES 1991-1992 8672**

**7416 SENATE HEALTH EDUCATION & SOCIAL SERVICES**

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

SECTIONAL ANALYSIS  
SENATE HEALTH, EDUCATION, & SOCIAL SERVICES  
COMMITTEE

SENATE BILL 242

12 September 1991

SECTIONAL ANALYSIS:

Section 1: Legislative Findings.

Section 2: AS 21.55.010 - creates small Employers Health Reinsurance Association.

Membership consists of all

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

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

Members shall represent:

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

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

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

establish administrative and accounting procedures  
take legal action as necessary

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

establish rules

**establish rates, rate schedules, etc.**

assess members for operating expenses

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

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

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 **These regulations continue in force until modified by the director or superseded by a plan submitted by the association and approved by the director.**

**The plan of operation must:**

establish procedures for

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

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

provide protection for guaranteed issue insurers<sup>1</sup> from the financial risk associated with small employers that present poor credit risks<sup>2</sup> that present **poor credit risks** (\*5)

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

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

**determine the adjusted average market premium prices<sup>3</sup> for small employer health plans sold in this state.**

establish participation standards at issue and renewal for reinsured cases

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1 "guaranteed issue insurer" means an Insurer that  
(a) is one of the top 10 insurers based on total premium volume in the small employer market *as determined by the board*; and  
(b) an insurer that informs the board that the insurer wishes to become a guaranteed issue insurer (a year in advance).

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

3 "adjusted average market premium price" means, *as determined by the board*, the arithmetic mean of all GII's premium rates for a given small employer health benefit plan sold to groups with similar case characteristics by all insurers or welfare arrangements selling small employer health benefit plans in the state.

establish and maintain a list of guaranteed issue insurers

establish standards for those conditions under which a guaranteed issue insurer would not be required to write business received from a particular agent or broker(\*6)

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

Sec. 21.55.050 a member **may only reinsure coverage of an eligible employee of a small employer (or dependent) under the following provisions:**

(1) regarding a small employer health benefit plan, the association shall reinsure the level of coverage provided.

(2) regarding a plan **other than** a small employer health benefit plan, **the association shall reinsure the level of coverage provided up to, but not exceeding, the level of coverage provided in a small employer health benefit plan. (\*7)**

(3) regarding the coverage provided to small employers, insurer or welfare arrangement<sup>4</sup> or to the extent permitted under 29 U.S.C. 1001 - 1459, other benefit arrangement shall be required to use high-cost case management, hospital precertification techniques, and other cost containment techniques as established by the association (\*8)

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

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

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<sup>4</sup> "welfare arrangement" means a multiple employer welfare arrangement as defined in 29 U.S.C. 1003, but does not include a multiple employer welfare arrangement that is fully insured as provided in 26 U.S.C. 1060.

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

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

(B) beginning on a date established by the board,

but not later than 18 months after the association becomes operational

on the first plan anniversary after the small employer coverage has been in effect

with the small employer for at least three years and every third year anniversary thereafter.

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

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

(B) beginning on a date established by the board,

but not later than 18 months after the association becomes operational

on the first plan anniversary after the small employer coverage has been in effect

with the small employer for at least three years and every third year anniversary thereafter.(\*10)

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

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

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

employer's plan; or

(C) beginning on a date established by the board, but not later than 18 months after the association becomes operational on the first plan anniversary after the small employer coverage has been in effect with the small employer for at least three years and every third year anniversary thereafter.<sup>5</sup> (\*11)

(8) employees or dependents reinsured under (4),(5),or (6) may not be provided reinsurance until \$5,000 in benefit payments has been made in that calendar year. *In this paragraph "benefit payments" include those payments that would have been reimbursed through reinsurance in the absence of the annual \$5000 deductible ; the amount of the deductible shall be periodically reviewed by the board and may be adjusted for appropriate factors as determined by the board. (\*12)*

(b) If an employer **group** is covered under a plan other than a small employer health plan and the insurer chooses to reinsure the group after the initial coverage period, or if a new individual joins the group and the insurer wants to reinsure that individual, the insurer may not require the **employer** to change to a small employer health plan and the insurer shall allow the **employer** to maintain the same benefit plan and reinsure only the portion of the plan consistent with a small employer health plan.

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

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

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

**adjusted average market premium price<sup>6</sup>** for that group, minus a ceding expense factor determined by the association. (\*13)

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

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

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

(f) **Assessing the members:**

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

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

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

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

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<sup>6</sup> "adjusted average market premium price" means, as determined by the board the arithmetic mean of all guaranteed issue insurer's premium rates for a given small employer health benefit plan sold to groups with similar case characteristics by all insurers or welfare arrangements selling small employer health benefit plans in the state.

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

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

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

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

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

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

Sec.21.55.070. The association is **exempt from the payment of fees and taxes** levied by the state or any of its political subdivisions except taxes levied on real or personal property.

Sec. 21.55.080. A member of the association is **not liable for civil damages** resulting from an act or omission of the member on behalf of the association unless the member acts with gross negligence or intentional misconduct. (\*16)

## ARTICLE 2. SMALL EMPLOYER HEALTH INSURANCE PLANS.

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

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

-a covered individual is reimbursed by a small employer for all or a portion of the premium, or

(2) the health benefit plan is treated by the employer or a covered individual as part of a plan or program for the purposes of 26 U.S.C 106 or 26 U.S.C. 162 (Internal Revenue Code).

(b) Except as provided in this chapter other provisions of law requiring the coverage or offer of **coverage of a health care service or benefit** or the reimbursement, utilization, or consideration of specific category of a **licensed or certified health care practitioner** do not apply <sup>7</sup> (\*17)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(7) a health benefit plan **may not limit or exclude**, by use of a rider or amendment applicable to a specific individual **coverage by type of illness, treatment, medical condition, or accident, except for preexisting conditions.** (See subsection 1)

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

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

(10) **rates for the same or similar coverage may not vary from the applicable midpoint rate by more than 35 percent of the applicable midpoint rate.**<sup>9</sup> (\*22)

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

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

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<sup>9</sup> "midpoint rate" means for a small employer with similar case characteristics and plan designs, as determined by the applicable insurer or welfare arrangement for a rating period, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate.

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

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

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

(A) the percent of change from the previous rating period to the new rating period **plus 15 percent** (adjusted pro rata for a rating period greater or lesser than one year) **of the base premium rate for the new rating period, and**

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

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

(A) how premium rates are established or adjusted.

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

(C) renewability of a policy

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

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

(b) guaranteed issue insurers may

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

(2) as provided in the association's plan

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

(B) **make special arrangements to cover an employee in a small employer group with exceptionally high employee**

**turnover rates**

(3) appeal to the board for a finding that the GII is experiencing an unfair share of administrative or credit risk,

**Sec. 21.55.130 SMALL EMPLOYER HEALTH BENEFIT PLANS.**

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

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

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

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

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

(e) After the director's approval of the plans submitted by the board, an insurer must certify that the plans are in **substantial compliance** with the provisions in the corresponding approved board plan. An insurer may then use that plan until the director, after notice and hearing, disapproves the use of the plan.

**Sec. 21.55.140. CONDITIONS FOR CEASING TO DO BUSINESS.** An insurer must provide notice of intent to cease to do business in the small employer market **one year in advance** and may not reenter the small employer marketplace for five years.

**Sec 21.55.250. DEFINITIONS - please refer to bill.**

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

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

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

SEC 6. Effective date.



# Alaska State Legislature

## Senate

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

Official Business

MEMORANDUM

March 30, 1992

SUBJECT: CSSB 242 ( )  
TO: Members, Senate HESS Committee  
FROM: Senator Virginia Collins *VC*

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

*NAIC*  
*MAIC*

(1) Fundamental Analysis. Very  
concerning for  
public groups.

(2) Concerning re  
continuity of coverage  
- Drafts per -  
competitor of group  
- Public liability  
- mechanism to  
State only for  
governance. Funding

*North American  
Group. (1988)*

*Approved by  
1-1-88  
1-1-88  
1-1-88  
1-1-88  
1-1-88*

**SMALL EMPLOYER MARKET REFORMS**

	<u>NAIC</u>	<u>CSSB 242 ( )</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 ( )</u>
<u>Reinsurance</u>	Prospective with opt out. Insurers elect whether to participate in the reinsurance mechanism.	Mandatory prospective. Insurers must 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, with Insurance Director as ex-officio member. Director appoints. At least two-thirds of members shall be small employer insurers. At least one member shall be insurer principally in small employer market; one principally in large employer market; one to be HSO, HSC, or MSO; one to be HMO; one to represent other benefit arrangement.

*Consider joining*

*Participates type of assessment*

*Check this*

Health Benefit  
Plan Committee

NAIC

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

CSBB 242 ( )

Appointed by Director. ✓  
Same representatives,  
but also includes  
Director as member.

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

Not Included

Guarantees issue only ✓  
to those permitted by  
charter.

# Alaska State Legislature

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## Senator Virginia Collins

CSSB 242 (3/28/92 Draft)

### Small Employer Health Insurance

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

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

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

- \* promote the availability of health insurance coverage to small employers regardless of their health status or claims experience;
- \* prevent abusive rating practices and require the disclosure of rating practices to purchasers;
- \* establish rules on renewability of coverage;
- \* establish limitations on preexisting condition exclusions;
- \* provide for the development of basic and standard health benefit plans offered to all small employers; and,
- \* establish the Small Employer Health Reinsurance Association.

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

# SB242

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

### MEMBERS OF THE HEALTH REINSURANCE ASSOCIATION

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

### BOARD OF DIRECTORS

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

#### \* PROPOSED REPRESENTATION

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

#### DIRECTOR OF INSURANCE

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

### COST

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

# SB242

## PURPOSE

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

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

## HIGHLIGHTS

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

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

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

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

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



Official Business

# Alaska State Legislature

## Senate

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

*Handwritten notes:*  
March 16, 1992  
Hess Committee  
Health Insurance

M E M O R A N D U M

March 30, 1992

**SUBJECT:** Sectional Summary of CSSB 242 (3/28/92 Draft)  
**TO:** Members, Senate HESS Committee  
**FROM:** Senator Virginia Collins *VMC*

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

Section 1 - Delineates the purpose of the bill.

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

Section 3 -

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

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

Sec. 21.55.030 - General powers of the association.

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

Sec. 21.55.050 - Establishes specific provisions that apply to reinsurance provided by a member to employees or dependents of employees of a small employer. Establishes a methodology for determining premium rates to be charged for reinsuring small employers and individuals covered under this section. Requires the association to report to the director of the

division of insurance the association's net loss for the previous calendar year. Requires association to establish a formula by which to make assessments against reinsuring insurers. Sets provisions for determining assessments.

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

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

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

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

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

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

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

Sec. 21.55.130 - Requires renewability of health benefit plans and provides under what conditions a plan would not be

renewable. Prohibits certain small employer insurers who do not renew a health benefit plan from writing a new business in the state for five years. Specifies when provisions apply to an insurer operating in an established geographic service area.

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

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

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

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

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

Sec. 21.55.250 - Definitions.

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

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

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

Section 7 - Transition section in regards to association's plan of operation, a small employer insurer's basic and standard health benefit plans, an insurer's filing net insurance premium earned from certain health insurance plans, and when the Health Benefit Plan Committee shall submit health benefit plans.

Section 8 - Effective date.

# Alaska State Legislature

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



P. O. BOX V  
ROOM 427  
STATE CAPITOL  
JUNEAU, ALASKA 99811  
(907) 465-3762

## Senate Committee on Health, Education and Social Services

MEMORANDUM

14 April 1992

TO: Senate HESS Committee Members

FROM: Senator Arliss Sturgulewski, Chair

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

### DO NOT RECOMMEND ADOPTION:

Pages 1-6 of amendments offered by div of insurance.  
These amendments combine the associations of SB 74 & SB 242

### RECOMMEND ADOPTION:

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

### DO NOT RECOMMEND ADOPTION:

Page 8-12 of amendment offered by division of insurance.  
Establishes a benefit committee to decide benefits offered by pool rather than outlining benefits to be covered in statute.

### DO NOT RECOMMEND ADOPTION:

Page 13 of amendments offered by division of insurance.  
This amendment is a clarifying amendment following adoption of amendments on pages 8-13.

### RECOMMEND ADOPTION:

*Do not include*

*yes*  
*Do not include*

*Do not include*

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

**DO NOT RECOMMEND ADOPTION:**

Page 15 of amendments offered by division of insurance.  
This amendment is a clarifying amendment following adoption of  
amendments on pages 8-13.

**RECOMMEND ADOPTION**

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

Page 18 is a duplicate.

**RECOMMEND ADOPTION**

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

**RECOMMEND ADOPTION**

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

**RECOMMEND ADOPTION**

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

**RECOMMEND ADOPTION**

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

**OTHER SUGGESTIONS:**

**RECOMMEND ADOPTION:**

Page 2, Line 5.

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

**RECOMMEND ADOPTION:**

Page 2, line 17 through 23:

*Yes*

*Do not include*

*Yes*

*Yes*

*Yes*

*Yes*

*Yes  
adj*

*Yes*

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

RECOMMEND ADOPTION

Page 8, Line 17:

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

the division of insurance suggests that the director, by regulation, be able to add eligibility requirements.<sup>1</sup>

Page 12, Lines 6 through 14

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

Page 14, Line 5

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

*Staff has no recommendation.*

Page 14, Line 10:

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

*Staff has no recommendation.*

---

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

AMENDMENT #1

OFFERED IN THE SENATE

BY SENATOR COLLINS

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

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

Delete [LESS], insert: more

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

Insert: and (2)

Page 22, line 27, before "of":

Delete [2], insert: 3

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

Insert: and (2)

AMENDMENT #2

OFFERED IN THE SENATE

BY SENATOR COLLINS

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

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

Delete [THE DIRECTOR AND SIX], insert: seven

Page 8, line 5, after "employers;"

Delete [AND]

Page 8, line 6, after "providers":

Insert: ; and

(5) one member who represents agents or brokers

AMENDMENT #3

OFFERED IN THE SENATE

BY SENATOR COLLINS

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

Page 8, line 23, after "every":

Delete [THREE], insert: two

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

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

AMENDMENT #4

OFFERED IN THE SENATE

BY SENATOR COLLINS

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

Page 14, line 4, after "insurer":

Insert: as provided under AS 21.06.180-.210

AMENDMENT #5

OFFERED IN THE SENATE

BY SENATOR COLLINS

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

Page 2, line 14, after "selected":

Insert: by participating members, subject to approval

Page 2, line 31, after "filled":

Insert: by participating members, subject to approval



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 7, 1992

SUBJECT: Amendment to CSSB 242 (3/28/92 Draft)  
TO: Members, Senate HESS Committee  
FROM: Senator Virginia Collins *VC*

Attached please find Amendment #1. to the above bill.

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

AMENDMENT #1

OFFERED IN THE SENATE

BY SENATOR COLLINS

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

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

Delete [LESS], insert: more

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

Insert: and (2)

Page 22, line 27, before "of":

Delete [2], insert: 3

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

Insert: and (2)

**SENATE AMENDMENT**

BY: Division of Insurance

TO: Page 2. line 3

SENATE BILL NO. CSSB 242 G

TO: \_\_\_\_\_

HOUSE BILL NO. \_\_\_\_\_

After: "PROHIBITED"

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

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

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

SENATE AMENDMENT

BY: Division of Insurance

TO: Page 2. line 17

SENATE BILL NO. CSSB 242 G

TO: \_\_\_\_\_

HOUSE BILL NO. \_\_\_\_\_

After: "insurer"

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

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

## SENATE AMENDMENT

BY: Division of Insurance

TO: Page 2, line 25

SENATE BILL NO. CSSB 242 G

TO: \_\_\_\_\_

HOUSE BILL NO. \_\_\_\_\_

After: "board"

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

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

## SENATE AMENDMENT

BY: Division of Insurance

TO: Page 3, line 31

SENATE BILL NO. CSSB 242 G

TO: \_\_\_\_\_

HOUSE BILL NO. \_\_\_\_\_

After: "program"

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

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

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

## SENATE AMENDMENT

BY: Division of Insurance

TO: Page 4, line 30

SENATE BILL NO. CSSB 242 G

TO: \_\_\_\_\_

HOUSE BILL NO. \_\_\_\_\_

After: "has"

Insert: "paid"

Delete: "incurred"

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

## SENATE AMENDMENT

BY: Division of Insurance

TO: Page 7, line 4

SENATE BILL NO. CSSB 242 G

TO: \_\_\_\_\_

HOUSE BILL NO. \_\_\_\_\_

After: "state"

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

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

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

## SENATE AMENDMENT

BY: Division of Insurance

TO: Page 8, line 1

SENATE BILL NO. CSSB 242 G

TO: \_\_\_\_\_

HOUSE BILL NO. \_\_\_\_\_

After: "of"

Delete: "the director and six"

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

SENATE AMENDMENT

BY: Division of Insurance

TO: Page 2, line 4

SENATE BILL NO. CSSB 242 G

TO: \_\_\_\_\_

HOUSE BILL NO. \_\_\_\_\_

After: "AS 21.55.180."

Insert: "\* Sec.   . AS 21.36.060(d) is amended to read:

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

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

## SENATE AMENDMENT

BY: Division of Insurance

TO: Page 12, line 16

SENATE BILL NO. CSSB 242 G

TO: \_\_\_\_\_

HOUSE BILL NO. \_\_\_\_\_

After: "(C)"

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

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

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

## SENATE AMENDMENT

BY: Division of Insurance

TO: Page 13, line 30

SENATE BILL NO. CSSB 242 G

TO: \_\_\_\_\_

HOUSE BILL NO. \_\_\_\_\_

After: "director"

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

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

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

SENATE AMENDMENT

BY: Division of Insurance

TO: Page 17. line 4

SENATE BILL NO. CSSB 242 G

TO: \_\_\_\_\_

HOUSE BILL NO. \_\_\_\_\_

After: "agent"

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

Delete: "or broker"

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

## SENATE AMENDMENT

BY: Division of Insurance

TO: Page 17. line 8

SENATE BILL NO. CSSB 242 G

TO: \_\_\_\_\_

HOUSE BILL NO. \_\_\_\_\_

After: "agent"

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

Delete: "or broker"

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

**SENATE AMENDMENT**

BY: Division of Insurance

TO: Page 17, line 13

SENATE BILL NO. CSSB 242 G

TO: \_\_\_\_\_

HOUSE BILL NO. \_\_\_\_\_

After: "agent"

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

Delete: "or broker"

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

**SENATE AMENDMENT**

BY: Division of Insurance

TO: Page 17, line 15

SENATE BILL NO. CSSB 242 G

TO: \_\_\_\_\_

HOUSE BILL NO. \_\_\_\_\_

After: "agent"

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

Delete: "or broker"

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

## SENATE AMENDMENT

BY: Division of Insurance

TO: Page 17. line 22

SENATE BILL NO. CSSB 242 G

TO: \_\_\_\_\_

HOUSE BILL NO. \_\_\_\_\_

After: "this"

Insert: "chapter by a person"

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

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

## SENATE AMENDMENT

BY: Division of Insurance

TO: Page 8, line 22

SENATE BILL NO. CSSB 242 G

TO: \_\_\_\_\_

HOUSE BILL NO. \_\_\_\_\_

After: "REPORT."

Insert: "(a) The board shall study and report at least once every three years to the legislature on the effectiveness of this chapter. The report must analyze the effectiveness of the chapter in promoting rate stability, product availability, and coverage affordability. The report may contain recommendations for actions to improve the overall effectiveness, efficiency, and fairness of the small group health insurance marketplace. The report must address whether insurers, agents, brokers, managing general agents, and third party administrators are fairly and actively marketing or issuing health benefit plans to small employers in fulfillment of the purposes of the chapter. The report may contain recommendations legislative or other regulatory action.

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

Delete: "The board shall study and report at least once every three years to the director on the effectiveness of this chapter. The report must analyze the effectiveness of the chapter in promoting rate stability, product availability, and coverage affordability. The report may contain recommendations for actions to improve the overall effectiveness, efficiency, and fairness of the small group health insurance marketplace. The report must address whether insurers and agents or brokers are fairly and actively marketing or issuing health benefit plans to small employers in fulfillment of the purposes of the chapter. The report may contain recommendations for market conduct or other regulatory standards or action."

SPONSOR STATEMENT: Legislative review of the program after three years should include the effect of the program on its target market as well as the overall health insurance market, and to determine whether the program should be continued.

**CS FOR SENATE BILL NO. 242 (HES)**

**IN THE LEGISLATURE OF THE STATE OF ALASKA**

**SEVENTEENTH LEGISLATURE - SECOND SESSION**

**BY THE SENATE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE**

**Offered:**

**Referred:**

**Sponsor(s): SENATORS COLLINS, Menard, Pearce**

**A BILL**

**FOR AN ACT ENTITLED**

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

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 is amended by adding a new chapter to read:

16 CHAPTER 55. SMALL EMPLOYER HEALTH INSURANCE.

17 ARTICLE 1. SMALL EMPLOYER HEALTH REINSURANCE ASSOCIATION.

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

23 Sec. 21.55.020. BOARD OF DIRECTORS; ORGANIZATION. (a) The board of  
24 directors of the association consists of nine individuals selected by participating members, subject  
25 to approval by the director. The director shall endeavor to appoint at least six board members  
26 who are also small employer insurers. If the director is unable to appoint six board members  
27 who are also small employer insurers, the director may fill the remaining seats with any insurer.  
28 In selecting members of the board, the director shall consider, among other things, whether all  
29 types of participating members are fairly represented.

30 (b) To the extent possible, one board member shall represent a health maintenance  
31 organization, one board member shall represent a hospital or medical service corporation, one

1 board members' principal health insurance business shall be in the small employer market, and  
2 one board member's principal health insurance business shall be in the large employer market.  
3 Members of the board may be reimbursed from the association for expenses incurred by them  
4 as members, but may not otherwise be compensated by the association for their services. The  
5 costs of conducting meetings of the association and its board of directors shall be borne by the  
6 association.

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

11 Sec. 21.55.030. GENERAL POWERS. The association may

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

14 (2) sue or be sued;

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

17 (4) establish administrative and accounting procedures for the operation of the  
18 association;

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

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

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

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

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

30 (10) appoint appropriate legal, actuarial, and other committees as are necessary  
31 to provide technical assistance in the operation of the association, design of a policy or contract,

1 or to assist in other functions of the association;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 calendar year from newly issued health benefit plans delivered or issued for delivery during the  
2 calendar year to small employers in this state by reinsuring insurers. In determining an  
3 assessment, if any, that is collected from a member, the following provisions apply:

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

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

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

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

22 (5) annually before March 1, the board shall determine and file with the director  
23 an estimate of the assessments needed to fund losses incurred by the association in the previous  
24 calendar year;

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

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 21.90.900;

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 calendar year, at least three but not  
16 more than 25 eligible employees, the majority of whom are employed within the state; in  
17 determining the number of eligible employees, companies that are affiliated companies or that  
18 are eligible to file a combined tax return for purposes of federal taxation, are considered one  
19 employer; except as otherwise specifically provided, provisions of this chapter that apply to a  
20 small employer that has a health benefit plan continue to apply until the plan anniversary  
21 following the date the 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.

*Propose rate base 6,000,000  
Consider the 2000 rate base*

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

BY

Offered:  
Referred:

Sponsor(s): SENATORS COLLINS, Menard, Pearce

A BILL

FOR AN ACT ENTITLED

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. 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

1 market.

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

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

5 \* Sec. 3. AS 21 is amended by adding a new chapter to read:

6 CHAPTER 55. SMALL EMPLOYER HEALTH INSURANCE.

7 ARTICLE 1. SMALL EMPLOYER HEALTH REINSURANCE ASSOCIATION.

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

13 Sec. 21.55.020. BOARD OF DIRECTORS; ORGANIZATION. (a) The board of  
14 directors of the association consists of nine individuals selected by the director. The director  
15 shall endeavor to appoint at least six board members who are also small employer insurers. If  
16 the director is unable to appoint six board members who are also small employer insurers, the  
17 director may fill the remaining seats with any insurer. The director or the director's designee  
18 shall serve as an ex officio member of the board. In selecting members of the board, the director  
19 shall consider, among other things, whether all types of participating members are fairly repre-  
20 sented.

21 (b) To the extent possible, one board member shall represent a health maintenance  
22 organization, one board member shall represent a hospital or medical service corporation, one  
23 board members' principal health insurance business shall be in the small employer market, and  
24 one board member's principal health insurance business shall be in the large employer market.  
25 Members of the board other than the director or the director's designee may be reimbursed from  
26 the association for expenses incurred by them as members, but may not otherwise be  
27 compensated by the association for their services. The costs of conducting meetings of the  
28 association and its board of directors shall be borne by the association.

29 (c) A member of the board serves for a term of three years and may be reappointed to  
30 an unlimited number of terms. The term of a board member shall continue until a successor is  
31 appointed. A vacancy on the board shall be filled by the director. A board member may be

1 removed by the director for cause.

2 Sec. 21.55.030. GENERAL POWERS. The association may

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

5 (2) sue or be sued;

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

8 (4) establish administrative and accounting procedures for the operation of the  
9 association;

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

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

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

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

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

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

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

27 Sec. 21.55.040. PLAN OF OPERATION. (a) The association shall submit to the  
28 director a plan of operation and amendments necessary or suitable to assure the fair, reasonable,  
29 and equitable administration of the association. The director may, after notice and hearing,  
30 approve the plan of operation if the director determines it to be suitable to assure the fair,  
31 reasonable, and equitable administration of the program and provides for the sharing of program

1 gains or losses on an equitable and proportionate basis under the provisions of this section. The  
2 plan of operation and amendments become effective upon approval in writing by the director.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

26 (1) the formula established under this subsection may not result in a reinsuring  
27 insurer having an assessment share that is less than 50 percent or more than 150 percent of an  
28 amount that is based on the proportion of the reinsuring insurer's total premiums earned in the  
29 preceding calendar year from health benefit plans delivered or issued for delivery to small  
30 employers in this state by reinsuring insurers to total premiums earned in the preceding calendar  
31 year from health benefit plans delivered or issued for delivery to small employers in this state

1 by all reinsuring carriers;

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

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

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

13 (5) annually before March 1, the board shall determine and file with the director  
14 an estimate of the assessments needed to fund losses incurred by the association in the previous  
15 calendar year;

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

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

1 (8) the board shall annually determine a member's proportion of participation in  
2 the association based on annual statements and other reports determined necessary by the board  
3 and filed by the member with the board; an insurer shall report to the board a claim payment  
4 made and administrative expense incurred in this state on an annual basis on a form prescribed  
5 by the director;

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

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

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

18 (e) The board, as part of the plan of operation, shall establish a methodology for  
19 determining premium rates to be charged by the program for reinsuring small employers and  
20 individuals under this section. The methodology must include a system for classification of small  
21 employers that reflects the types of case characteristics commonly used by small employer  
22 insurers in the state. The methodology must provide for the development of base reinsurance  
23 premium rates that shall be multiplied by the factors set out in (b) of this section to determine  
24 the premium rates for the association. The base reinsurance premium rates shall be established  
25 by the board, subject to the approval of the director, and shall be set at levels that reasonably  
26 approximate gross premiums charged to small employers by small employer insurers for health  
27 benefit plans with benefits similar to the standard health benefit plan. The board shall review  
28 the methodology established under this subsection to ensure that the methodology reasonably  
29 reflects the claims experience of the program. Changes to the methodology may be proposed by  
30 the board, and are subject to approval by the director.

31 Sec. 21.55.060. HEALTH BENEFIT PLAN COMMITTEE. (a) The health benefit plan

1 committee is established in the association. The committee is composed of the director and six  
2 members selected by the director as follows:

- 3 (1) three members who are representatives of participating insurers;
- 4 (2) one member who represents small employers;
- 5 (3) one member who represents employees of small employers; and
- 6 (4) one member who represents health care providers.

7 (b) The committee shall recommend benefit levels, cost sharing levels, exclusions and  
8 limitations for the basic and standard health benefit plan offered under AS 21.55.140. The  
9 committee shall also design a basic health benefit plan and a standard health benefit plan that  
10 contain benefit and cost sharing levels that are consistent with the basic method of operation and  
11 the benefit plans of health maintenance organizations, including restrictions imposed by federal  
12 law. The plans recommended by the committee may include the following cost containment  
13 features:

- 14 (1) utilization review of health care services, including review of the medical  
15 necessity of hospital and physician services;
- 16 (2) case management;
- 17 (3) selective contracting with hospitals, physicians, and other health care  
18 providers;
- 19 (4) reasonable benefit differentials applicable to providers that participate or do  
20 not participate in arrangements using restricted network provisions; and
- 21 (5) other managed care provisions.

22 Sec. 21.55.070. **REQUIRED REPORT.** The board shall study and report at least once  
23 every three years to the director on the effectiveness of this chapter. The report must analyze  
24 the effectiveness of the chapter in promoting rate stability, product availability, and coverage  
25 affordability. The report may contain recommendations for actions to improve the overall  
26 effectiveness, efficiency, and fairness of the small group health insurance marketplace. The  
27 report must address whether insurers and agents or brokers are fairly and actively marketing or  
28 issuing health benefit plans to small employers in fulfillment of the purposes of the chapter. The  
29 report may contain recommendations for market conduct or other regulatory standards or action.

30 Sec. 21.55.080. **ADMINISTRATIVE PROCEDURE ACT.** The association is exempt  
31 from the Administrative Procedure Act (AS 44.62).

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

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

7           ARTICLE 2. SMALL EMPLOYER HEALTH INSURANCE PLANS.

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

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

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

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

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

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

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

31                   (1) the premium rate charged or offered during a rating period to small employers

1 with similar case characteristics as determined by the insurer for the same or similar coverage  
2 may not vary from the applicable index rate by more than 35 percent of the applicable index rate;

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

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

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

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

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

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

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

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