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7417 SENATE HEALTH EDUCATION & SOCIAL SERVICES

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

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

(7) a small employer insurer shall

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

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

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

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

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

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

(2) the provisions of the health benefit plan

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

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

(C) relating to any preexisting condition provision.

(c) A small employer insurer shall

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

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

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

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

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

(C) if the information is relied upon in determining that a violation of this chapter occurred.

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

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

(1) nonpayment of the required premiums;

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

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

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

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

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

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

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

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

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

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

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

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

(b) A small employer insurer shall file with the director, 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.

(c) The director at any time may, after providing notice and an opportunity for a hearing to a small employer insurer, disapprove the continued use by the small employer insurer of a basic or standard health benefit plan if the plan does not meet the requirements of this chapter.

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

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

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

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

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

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

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

(4) requirements used by a small employer insurer in determining whether to

provide coverage to a small employer shall be applied uniformly among all small employers with the same number of eligible employees applying for coverage or receiving coverage from the small employer insurer, except that a small employer insurer may vary application of minimum participation requirements and minimum employer contribution requirements by the size of the small employer group;

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

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

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

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

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

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

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

(4) if the certificate of authority or bylaws of the insurer do not permit the insurer to issue coverage on a marketwide basis; an insurer described in this subparagraph shall comply with AS 21.55.140 regarding small employers that meet the requirements of the insurer's

certificate of authority or bylaws; this subparagraph does not apply to insurers who limit coverage based on health status or health risk.

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

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

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

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

(b) Except as provided in this subsection, a small employer insurer may not, directly or indirectly, encourage or direct small employers to refrain from filing an application for coverage with the small employer insurer because of the health status, claims experience, industry, occupation, or geographic location of the small employer, or encourage or direct small employers to seek coverage from another insurer because of the health status, claims experience, industry, occupation, or geographic location of the small employer. This subsection does not apply to

information provided by a small employer insurer to a small employer regarding the established geographic service area or a restricted network provision of a small employer insurer.

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

(d) A small employer insurer

(1) shall provide reasonable compensation, as provided under the plan of operation of the program, to an agent or broker, if any, for the sale of a basic or standard health benefit plan;

(2) or agent or broker may not induce or otherwise encourage a small employer to separate or otherwise exclude an employee from health coverage or benefits provided in connection with the employee's employment;

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

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

(f) A violation of this section by a small employer insurer or an agent or broker is an unfair trade practice for purposes of AS 21.36.

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

Sec. 21.55.250. DEFINITIONS. In this chapter,

(1) "actuarial certification" means a written statement by a member of the American Academy of Actuaries or another individual acceptable to the director indicating that based on the person's examination, including a review of the appropriate records, actuarial

assumptions, and methods used by the insurer in establishing premium rates for applicable health insurance plans that a small employer insurer is in compliance with the provisions of AS 21.55.120;

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

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

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

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

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

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

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

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

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

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

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

an employee who works on a part-time, temporary, or substitute basis;

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

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

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

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

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

(A) the individual

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

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

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

(B) the individual is employed by an employer who offers multiple health

benefit plans and the individual elects a different health benefit plan during an open enrollment period; or

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

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

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

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

(21) "premium" means money paid by a small employer and eligible employees as a condition of receiving coverage from a small employer insurer and includes fees or other contributions associated with the health benefit plan;

(22) "qualifying previous coverage" and "qualifying existing coverage" mean benefits or coverage provided under

(A) Medicare or Medicaid;

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

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

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

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

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

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

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

(28) "standard health benefit plan" means a health benefit plan developed under AS 21.55.140;

(29) "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.

* Sec. 4. AS 21.86.260(a) is amended to read:

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

* Sec. 5. AS 21.87.340 is amended to read:

Sec. 21.87.340. OTHER PROVISIONS APPLICABLE. In addition to the provisions contained or referred to previously in this chapter, the following chapters and provisions of this title also apply with respect to service corporations to the extent applicable and not in conflict with the express provisions of this chapter and the reasonable implications of the express

provisions, and for the purposes of the application the corporations shall be considered to be mutual "insurers":

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

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

(1) the percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period; in the case of a health benefit plan

into which the small employer insurer is no longer enrolling new small employers, the small employer insurer shall use the percentage change in the base premium rate, provided that the change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan into which the small employer insurer is actively enrolling new small employers; and

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

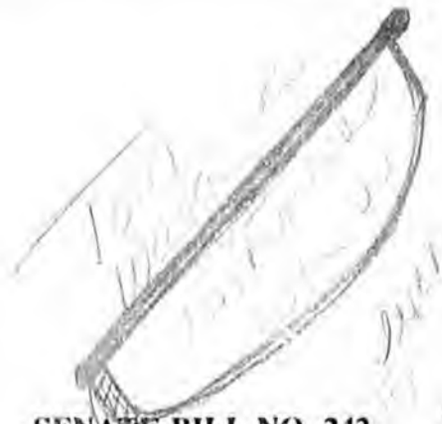
* Sec. 7. TRANSITION. (a) Within 180 days after the board is appointed under AS 21.55.020, enacted in sec. 3 of this Act, the board of directors of the Small Employer Health Reinsurance Association shall submit a small employer health benefit plan to the director of the division of insurance for approval. If the association fails to submit a suitable plan of operation, the director may, after notice and hearing, adopt reasonable regulations necessary or advisable to effectuate the provisions of this chapter. These regulations continue in force until modified by the director or superseded by a plan submitted by the association and approved by the director.

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

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

(d) The Health Benefit Plan Committee, enacted in sec. 3 of this Act, shall submit the required health benefit plans within 180 days after the members of the committee are appointed.

* Sec. 8. This Act takes effect July 1, 1992.



SENATE BILL NO. 242

IN THE LEGISLATURE OF THE STATE OF ALASKA

SEVENTEENTH LEGISLATURE - FIRST SESSION

BY SENATOR COLLINS

Introduced: 4/5/91
Referred: L&C, HES, Finance

A BILL

FOR AN ACT ENTITLED

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

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

* **Section 1.** FINDINGS. The legislature finds that

(1) an unacceptable number of residents of this state are without appropriate health care because of the rapid increase in the cost of health care, the lack of access to health care, and the lack of availability of health insurance coverage;

(2) maintenance of proper coverage of employees and dependents of employees of small employers under a health benefit plan is important to ensuring the availability of appropriate health care for the residents of this state and provides more stability and predictability of both rate increases and coverage continuation.

* Sec. 2. AS 21 is amended by adding a new chapter to read:

CHAPTER 55. SMALL EMPLOYER HEALTH INSURANCE.

ARTICLE 1. SMALL EMPLOYER HEALTH REINSURANCE ASSOCIATION.

Sec. 21.55.010. CREATION; MEMBERSHIP. There is established a nonprofit incorporated legal entity to be known as the Small Employer Health Reinsurance Association. Membership consists of all licensed hospital or medical service corporations in the state that offer subscriber contracts for health benefits, all welfare arrangements, and all insurers licensed to transact health insurance in the state that offer a health benefit plan. All members shall maintain membership in the association as a condition of doing health insurance business, or being able to offer subscriber contracts, in the state.

Sec. 21.55.020. BOARD OF DIRECTORS; ORGANIZATION. (a) The board of directors of the association consists of nine individuals selected by participating members, subject to approval by the director. The director or the director's designee shall serve as a nonvoting ex officio member of the board. In approving members of the board, the director shall consider, among other things, whether all types of participating members are fairly represented.

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

Sec. 21.55.030. GENERAL POWERS. The association may

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

(2) sue or be sued;

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

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

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

(6) design the array of health coverage products for which reinsurance will be

provided and issue reinsurance policies;

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

(8) establish appropriate rates, rate schedules, rate adjustments, rate classifications, and other actuarial functions appropriate to the operation of the association;

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

(10) appoint from among members appropriate legal, actuarial, and other committees as are necessary to provide technical assistance in the operation of the association.

Sec. 21.55.040. PLAN OF OPERATION. (a) The association shall submit to the director a plan of operation and amendments necessary or suitable to assure the fair, reasonable, and equitable administration of the association. The plan of operation and amendments become effective upon approval in writing by the director. If the director has not approved or disapproved a plan of operation submitted by the association within 90 days after receiving the plan of operation, the plan of operation is considered approved by the director. If the association fails to submit a suitable plan of operation by a date that is 180 days after the effective date of this Act, or if at subsequent time the association fails to submit suitable amendments to the plan, the director may, after notice and hearing, adopt reasonable regulations necessary or advisable to effectuate the provisions of this chapter. These regulations shall continue in force until modified by the director or superseded by a plan submitted by the association and approved by the director.

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

(c) The plan of operation must

(1) establish procedures for the performance of the powers and duties of the association under this chapter;

(2) establish procedures for handling assets of the association and for an annual fiscal report to the director;

(3) establish the amount and method of reimbursing members of the board under AS 21.55.020;

(4) establish regular places and times for meetings of the board;

(5) establish procedures for records to be kept of all financial transactions of the association, its agents, and the board;

(6) provide that a member insurer aggrieved by a final action or decision of the association may appeal to the director within 30 days after the action or decision;

(7) establish procedures for the submission to the director of selections for the board;

(8) provide for reinsuring risks under the provisions of this section;

(9) provide for collecting assessments from all members to provide for claims reinsured by the association and for administrative expenses incurred or estimated to be incurred during the period for which the assessment is made;

(10) provide protection for guaranteed issue insurers from the financial risk associated with small employers that present poor credit risks;

(11) establish standards for the coverage of small employers that have high employee turnover;

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

(13) determine the adjusted average market premium prices for small employer health plans sold in this state;

(14) establish participation standards at issue and renewal for reinsured cases;

(15) establish and maintain a list of guaranteed issue insurers;

(16) 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; and

(17) provide for selection of an administering insurer and establish the administering insurer's powers and duties;

(18) contain additional provisions necessary or proper for the execution of the powers and duties of the association.

Sec. 21.55.050. HEALTH CARE REINSURANCE. (a) A member may only reinsure coverage of an eligible employee of a small employer or a dependent of an eligible employee of a small employer with the association 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;

(3) regarding the coverage provided to small employers, the insurer or welfare arrangement, 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;

(4) regarding eligible employees, and their dependents, who are hired subsequent to the commencement of the employer's coverage by an insurer, welfare arrangement, or other benefit arrangement and who are not late enrollees, coverage may be reinsured by a nonguaranteed issue insurer within 60 days of the commencement of coverage under the plan;

(5) regarding eligible employees, and their dependents, who are hired subsequent to the commencement of the employer's coverage by a guaranteed issue insurer and who are not late enrollees, coverage may be reinsured by the guaranteed issue insurer

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

(B) commencing 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) regarding eligible employees, and their dependents, who are employed by a small employer as of the date the employer's coverage by the guaranteed issue insurer commences, coverage may be reinsured

(A) within 60 days of the commencement of the employer's coverage with the insurer or welfare arrangement, or other benefit arrangement except in the case of late enrollees; or

(B) commencing 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;

(7) regarding eligible employees and their dependents, a guaranteed issue insurer

may reinsure the entire employer group

(A) within 60 days of the commencement of the group's coverage under the plan;

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

(C) commencing 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;

(8) regarding employees or dependents reinsured under (4), (5), or (6) of this subsection, reinsurance may not be provided until $5,000 in benefit payments have been made for services provided during that calendar year for that reinsured employee or dependent; in this paragraph "benefit payments" include those payments that would have been reimbursed through reinsurance in the absence of the annual $5,000 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.

(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 subsequent to 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 provided in (d) of this section, premium rates charged for coverage reinsured by the association shall be established as follows:

(1) for whole group reinsurance coverage, 1.5 multiplied by the adjusted average market premium price established by the association for that classification or group with similar characteristics and coverage, for eligible employees, and dependents of eligible employees, of a small employer all of whose coverage is reinsured with the association, minus a ceding expense factor determined by the association;

(2) for individual reinsurance coverage, 5.0 multiplied by the adjusted average

market premium price established by the association for an individual in that classification or group with similar characteristics and coverage, with respect to an eligible employee, or the employee's dependents, minus a ceding expense factor determined by the association.

(d) Premium rates charged for reinsurance by the association to a health maintenance organization that is approved by the Secretary of Health and Human Services as a federally qualified health maintenance organization under 42 U.S.C. 300 and, as a health maintenance organization, is subject to requirements that limit the amount of risk that may be ceded to the association, may be modified to reflect the portion of risk that may be ceded to the association.

(e) If a health benefit plan coverage for a small employer is entirely or partially reinsured with the association, the premium charged to the small employer for a rating period for the coverage issued under this section may not be more than 1.5 times the adjusted average market premium price established by the association for that classification or group with similar characteristics and coverage.

(f) In determining the assessment, if any, that is collected from a member, the following provisions apply:

(1) following the close of a fiscal year, the administering insurer shall determine the net premiums, the association expenses for administration and the incurred losses, if any, for the year, taking into account investment income and other appropriate gains and losses; for purposes of this subsection, health benefit plan premiums earned by an insurer, welfare arrangement, or other benefit arrangement shall be established by adding paid claim losses and administrative expenses of the insurer, welfare arrangement, or other benefit arrangement; health benefit plan premiums and benefits paid by a member that are less than an amount determined by the board to justify the cost of collection may not be considered for purposes of determining an assessment; in this paragraph, "net premiums" means health benefit plan premiums less administrative expense allowances;

(2) a net loss for the year shall be covered first by assessment against members to the extent provided as follows:

(A) assessments shall first be apportioned by the board among all members in proportion to the member's respective share of the total premiums net of reinsurance premiums paid for coverage under this chapter earned in this state from health benefit plans covering small employers and to the extent permitted under 29 U.S.C.

1001 - 1459, apportioned among other benefit arrangements covering small employers during the calendar year coinciding with or ending during the fiscal year of the association, or apportioned on another equitable basis reflecting coverage of small employers as may be provided in the plan of operation; an assessment shall be made under this subparagraph against a health maintenance organization that is approved by the secretary of health and human services as a federally qualified health maintenance organization under 42 U.S.C. 300e, subject to an assessment adjustment formula adopted by the board and approved by the director for qualified health maintenance organizations that recognizes the restrictions imposed on qualified health maintenance organizations under federal law; the adjustment formula shall be adopted by the board and approved by the director before the first anniversary of the operation of the association;

(B) an assessment under (2)(A) of this subsection shall be capped at four percent of premiums charged for health benefit plans covering small employers;

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

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

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

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

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

receiving a deferment shall remain liable to the association for the amount deferred; the director may attach conditions to a deferment.

Sec. 21.55.060. ADMINISTRATIVE PROCEDURE ACT. The association is exempt from the Administrative Procedure Act (AS 44.62).

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

Sec. 21.55.080. LIMITATION OF LIABILITY. A member of the association is not liable for civil damages resulting from an act or omission of the member on behalf of the association unless the member acts with gross negligence or intentional misconduct.

ARTICLE 2. SMALL EMPLOYER HEALTH INSURANCE PLANS.

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

(1) all or a portion of the premium or benefits is paid by a small employer or a covered individual is reimbursed, through wage adjustments or otherwise, 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 the offer of coverage of a health care service or benefit and other provisions of law requiring the reimbursement, utilization, or consideration of a specific category of a licensed or certified health care practitioner do not apply to a health benefit plan offered or delivered to a small employer.

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

(1) inhibit an insurer, welfare arrangement, or other benefit arrangement from contracting with providers or groups of providers regarding health care services or benefits;

(2) impose a restriction on the ability to negotiate with providers regarding the level or method of reimbursing care or services provided under the health benefit plan;

(3) require an insurer, welfare arrangement, or other benefit arrangement to either

include a specific provider or class of provider when contracting for health care services or benefits, or to exclude a class of provider that is generally authorized by law to provide health care.

Sec. 21.55.110. UNDERWRITING AND RATING REQUIREMENTS. Health benefit plans covering small employers and, to the extent permitted under 29 U.S.C. 1001 - 1459, other benefit arrangements covering small employers, are subject to the following provisions:

(1) preexisting conditions provisions may not exclude or limit coverage for a period beyond 12 months following the individual's effective date of coverage and may only relate to conditions that had, during the six months immediately preceding the effective date of coverage, occurred in a manner that would cause an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment or for which medical advice, diagnosis, care, or treatment was recommended or received, or that related to a pregnancy existing on the effective date of coverage;

(2) in determining whether a preexisting condition limitation provision applies to an eligible employee or dependent, all health benefit plans shall credit the time the person was covered under a previous employer based health benefit plan provided by an insurer or welfare arrangement if the previous coverage was continuous to a date not more than 30 days before the effective date of the new coverage, exclusive of the applicable service waiting period under the health benefit plan;

(3) the health benefit plan and, to the extent permitted under 29 U.S.C. 1001 - 1459, other benefit arrangements covering small employers must be renewable with respect to all eligible employees or dependents at the option of the policyholder, contract holder, or small employer except for

(A) nonpayment of the required premiums by the policyholder, contract holder, or employer;

(B) noncompliance with health benefit plan provisions;

(C) a health benefit plan of an employer under which the total number of insured individuals covered under all of the health benefit plans of one employer is less than the total number of individuals or percentage of individuals required by participation requirements under a specific health benefit plan of that employer; or

(D) a health benefit plan issued by an insurer or welfare arrangement that

ceases doing business in the small employer market under AS 21.55.140;

(4) notwithstanding (3) of this section, a health benefit plan or coverage provided to an individual covered by a health benefit plan subject to the provisions of this chapter may be rescinded, cancelled, or not renewed for fraud, material misrepresentation, or concealment by an applicant, employee, dependent, or small employer or an agent of an applicant, employee, dependent, or small employer;

(5) an insurer or a welfare arrangement, and, to the extent permitted by 29 U.S.C. 1001 - 1459, a benefit arrangement may not exclude an eligible employee or dependent who would otherwise be covered under a health benefit plan on the basis of an actual or expected health condition of the person, except that an insurer, welfare arrangement, or other benefit arrangement may exclude a late enrollee for the greater of 18 months or the remainder of the three-year reinsurance period, as provided under AS 21.55.060;

(6) an insurer or a welfare arrangement doing business in the small employer market retains the authority to underwrite and rate small employer groups using accepted underwriting and actuarial practices; small employer groups that are declined because they fail to satisfy insurer or welfare arrangement underwriting requirements shall be notified by the insurer or welfare arrangement that the insurer or welfare arrangement will not issue a health benefit plan to the small employer, that the small employer is eligible for a small employer health plan provided by a guaranteed issue insurer, and shall be provided with a list, prepared by the board, containing the address, telephone number, and service area of all guaranteed issue insurers;

(7) a health benefit plan issued by a insurer, welfare arrangement, or, to the extent permitted by 29 U.S.C. 1001 - 1459, another benefit arrangement, 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 or diseases as permitted under (1) of this section;

(8) a health benefit plan and, to the extent permitted by 29 U.S.C. 1001 - 1459, another benefit arrangement shall make coverage available to eligible employees of a small employer without a service waiting period, except that a small employer may impose a service waiting period for eligible employees of the small employer if the small employer chooses from the service waiting periods offered by the insurer or welfare arrangement; a service waiting period offered by an insurer or welfare arrangement may not exceed 90 days;

(9) the benefit structure of a health benefit plan subject to the provisions of this chapter may be changed by the insurer or welfare arrangement to make it consistent with the benefit structure contained in a health benefit plan being marketed to new groups;

(10) regarding a health benefit plan of an insurer or welfare arrangement, the premium rates charged or offered for a rating period for the same or similar coverage under a health benefit plan covering a small employer with similar case characteristics as determined by the insurer or welfare arrangement may not vary from the applicable midpoint rate by more than 35 percent of the applicable midpoint rate, as to

(A) a health benefit plan issued on or after July 1, 1991; and

(B) within three years after July 1, 1991, for a health benefit plan issued before July 1, 1991;

(11) regarding a health benefit plan issued before July 1, 1991, if an insurer or welfare arrangement charged or offered a premium rate for the same or similar coverage under a health benefit plan covering a small employer with similar case characteristics as determined by the insurer or welfare arrangement, and the premium rate exceeds the applicable midpoint rate by more than 35 points of the applicable midpoint rate, an increase in premium rates for a new rating period may not exceed the sum of

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

(B) an adjustment due to a change in case characteristics or plan design of the small employer, as determined by the insurer or welfare arrangement;

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

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

(A) a percentage change in the base premium rate measured from the first day of the prior rating period to the first day of the new rating period plus 15 percent, adjusted on a pro rata basis 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 of the small employer, as determined by the insurer or welfare arrangement;

(14) when offering for sale a health benefit plan to a small employer, an insurer or welfare arrangement shall make a reasonable disclosure as part of its solicitation and sales materials of

(A) the extent to which premium rates for a specific small employer are established or adjusted in part based on the actual or expected variation in claims costs or actual or expected variation in health condition of the employees and dependents of the small employer;

(B) the provisions concerning the insurer's or welfare arrangement's right to change a premium rate; and

(C) provisions relating to renewability of a policy or contract;

(15) compliance with the underwriting and rating requirements contained in this chapter shall be demonstrated through actuarial certification; insurers or welfare arrangements offering a health benefit plan to a small employer shall file annually with the director an actuarial certification stating that the underwriting and rating methods of the insurer or welfare arrangement

(A) comply with accepted actuarial practices;

(B) are uniformly applied to health benefit plans covering small employers; and

(C) comply with the provisions of this chapter.

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

(b) Guaranteed issue insurers may

(1) reinsure an individual with a group or may reinsure an entire group subject to the provisions of AS 21.55.060;

(2) as provided for in the association's plan of operation,

(A) require advance premium deposits for poor credit risks; and

(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 guaranteed issue carrier is

experiencing an unfair share of administrative or credit risk; if the board determines that a guaranteed issue carrier has experienced an unfair burden, the board may grant the guaranteed issue carrier a decreased reinsurance price to offset administrative expenses or temporarily suspend the guaranteed issue insurer's requirement to guarantee issue.

Sec. 21.55.130. SMALL EMPLOYER HEALTH BENEFIT PLANS. (a) The board shall design small employer health benefit plans that are eligible for reinsurance by the association. The board shall establish the form and level of coverage to be made available by insurer or welfare arrangements, and to the extent permitted under 29 U.S.C. 1001 - 1459, other benefit arrangements in the small employer health benefit plans. In designing the small employer health benefit plans, the board shall also establish benefit levels, deductibles, coinsurance factors, exclusions, and limitations for the small employer health benefit plans. The form and level of coverage established by the board must specify those components of a health benefit plan offered by an insurer of a small employer that may be reinsured.

(b) A small employer health benefit plan may include cost containment features including, but not limited to

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

(2) case management benefit alternatives;

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

(4) reasonable benefit differentials applicable to participating and nonparticipating providers; and

(5) other provisions for the cost effective management of a small employer health benefit plan.

(c) The small employer health benefit plan established for use by health maintenance organizations must be consistent with the basic method of operation of health maintenance organizations.

(d) A small employer health benefit plan shall be submitted to the director for approval.

(e) After the director's approval of the small employer health benefit plans submitted by the board, an insurer or welfare arrangement, or, to the extent permitted by 29 U.S.C. 1001 - 1459, other benefit arrangements may certify to the director, in the form and manner prescribed

by the director, that the small employer health benefit plans filed by the insurer or welfare arrangement, or other benefit arrangement are in substantial compliance with the provisions in the corresponding approved board plan. Upon receipt by the department of certification described in this subsection, the insurer or welfare arrangement, or other benefit arrangement may use the certified 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 or a welfare arrangement may cease doing business in the small employer market if the insurer or welfare arrangement provides notice of the decision to cease doing business in the small employer market to the division, the board, the policyholder or contract holder, and the employer, and coverage under a health benefit plan subject to this chapter is continued for one year after the date of the notice required under this section. An insurer or a welfare arrangement that ceases doing business in the small employer marketplace may not reenter the small employer marketplace for a period of five years from the date of the notice required under this section.

Sec. 21.55.250. DEFINITIONS. In this chapter,

(1) "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;

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

(3) "base premium rate" means

(A) as to a health benefit plan covering one or more employees of a small employer, the lowest new business premium rate prescribed by the insurer or welfare arrangement for the same or similar coverage under a plan or arrangement covering a small employer with similar case characteristics; and

(B) as to an insurer or welfare arrangement not issuing a new health benefit plan to a small employer, the lowest rate charged a small employer for the same or similar coverage under a plan covering a small employer with similar case characteristics;

(4) "board" means the board of directors of the association;

(5) "case characteristics" means with respect to a small employer, the geographic

area in which the employees reside, the age and sex of the individual employees and dependents, the appropriate industry classification as determined by the insurer or welfare arrangement, or other benefit arrangement, the number of employees and dependents and other objective criteria as may be established by the insurer or welfare arrangement, or other benefit arrangement;

(6) "dependent" means the spouse or child of an eligible employee, subject to applicable terms of the health benefit plan covering the employee;

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

(8) "financially impaired" means a member that is not insolvent but is

(A) determined by the director to be potentially unable to fulfill the member's contractual obligations; or

(B) placed under an order of rehabilitation or conservation by a court of competent jurisdiction;

(9) "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, except that an insurer wishing to become a guaranteed issue insurer shall notify the board of the insurer's intention to become a guaranteed issue insurer one year in advance of the insurer becoming a guaranteed issue insurer;

(10) "health benefit plan" means a hospital or medical expense policy, health, hospital, or medical service corporation contract, a plan provided by an insurer or welfare arrangement, and a health maintenance organization contract offered by an employer, but does not include a policy covering only accident, credit, dental, disability income, long-term care, hospital indemnity, Medicare supplement, specified disease, vision care, coverage issued as a supplement to liability insurance, worker's compensation insurance, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in a liability insurance policy or equivalent self-insurance;

(11) "initial enrollment period" means the period of time specified in the health benefit plan during which an individual is first eligible to enroll in a small employer health benefit plan; the period of time may not be less than 30 days nor more than 60 days commencing on the day following the end of a service waiting period required by the small employer of all employees before the employees are eligible to participate in a small employer health benefit plan;

(12) "insurer" has the meaning given in AS 21.90.900 and includes a health maintenance organization, a hospital service corporation, and a medical service corporation;

(13) "late enrollee" means an eligible employee or dependent who requests enrollment in a small employer's health benefit plan following the initial enrollment period provided under the terms of the first plan for which the employee or dependent was eligible through the small employer, except that an eligible employee or dependent may not be considered a late enrollee if

(A) the individual

(i) was covered under another employer provided health benefit plan at the time the individual was eligible to enroll;

(ii) states, at the time of the initial eligibility, that coverage under another employer health benefit plan was the reason for declining enrollment;

(iii) has lost coverage under another employer health benefit plan as a result of the termination of employment, the termination of the other plan's coverage, death of a spouse, or divorce or dissolution of marriage; and

(iv) requests enrollment within 31 days after the termination of coverage under another employer health benefit plan; or

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

(C) a court has ordered coverage to be provided for a spouse or minor child under a covered employee's plan and request for enrollment is made within 31 days after issuance of the court order;

(14) "member" means all insurers issuing health benefit plans, welfare arrangements and, to the extent permitted under 29 U.S.C. 1001 - 1459 (Employee Retirement

Income Security Act), other benefit arrangements providing health benefit plans in this state;

(15) "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;

(16) "other benefit arrangement" means a health benefit plan offered by a small employer who is in whole, or in part, self-insured;

(17) "plan of operation" means the articles, bylaws, and operating rules of the association adopted by the board;

(18) "preexisting conditions provision" means a policy provision that excludes or limits coverage for charges or expenses incurred during a specified period following the insured's effective date of coverage as to a condition that, during a specified period immediately preceding the effective date of coverage, had manifested itself in a manner that would cause an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment, or for which medical advice, diagnosis, care, or treatment was recommended or received and includes a pregnancy existing on the effective date of coverage;

(19) "service waiting period" means a period of time after full-time employment begins before an employee is first eligible to enroll in an applicable health benefit plan offered by the small employer;

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

(21) "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.

* **Sec. 3.** AS 21.86.260(a) is amended to read:

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

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

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

(1) AS 21.03

(2) AS 21.06

(3) AS 21.09, except AS 21.09.090

(4) AS 21.18.010

(5) AS 21.18.030

(6) AS 21.18.040

(7) AS 21.18.120

(8) AS 21.21.321

(9) AS 21.36

(10) AS 21.42.345 - 21.42.365

(11) AS 21.51.120

(12) AS 21.53

(13) AS 21.54.020

(14) **AS 21.55**

(15) AS 21.69.400

(16) [(15)] AS 21.69.520

(17) [(16)] AS 21.69.600, 21.69.620, and 21.69.630

(18) [(17)] AS 21.78

(19) [(18)] AS 21.89.040

(20) [(19)] AS 21.89.060

(21) [(20)] AS 21.90.

* Sec. 5. TRANSITION. Within 180 days after the board is organized under AS 21.55.020, enacted in sec. 2 of this Act, the board of directors of the Small Employer Health Reinsurance Association shall submit a small employer health benefit plan to the director of the division of insurance for approval. Notwithstanding AS 21.55.120(a), enacted in sec. 2 of this Act, a guaranteed issue insurer is not required to offer a small employer a health benefit plan until 60 days after the director of the division of insurance has approved a small employer health benefit plan.

* Sec. 6. This Act takes effect July 1, 1991.

POSITION PAPER

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

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

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

Pg2, Line 2 Section 2 should be broadened to prohibit violation of any provision of Chapter 55 by any person. The prohibition should not be limited to some licensed individuals or to one section of the law.

Pg2 Line 18 AS 21.55.020(a) should delete the director as an ex-officio member of the board. The director cannot be in a position of regulating the activities of the small employer health reinsurance association and be a member of its administrative arm.

Pg 2 Line 25 AS 21.55.020(b) should delete the exception to the Division of Insurance's expenses. This program should be self-supporting. Furthermore, the division by statute is funded by fees for services provided.

Pg 3 Line 31, Pg 4, Line 1 AS 21.55.040 provides for the sharing of program gains. A legal opinion and perhaps a tax accountant's opinion should be secured to determine if reinsurers' sharing of gains would adversely affect the nonprofit status of the association and make it subject to taxation by the Internal Revenue Service.

Pg 3, Line 27 AS 21.55.040 should require that the plan of operation establish procedures to be self-supporting and fiscally sound.

Pg 4, Line 29 AS 21.55.050(a)(5) should allow the association to reimburse a reinsuring insurer if the insurer has paid the initial level of claims rather than when the insurer has incurred the initial level of claims. Reinsurers traditionally reimburse after the primary insurer has paid the loss, not when the primary insurer has reserved the loss.

Pg 7 Line 1

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

Pg8, Line1

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

P8, Line 7

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

Pg8, Line 22

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

Pg9, Line 28

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

Pg10, Line 26

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

Pg 13, Line 22

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

Pg 14, Line 19

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

Pg 16, Line 20

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

Pg 18 lines 7+16

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

Pg 21, line 21

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

Nancy Bear Usera, Commissioner
Department of Administration

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

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

Date: 4-13-92

6091c
041392a

Dep ment of Commerce
& Economic Development / POSITION PAPER

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

The department is in favor of this legislation.

One of the more challenging issues facing this country and Alaska is the ever-increasing number of people unable to afford or even find health care insurance. Persons going from one employer to another who have acquired a medical condition find themselves, in too many cases, uninsurable.

Certain underlying conditions need to be met to satisfy public expectations of a health insurance market that can continue to be provided by private health insurers. These include: guaranteed access to coverage; coverage for entire groups, renewability of coverage; limits on pricing; and continuity of coverage. This legislation addresses these issues by establishing a reinsurance mechanism comprised of all entities writing health care coverages in Alaska. Through this mechanism, coverage is made available that provides that the preexisting conditions restriction is applicable to a person only one time. Once a covered person has satisfied the plans preexisting condition restriction, he or she would not have to again face the restrictions when changing employers or insurance company. The plan contained in the bill assures availability of coverage, prevents picking and choosing of employees in a group, assures renewability and places a cap on premium increases.

This legislation gives the private health care insurance system an opportunity to address these challenges.

Asst. Comm.

Glenn A. Olds, Commissioner

Date: 4-18-91

GAO/DK/dgl9415D
041891b

STATE OF ALASKA

WALTER J. HICKEL, GOVERNOR

DEPARTMENT OF COMMERCE & ECONOMIC DEVELOPMENT

7th FLOOR FRONTIER BLDG.
3601 C STREET, SUITE 740
ANCHORAGE, ALASKA 99503-5934
PHONE: (907) 562-3626

DIVISION OF INSURANCE

December 20, 1991

Ms. Melissa Fouse
Office of Sen. Arlis Sturgelewski
3111 C Street, Suite 550
Anchorage, AK 99503

Re: Notes and Questions to SB 242

In accordance with the above-referenced questionnaire dated September 16, 1991, the Division of Insurance provides the following responses:

2) Does the legislature wish, as a matter of public policy, to allow the association to design health coverage products or does the Legislature wish to examine models that set out basic health care plans and incorporate them into the bill.
   We advise the legislature to adopt NAIC's model bill on health coverage products.

3) The director of the division of insurance is required to approve the plan of operation for the Association. However, if the Association does not submit a plan, the director is required to adopt regulations governing the operation of the association.

   Should the director be required to take action that the Association fails to take?
   The director should not be required to design the program if the association fails to take action.

4) Should the director be an arbiter for the association? The bill provides that a member may appeal to the director from association action or decision.
   The director should not be an arbiter.

5) Is there an industry standard for poor credit risks? What does this mean?
   This bill is addressing people who do not necessarily pay their bills and there is no specific industry standard standard for poor credit risks to my knowledge.

6) Under what circumstances does the bill envision a guaranteed issue insurer would not be required to write business received from a particular agency or broker?
   An insurer always has the right to reject business from a broker or agent who has proved not to pay the bills to the insurer.

7) What kind of plan does the bill envision being reinsured here?
The plan would be one established by the Association, to be called the Small Employer Health Benefit Plan. It is difficult to say what this plan would look like, as it would be a product of the Association with input from the director of the Division of Insurance.

8) Should the legislature, as a matter of public policy, enumerate a standard of cost-containment beyond which the association may not go, i.e., can the association limit choice of physicians?
Technically, the Association could limit the choice of physicians if it is a pure preferred provider agreement arrangement. However, the Association can protect itself against such by modifying the contract to a scheduled benefit arrangement, which means the member would only pay a specific amount for a specific treatment.

12) Should the bill cap the amount of the deductible or should the board be able to change the amount? Does this section authorize the board to change the amount of the deductible without going through the director?
The board should be able to change the amount of the deductible. However, the board would have to gain approval from the director of the Division of Insurance to change the deductible.

13) Are the premium rates in this section the rates charged by the reinsurance association to the insurer or the rates charged by the insurer to the employer?
The bill addresses the premium rates charged to the insurer as well as those charged to the employer. At present, the reinsurance association could charge the insurer up to 1.5 times the rates established by the association for whole group or up to 5 times the standard rates for an individual. The insurer can charge the employer a maximum of 1.5 times the rates, also established by the association.

14) Who is responsible for paying for the program if the costs exceed the four percent assessments to the members?
If insufficient funds exist after the assessment of four percent, the Association will have to pick up loans or modify the contracts accordingly so that the bills can be paid. Technically, there is no one else responsible for paying for the program if the costs exceed the four percent assessment to the members.

15) Should the director, rather than the board, be allowed to grant deferments. Does this create liability on the part of the state to make up the difference if the insurer doesn't pay?
It is not recommended that the state be responsible to make up the difference if the insurer doesn't pay. The director, in coordination with the board, may be allowed to grant deferments.

16) Does the Legislature wish to use this standard of proof for exempting from liability for acts or omissions on the part of a member of the association?
This is an issue that the Legislature should address.

17) Does the Legislature intend to exempt current statutory requirements for services and payments to providers from this bill?

It doesn't appear that the Legislature intends to exempt current statutory requirements for services and payments to provider from this bill.

18) Does the Legislature wish to give the Association the authority to limit access to providers by insured?

This decision would have to be made by the board and the director, versus by the Legislature.

19) The effect of this section may be to prevent persons from seeking medical care in the six months prior to being covered.

This bill does not allow a service waiting period in excess of 90 days. The six months pertain to pre-existing conditions and would not pay service for such.

20) Should pregnancies be exempt from coverage?

Pregnancy should not be exempt from coverage.

21) This subsection does not make it clear if a plan may be changed at any time or only upon renrewal.

While it is not clearly addressed, plans generally are changed only upon renewal and would be a standard condition that the board as well as the director would request.

22) An example of possible premium spread among individuals with similar case characteristics under this bill is as follows:

Allowable variation is monthly premium based on industry classification (15 percent variation) - low, $127.50; midpoint $150.00; high $172.50. Highest possible premium (35 percent above high risk business group midpoint) - $232.87. Lowest possible premium (35 percent below risk business group midpoint) - $82.87. Spread between lowest premium and highest premium among individuals with similar case characteristics - 280 percent.

This is not entirely clear. At present, an insurer still could charge 1.5 times the standard rate and it does not clearly address a discount for good experience.

I hope this clarifies the issues you brought to our attention. Please feel free to contact me if you need to discuss the matter further.

Sincerely,

Thelma Snow Walker

Thelma Snow Walker
Deputy Director

TSW/ngk
0522Y

MEMORANDUM State of Alaska

TO: Thelma Snow Walker, Deputy Director
Division of Insurance

DATE: December 20, 1991

FILE NO:

TELEPHONE NO:

THRU:

SUBJECT: SB 242 Introduced by Senator Collins on 4/5/91

FROM: Christian F. Ulmann
Insurance Market Analyst

This memo serves as an addition to our position paper on the named SB 242 dated 4/18/91.

This bill seems to have been created with focus on AVAILABILITY. This goal is fully achieved by the structure of such bill.

However, the AFFORDABILITY is a matter which needs to be further discussed. After further study, we are in a position to offer some observations and suggestions:

This bill will most likely increase the average cost of group health insurance. Such is possible because even insurers which are not guaranteed issue insurers will be assessed by the proposed SMALL EMPLOYER HEALTH REINSURANCE ASSOCIATION (SEHRA) for claims reinsured by SEHRA and administrative expenses ([Sec. 21.55.040 Plan of Operation (c) (9)]). Further, if a health benefit plan coverage for a small employer is entirely or partially reinsured by SEHRA, the premium charged to the small employer may not be more than 1.5 times the adjusted average market premium price established by SEHRA for that classification or group with similar characteristics and coverage ([Sec. 21.55.050 Health Care Reinsurance (e)]). SEHRA will charge the insurer a premium for whole group reinsurance of 1.5 times the adjusted average market premium price established by SEHRA and up to 5 times the same for an individual. If such amounts do not cover the loss expenses for SEHRA, then assessment on the members will be made.

At the present time, we observe that group and community-rated plans are more expensive than individual coverage. Some insurers have made good groups of insureds their target. These insurers offer an individual policy for much less money. As a result, we have seen that some employers offer their employees the option of buying from them an individual policy if such employee qualifies.

This means that some employees have no coverage, others do. This practice would not be stopped by this bill, but rather would enhance it. There is another very important issue; apparently it is assumed that nothing in the marketplace is subject to change but the contrary is true. We see more and more rather large groups that would also be subject to assessment by SEHRA, leaving the marketplace by becoming self-insured. Just imagine the impact it would have on the assessments if the State employees would become self-insured. An employer would be forced in some cases not to provide insurance at all or buy individual policies for the employees. While this is pretty much the same scenario we have today, at least there is no burden of assessments. In any scenario this assessment approach creates a severe injustice by only assessing the insured and not assessing the self-insured group. We are not assured that the assessments would affect a Multiple Employers Trust Arrangment whereas the policy is issued and delivered in another state. This could be significant for assessment purposes. Further, it must be kept in mind that any system that increases the cost of insurance to the insurance buying population results in people leaving the marketplace and increases the number of uninsured. This again has the effect of increased cost shifting from the uninsured population to the insured population.

Recommendations

While we believe that expanded group insurance is part of the solution, we suggest a reconsideration of the top premiums to be charged to the employer. This might be possible by capping the maximum increase at 30 %. Also the assessment approach might be modified by creating additional revenue sources for SEHRA, i.e., employer tax, change in tobacco/alcohol tax, etc.

We also must keep in mind that this bill will put the insurance industry in the driver seat and the industry is not assuming any risk by being subject to this arrangment.

CU/cjk
0337k

HIAA

Health Insurance Association of America

May 17, 1991

The Honorable Arliss Sturgulewski
Alaska State Senator
P. O. Box V
Juneau, AK 99811

Dear Senator Sturgulewski:

Thank you very much for the courtesies you and the members of the Senate HESS Committee afforded me during both hearings on SB-242.

During the May 15 hearing, Mr. Skaggs recommended that during the committee's interim study on SB-242, they review the different premiums to be charged varying size small employer groups under SB-242. While the request appears simple on the surface, it is not -- in fact, it is impossible. The promise of guaranteed availability included within SB-242, relies on a reinsurance mechanism for those small employer groups or the individuals within those groups which otherwise would be considered uninsurable risks. The reinsurance mechanism in SB-242 provides access to individuals within the groups not previously eligible for insurance, similar to Mr. Skaggs' son. The Small Employer Reinsurance Association Board created by SB-242 is charged with the responsibility of designing the health plans and the benefits contained in those plans which would be eligible for reinsurance. As the reinsurance association board will not be formed until SB-242 is enacted, it is not possible to assume what the premiums for the health plans will be, let alone the varying premium prices by group size.

SB-242 increases access to insurance by guaranteeing availability to groups and individuals within those groups who were previously considered medically uninsurable. SB-242 also requires premium pricing limits, that is, the amount insurers may vary their rates for groups similar in geography, demographic composition and plan design. The rates will vary by insurance company as the rating limitations are based on each insurance company's variance from the midpoint of their similar type groups.

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Also during the May 15 hearing, the recent MacNeil-Lehrer report on access to care was mentioned. HIAA President Carl Schramm was one of the panel discussing access to care. Enclosed is a copy of the videotape of that television presentation.

HIAA submitted an article for the JAMA issue devoted to access, however, rather than including it in the May special issue, JAMA has indicated that it will publish it later this summer. A copy of that article is also enclosed.

If I can be of any further assistance to you, or the committee during its interim study on SB-242, please do not hesitate to contact me.

Sincerely,

Jan Andrea Meisels
State Affairs Associate

JAM:mlp

cc: Senator Virginia Collins
Gordon Evans

HIAA

Health Insurance Association of America

May 17, 1991

Mr. Sam Skaggs
709 Gold Street
Juneau, AK 99801

Dear Mr. Skaggs:

Thank you very much for your support of the HIAA small employer market reform legislation -- Alaska SB-242. Our proposal incorporates a comprehensive set of small group market reforms that we believe can be achieved in the context of a viable private marketplace. The changes SB-242 require provide substantially more predictability and protection to the purchasers of coverage:

Guaranteed availability -- all small employer groups would be able to obtain private health insurance regardless of the health risk they present;

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

Renewability of coverage -- employer groups and/or individuals in these groups, at renewal time, would be assured that their coverage would not be canceled because of deteriorating health;

Continuity of coverage -- once a person is covered in the small employer market and satisfied a plan's preexisting condition restrictions, he or she would not have to meet those requirements again when changing jobs or when the employer changes carriers; and

Premium pricing limits -- insurance carriers would be required to limit how much their rates could vary for groups similar in geography, demographic composition and plan design.

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Under our proposal, as a small employer of between 3-25 employees, your cerebral palsied child would be eligible for insurance due to the guaranteed availability portion of our proposal which increases accessibility to insurance to small groups that have otherwise medically uninsurable risks. Your son's coverage, included in your employer plan, would most likely be reinsured by the guaranteed issue carrier. Only the benefits included in the health plans designed by the Small Employer Health Reinsurance Association are eligible for reinsurance. As the Small Employer Health Reinsurance Association Board will not be formed until the legislation is enacted, it is not possible to determine what benefits would be included in the health plans, and, therefore, it is not possible to know the proposed plan premium rates until the board has designed them. Therefore, it is not possible for the Senate HESS Committee, during its interim study, to review the various premium rates for differing size small employers' policies under SB-242.

Again, on behalf of the Health Insurance Association of America, we are very appreciative of your testimony in support of SB-242. If you have any questions regarding SB-242, please do not hesitate to contact me directly or through our Alaska-retained counsel, Gordon Evans.

Sincerely,

Jan Andrea Meisels
State Affairs Associate

JAM:mlp

cc: Senator Virginia Collins
Senator Arliss Sturgulewski
Gordon Evans

HIAA

Health Insurance Association of America

April 23, 1991

Ms. Melissa Fouse
Senior Advisor
Office of Senator Arliss Sturgulewski
Alaska State Legislature
P. O. Box V
Juneau, AK 99811

Dear Melissa:

Thank you for meeting with Gordon Evans and myself when I was in Juneau last week, regarding SB-242. I hope that you have had time to review the bill and my written statement which describes, section-by-section, the provisions contained in SB-242. The Health Insurance Association of America and its 300 member companies believe Senator Collins' bill is the most appropriate mechanism to provide Alaska's small employers and their employees with guaranteed availability, renewability and rate predictability of health insurance rates. The Alaska Division of Insurance has given SB-242 a strong recommendation for passage this session, and has placed a fiscal note of only $6,000 in the first and $1,500 in each of the following years. SB-242 does not require the establishment of a government bureaucracy to set health care provider rates, but it does provide coverage for medically necessary care.

I hope that you have had the opportunity to discuss our legislation with Senator Sturgulewski and to discuss with her the possibility of cosponsoring SB-242. If you have any questions regarding the legislation, please feel free to contact me at the telephone number listed below or our local, retained counsel, Gordon Evans.

Sincerely,

Jan Andrea Meisels
State Affairs Associate

JAM:mlp

cc: Gordon Evans

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HIAA

ON HEALTH CARE FINANCING FOR ALL AMERICANS

SIMPLIFIED NUMERICAL RATING LIMIT ILLUSTRATIONS

Year 1991

Typical Employer[1] - Carrier XYZ is selling a health plan to a typical employer at a midpoint premium rate that amounts to $200 per month, per employee (i.e., this figure would be an average of the premiums for some single persons and some families). The employer pays, on average, 80 percent of the premium ($160); the employee pays 20 percent of the premium ($40).

Low Risk Employer - While a second employer has similar demographic, area, and industrial composition as the typical employer, it has, on, average a very low health risk. Because the employer is low risk, Carrier XYZ agrees to sell coverage at a rate which is 35 percent below the midpoint rate of $200 per employee. In this instance, the health plan would cost $130 per month, per employee. Of this amount, 80 percent ($104) is contributed by the employer and 20 percent ($26) is contributed by the employee.

High Risk Employer - A third employer has demographic, area, and industrial compositions similar to the above employers but has a very high medical risk. Carrier XYZ may charge this employer no more than $270 per month, per employee for the same health plan (35 percent above the midpoint rate of $200). Of this amount, $216 (80 percent) is contributed by the employer and $54 (20 percent) is contributed by the employee.

Year 1992

Assumption: Carrier XYZ's "trend" (the percentage increase in their lowest new business rate[2] from 1991 to 1992) is 12 percent.

Typical Employer - Although the typical employer's workforce remained the same, a number of employees became seriously ill during 1991 and submitted major claims. From 1991 to 1992, carrier XYZ may increase the typical employer's rates by no more than 15 percent above "trend." Therefore, the rate charged to the typical employer in 1991 would be no more than $254 per employee (12 percent+15 percent above the midpoint rate of $200). Of this amount, $51 is contributed by the employee and $203 is contributed by the employer.

High Risk Employer - While the high risk employer's workforce also remained the same, several additional employees became seriously ill and submitted major claims. Since the high risk employer is already at the top of carrier XYZ's rating limit, XYZ can increase the high risk employer's rates by no more than the trend. Therefore, the rate charged to the high risk employer in 1992 could be no more than $302 per month, per employee for the health plan (35 percent above the group's 1992 mid-point rate of $224), which amounts to an increase from 1991 to 1992 of no more than trend (12 percent). Of this amount, $60 is contributed by the employee and $242 is contributed by the employer.

Health Insurance Association of America

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

HIAA

Health Insurance Association of America

STATEMENT OF HIAA

ON

SMALL GROUP MARKET REFORM

SENATE BILL 242

PRESENTED BY

JAN ANDREA MEISELS

STATE AFFAIRS ASSOCIATE

BEFORE THE

ALASKA SENATE COMMITTEE ON LABOR AND COMMERCE

April 19, 1991

6052 Hackers Lane
Agoura, California 91301
818-991-6817

CORRECTION

THIS DOCUMENT
HAS BEEN REPHOTOGRAPHED
TO ASSURE LEGIBILITY

HIAA

ON HEALTH CARE FINANCING FOR ALL AMERICANS

SIMPLIFIED NUMERICAL RATING LIMIT ILLUSTRATIONS

Year 1991

Typical Employer[1] - Carrier XYZ is selling a health plan to a typical employer at a midpoint premium rate that amounts to $200 per month, per employee (i.e., this figure would be an average of the premiums for some single persons and some families). The employer pays, on average, 80 percent of the premium ($160); the employee pays 20 percent of the premium ($40).

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[1] By "typical" we mean a small-employer group that does not contain an unusually large number of cases with high or low medical risk. For example, a small employer group that has been covered by a carrier for several years is often going to be a typical employer. On the other hand, a small employer group that is newly covered is more apt to be considered low risk since in the first year or so health plan costs are often lower (due to preexisting condition limits, for example).

[2] This is believed the best measure of a carrier's general yearly increase in premiums.

June 1991

HIAA

Health Insurance Association of America

STATEMENT OF HIAA

ON

SMALL GROUP MARKET REFORM

SENATE BILL 242

PRESENTED BY

JAN ANDREA MEISELS

STATE AFFAIRS ASSOCIATE

BEFORE THE

ALASKA SENATE COMMITTEE ON LABOR AND COMMERCE

April 19, 1991

6052 Hackers Lane
Agoura, California 91301
818-991-6817

I am Jan Andrea Meisels, State Affairs Associate, Health Insurance Association of America. HIAA is a trade association of 300 private health insurance companies which provide health insurance for 95 million Americans. HIAA actively supports SB-242.

The small employer market provides one of the most vivid examples of how health care cost inflation continues to afflict our financing system. Faced with unrelenting demands to hold health care costs down, insurers and employers have intensified the search for ways to moderate premium increases. Leaving high-risk individuals out of group coverage has been one such response. The "excessive employer churning" that newspaper accounts often bring to our attention is largely a function of employers seeking the lowest available rate. We, too, constantly hear the charge by small employers that the presence of a high-risk individual in their group has made it impossible to obtain coverage at any price.

This dynamic is complicated further by the tumultuous labor market of a small employer. Small employers are far more likely than larger organizations to go in and out of business. Our own annual employer survey suggests that employees of small firms also are more likely to change jobs. Employee turnover among small, insured firms is about 23 percent annually and is twice that level for small employers without coverage. These factors contribute to the reluctance of such employers to offer coverage as well as the difficulties of serving the market.

As the complexities of the small employer market have grown, and the likelihood of individuals' being separated from the financing system has increased, there is a growing perception

that even if they have coverage, they stand a reasonable chance of losing it if they change employers, or if they have poor claims experience.

Madam Chairperson and members of the committee, we have now reached the point where substantial small employer market changes are needed if we are to serve the longer-term interests of small employers and meet the concerns of policymakers. SB-242 incorporates a comprehensive set of small group market reforms that HIAA believes can be achieved in the context of a viable private marketplace. The essence of SB-242 is to make certain changes in the market so that it provides substantially more predictability and protection to the purchasers of coverage. Let me emphasize that to work, these changes will have to apply to all players in the small employer market -- insurance companies, medical service plans, multiple employer welfare associations, etc. All competing entities in the small employer market, including non-insured benefit plans, would have to be bound by the same rules in order to prevent any company or segment of the market from being placed at a disadvantage. The reforms included in SB 242 ensures fair access to and continuity of coverage for small employers and their employees. The issues embraced in SB 242 are:

<u>guaranteed availability</u> -- all small employer groups would be able to obtain private health insurance regardless of the health risk they present.

<u>coverage of whole groups</u> -- coverage would be made available to entire employer groups; neither an employer nor an insurer would

be able to exclude from the group's coverage individuals who present high medical risks.

renewability of coverage -- at renewal time, employer groups and/or individuals in these groups would be assured that their coverage would not be cancelled because of deteriorating health.

continuity of coverage -- once a person is covered in the small employer market and satisfied a plan's preexisting condition restrictions, he or she would not have to meet those requirements again when changing jobs or when the employer changes carriers.

premium pricing limits -- insurance carriers would be required to limit how much their rates could vary for groups similar in geography, demographic composition and plan design.

To give effect to these proposals, SB 242 authorizes a private not-for-profit Small Employer Health Reinsurance Association. Without the Reinsurance Association these reforms are not achievable. The Reinsurance Association allows insurers to pay a premium in exchange for having the reinsurer bear the risk for reinsured individuals. This allows insurers to treat all individuals in a group the same way -- as SB 242 does not break up groups for the purpose of reinsurance -- all members would have the same benefits. The reinsurer stands behind the insurer and simply reimburses for claims associated with reinsured individuals. This allows insurers to spread high risks, broadly through the private market rather than concentrated in one small employer group. S.B. 242 is a carefully crafted balance between carrier disincentives to write the guaranteed issued business, adequate protections for carriers from internalizing too much

risk and ensuring that the losses of the reinsurance program do not grow too large.

Besides the small group market reforms discussed above, one of the most effective means to obtain cost control is to improve our health delivery and financing system through effective managed care programs. Managed care has proved it can control costs. A growing number of studies from the seminal Rand Study of HMOs in the mid 1970's to the recent Laventhol and Horwath study which assessed the cost savings of managed care in the CHAMPUS Reform Initiative (savings to both the Defense Department and CHAMPUS beneficiaries of $148.9 million in 1988 and 1989). For these and other reasons cost containment provisions including aspects of managed care may be incorporated into the small employer health plans developed by the Small Employer Health Reinsurance Board.

Small employers are also the affected party when various legislatures mandate their plans include specific providers or services. The cumulative effect of the various mandated benefits is to increase the overall cost of the insurance plan to the small employers who is in the most need of relief for the high cost of health care and are too small to self-insure and thus escape these mandates. A study in 1989 by a University of Illinois economist concluded that 16 percent of small employers not providing health insurance would offer benefits in the absence of state mandates. Therefore, SB 242 exempts small employer health plans from any laws that would impose restrictions on insurers negotiating with providers for services

or prices of services or requires the small employer plans to include specific benefits or services rendered by certain providers.

The following is a brief discussion of each section of SB-242:

Section 1. Findings -- describes the need for Alaska to address the issue of the uninsured and to make available to small employers, health insurance with stability and predictability of rate increases as well as guaranteed availability of insurance and coverage continuation.

Section 2. Small Employer Health Reinsurance Association. 21.55.10 -- creates a not-for-profit private legal entity whose membership consists of all insurers in the small employer insurance market -- insurance companies, hospital and medical service corporations, HMOs, and welfare arrangements.
21.55.020 -- describes the Reinsurance Association board composition which assures representation for all types of insurers doing business in the small group market including welfare arrangements and guarantees a majority of seats to insurers in the small group market. The director of insurance serves as an ex-officio member of the board.
21.55.030 -- discusses the various powers of the Association board. This includes the establishment and maintenance of a list of guaranteed issue carriers, those top ten insurers based on total premium volume in the small employer market in Alaska, who are required to accept all applicants from the small employer marketplace. An insurer other than one of the "top ten" may

inform the Association board of their desire to become a guaranteed issue carrier. In addition, the board is empowered to design an array of health coverage products by which reinsurance will be provided.

21.55.040 -- requires the reinsurance association to submit a plan of operation to the Insurance Director for approval. This plan assures fair, reasonable and equitable administration of the Association. It does permit the Director of Insurance, after notice and hearing, to adopt reasonable regulations if the Association fails to submit a suitable plan of operation within 180 days from the effective date of the bill.

21.55.050 -- establishes specific provisions for reinsurance of eligible employees of a small employer or dependents of eligible employees. By requiring guaranteed issue carriers to accept groups with greater than normal risks, insurers need assistance in spreading the greater risk, therefore, the establishment of the Reinsurance Association. To reduce the volume of reinsured claims, reinsurance is available on a three-year basis. If reinsurance were permitted annually, insurers would declare more groups or individuals high-risk and utilize reinsurance more often increasing reinsurance losses to unacceptable levels. Because reinsurance would be aimed at employer groups and employees known to be high risk, and because the premium price is capped (1.5 times the adjusted average market premium for groups and 5.0 times for individuals) to encourage carriers to participate in the small employer market, in the aggregate the cost of reinsured persons may well exceed the reinsurance

premiums. The administrating insurer will determine any losses annually. Any losses are covered through assessments from all members in the Reinsurance Association based on the member's share of total premiums net of reinsurance premiums paid for coverage under the chapter in the small employer market, including, to the extent permitted under ERISA, other benefit arrangements covering small employers. Assessments are capped at four percent of premiums charged for health benefit plans covering small employers.

To assure that insurers only cede risk to the reinsurance mechanism when necessary, the premiums charged by the reinsurer are set at 1.5 times the average adjusted market premium price for similar type groups and benefits or 5 times the average adjusted premium market price for individuals with similar type benefits. Insurers are constrained from recouping the increased reinsurance costs as they may only attempt to recoup the 1.5 times average adjusted market premium price within the constraints of the overall rating bands described below. Only the level of coverage provided up to but not exceeding the coverage provided in a small employer health benefit plan is eligible for reinsurance.

These plans are required to incorporate cost containment techniques developed by the board, including but not limited to high cost case management, hospital precertification techniques and other cost containment techniques established by the Association.

Within a specified time of the coverage commencing nonguaranteed issue insurers may reinsure eligible employees and dependents who were hired subsequent to the coverage being offered by the insurer and who are not late enrollees . This section also recognizes that federally qualified HMOs reinsurance premium may be modified to reflect the portion of the risk ceded to the Association, i.e., federally qualified benefits may be different from the benefits determined to be included in the reinsured health plans by the reinsurance board.

21.55.060-21.55.080 -- are sections exempting the Association from the Administrative Procedures Act, imposition of taxes and limits the liability of the Association board.

21.55.100 -- Small Employer Health Insurance Plans. The program applies to all health insurance plans for individuals and group health benefit plans if they provide coverage to one or more employees and the employer pays all or part of the premium and the health plan is applicable to the IRS code section 26 U.S.C. 106 or 26 U.S.C. 162.

This section also exempts all small employer health plans (25 employees or less) from any restrictions on an insurer's ability to negotiate with providers regarding reimbursement for services and eliminates the requirement that the benefit plan cover specific mandated benefits or classes of providers. These provisions will increase the affordability of small employer health plans while providing quality health care to Alaska residents.

21.55.110 -- Underwriting and Rating Requirements. This provision provides stability and predictability of rates; renewability of the insurance contract; guarantees the availability of insurance to all small employers and removes the concern of people with preexisting conditions that they would have to satisfy additional preexisting condition exclusions if they change jobs or if their employer changed insurance carriers. Once someone had satisfied a plan's 12-month preexisting condition restriction, he or she would no longer be required to satisfy those requirements again when changing jobs or when the employer changes insurers.

The premium pricing limitations included in this chapter limits an insurer's ability to vary rates for groups in similar geography, demographic composition and plan design. Specifically, an insurers premiums for similar groups could not vary by more than 35 percent for the carrier's midpoint rate. There is also a 15 percent limitation on how much a carrier could vary rates by industry. Finally, carriers would have to limit a group's year-to-year premium increases to no more than 15 percent above the carrier's trend (the year-to-year increase in the lowest new business rate). These provisions assure the small employer availability of and accessibility to predictable and renewable insurance rates.

21.55.120 Guaranteed Issue Carriers. The top 10 insurers in Alaska based on total premium volume in the small employer market are determined to be guaranteed issue carriers. Other insurers

are permitted to be guaranteed issue carriers if they notify the Reinsurance Board one year in advance of the insurer becoming a so designated. Guaranteed issue carriers are required to offer at least one small employer health plan to a small employer requesting small employer coverage. These carriers may reinsure an individual or group within the provisions of 21.55.060 and must comply with the Reinsurance Board's plan of operation requirements for guaranteed issue insurers.

21.55.130 Small Employer Benefit Plans. The Reinsurance Association board is required to design small employer health benefit plans that are eligible for reinsurance. The board also designs the benefit levels, copayments and deductibles for these plans. The small employer benefit plans designed by the reinsurance board are the only benefit plans which may be reinsured. Benefit plans with benefits exceeding the small employer benefit plan will only be reinsured to the level of benefits included in the board's approved plan. The plans are permitted to include various cost containment features to assure the services are medically appropriate, rendered in the appropriate setting at reasonable prices.

21.55.140 Conditions for Ceasing to Do Business. Insurers ceasing to do business in the small employer market are required to give notice of this decision to the insurance department, the reinsurance board, the policyholder and the employer. Coverage is required to be continued for one year after the date of notification. An insurer is also prevented from reentering the small group market for at least five years from the date the

notice was given that they decided to cease to do business in this Alaska market.

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

Section 3

The term "insurer" was redefined for this chapter to include HMOs. Therefore, it is necessary to cross reference the definition of HMO for these purposes to the provisions of this chapter. Section 3 achieves this purpose.

Section 4

The term "insurer" was redefined for this chapter to include hospital or medical service corporations. Therefore, it is necessary to cross reference the other sections of the insurance code related to these organizations for the purpose of applicability to this chapter.

Section 5 Transition. Not all sections of the chapter become effective upon enactment. This section lists those portions of the chapter which begin at dates later than the July 1, 1991 effective date.

Section 6 Lists the effective date of the chapter as July 1, 1991.

March 11, 1991

SMALL EMPLOYER MARKET REFORMS AND REINSURANCE MECHANISM

On February 21, 1991 the HIAA Board of Directors reaffirmed its commitment to the comprehensive set of recommendations adopted a year ago that the Association believes can be achieved in the context of a viable private marketplace. The essence of our proposal is to make certain changes in the market so that it provides substantially more predictability and protection to the purchasers of coverage.

The small employer market precepts that the HIAA recommends are:

1. **Guaranteed Access to Coverage.** All small employer groups would be able to obtain private health insurance for basic coverage regardless of the health risk they present. A reinsurance mechanism would allow carriers to make this basic prototype benefit coverage available to any small employer for no more than 150 percent of the average premium for similar groups.

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

3. **Renewability of Coverage.** At renewal time, employer groups and/or individuals in these groups would be assured that their coverage would not be canceled because of deteriorating health.

4. **Continuity of Coverage.** Once a person is covered in the small employer market and satisfied a plan's preexisting condition restrictions, he or she would not have to meet those requirements again when changing jobs or when the employer changes carriers.

5. **Premium Pricing Limits.** Insurance carriers would be required to limit how much their rates could vary for groups similar in geography, demographic composition and plan design. More specifically, a carrier's premiums for similar groups could not vary by more than 35 percent from the carrier's midpoint rate (halfway between the lowest and highest rate). There would also be a 15 percent limitation on how much a carrier could vary rates by industry. Finally, carriers would have to limit a group's year-to-year premium increase to no more

than 15 percent above the carrier's "trend" (the year-to-year increase in the lowest new business rate).

GUARANTEEING AVAILABILITY

The "top ten" carriers in a states' small employer market would have to guarantee issue prototype benefit coverage to all applicant small employer groups. Other (non-top ten) carriers could choose to also act as guaranteed issue carriers, although they would not be required to do so. There would be a publicly available list of guaranteed issue companies. Insurers rejecting groups would be responsible for referring the group to this list (or telephone number).

Guaranteed issue carriers would have access to both individual and group reinsurance at issue, renewal and for new entrants. These carriers would have to make prototype benefits available to all small employers, at a rate of no more than 150 percent of adjusted average market premiums. They would face no cost-sharing for group reinsurance (priced at 150 percent of adjusted average market premium minus a ceding factor), could require an advance premium deposit (not to exceed three months) for poor credit risks, and could make special arrangements to cover employees in groups with exceptionally high employee turnover rates.

Insurers that choose not to guarantee issue would not be obligated to accept all applicant small employer groups. However, consistent with the whole group precept, they would be required to accept or reject entire employer groups. These carriers would only access to individual reinsurance and only for new entrants to existing cases. This is to provide financial relief for the new entrants that they would be required to accept under the continuity precept.

Both guaranteed issue and other carriers would have access to individual reinsurance (priced at 500 percent of adjusted average market claims experience, and including a $5,000 deductible but no coinsurance payments). Both carrier types would be included in the assessment base for tier one financing of reinsurance losses.

Non-guaranteed issue carriers that wish to become guaranteed issue carriers, or guaranteed issue wishing to become non-guaranteed issue, would be required to announce one year in advance their intentions to change. Carriers newly converting to guaranteed issue would not be allowed to apply more favorable guaranteed issue reinsurance terms to business already on their books when they make such a change.

Guaranteed issue carriers would be able to appeal to the reinsurance board in the event that they experienced an unfair share of administrative and credit risks. Where the Board finds

that a carrier has experienced such an unfair burden, a decreased reinsurance price to offset administrative expenses may be allowed, or a temporary suspension of guaranteed issue may be granted to the carrier.

A carrier would not have to guarantee issue business received from any agent or broker, but would be free to directly issue coverage to such business or to refer the business to one of its own agents.

HIAA believes this approach allays apprehension over who the designated carrier would be and what their practices are. Another major advantage of this approach is that it does not mandate that every carrier in the market guarantee issue. This will be more efficient since carriers that are only marginally operating in a number of local markets would not have to incur all of the fixed costs associated with acting as a designated carrier (e.g., offering a prototype plan). Further, it will be easier to monitor carriers' cost management of reinsured cases since there will be fewer designated carriers to oversee. Finally, it avoids the problem of one designated carrier (or a very small number of designated carriers) being treated by legislators as a quasi-governmental program and subject to extremely adverse regulatory or financial treatment (e.g., setting rates below market norms).

DEFINING SMALL EMPLOYER GROUPS

Employer-based plans issued to firms with only one or two employees should be excluded from the small employer market reforms and reinsurance. Such plans should continue to be regulated under a state's group or individual insurance laws.

High risk pools should be established in every state and would act to guarantee availability of coverage to persons without access to employer based coverage (i.e., individuals without an attachment to the workplace, as well as high risk persons employed by businesses with one or two employees). High risk pools would not be available to individuals working for firms with at least three employees offering employer-financed coverage to any or all employees.

The following small employer market reforms would <u>not</u> apply to employer-based individual policies: (a) guarantee issue -- carriers would not be required to guarantee issue individual policies to new employer-based groups of individuals (except for new adds to existing groups of individuals as described below) and (b) rating and renewability regulation -- individual rates will not be regulated if there is effective rate regulation in a particular state. In making a determination as to whether there is effective regulation of rates one should analyze the Department's practices rather than relying solely on the

statutory or regulatory authority in place in a particular state.

Individual policies would not have access to the small employer reinsurance mechanism. However, reinsurance assessments would be imposed on employer-based individual policies for employers with 3 to 25 lives to offset the relatively higher costs due to the guaranteed availability of small group coverage to all small employers.

The following small employer market reforms would apply to individual (as well as group) employer-based plans for small employers with 3 to 25 employees: (a) The HIAA precept on whole groups: the same plan must be made available to all eligible employees of the firm, including high risk employees and new adds and (b) Pre-existing conditions: if a person was covered by (or satisfied preexisting condition exclusions under) the previous employer-based plan, the new employer-based plan must waiver preexisting condition requirements for those conditions.

FINANCING SOURCES

First tier assessments should be capped at four percent of small employer market premium. For second tier financing, HIAA should be open to a range of alternative broad sources of financing that might be achievable in a given state.

Metropolitan Life Insurance Company
One Madison Avenue, New York, NY 10010-3690

Robert O. Fleckenstein
Assistant Vice-President
Government and Industry Relations

Metropolitan Life
AND AFFILIATED COMPANIES

The Honorable Virginia M. Collins
Vice Chair, Labor & Commerce Committee
State Senate
Juneau, Alaska 99811

RE: SB 242

Dear Senator Collins

Metropolitan Life supports efforts to reform the small group health insurance practices embodied in SB 242. We respectfully urge your Committee to favorably report this bill.

Sincerely,

Robert O. Fleckenstein

Assistant Vice President

April 19, 1991
ROF:wsb

cc: Ms. Jan A. Meisels
HIAA

the Principal Financial Group

Principal Mutual
Life Insurance Company

April 19, 1991

The Honorable Virginia Collins
Alaska Senate
Vice Chairperson
Senate Labor & Commerce Committee
Juneau, Alaska 99811

RE Senate Bill 242 (Small Group Health Insurance Reform)

Dear Senator Collins

I am writing on behalf of Principal Mutual Life Insurance Company to support Senate Bill 242 relating to reforms in the Alaska small group health insurance markets. Principal Mutual is currently the sixth largest life insurance company in the United States measured by premium income and has been a major group health insurance carrier for many years.

We believe that Senate Bill 242 will effectively address the problem that many small businesses face today in obtaining health insurance at a reasonable premium rate for all employees. Senate Bill 242 will guarantee access to coverage for those employees by establishing an industry supported reinsurance pool which spreads the losses associated with high risk employer groups. The National Association of Insurance Commissioners just this week took preliminary steps toward approving a model act which would be very similar to Senate Bill 242. Senate Bill 242 will refine the existing insurance mechanism without unduly disrupting the marketplace.

Senate Bill 242 is a responsible approach to dealing with the problem of employee access to small group health insurance. We strongly encourage your support of this measure. It will work for Alaskans.

Sincerely,

Merle T. Pederson
Assistant Counsel

MTP:paa
\mtp\0419vc.ltr

Mailing Address: Des Moines, IOWA 50392-0001 (515) 247-5111

ALASKA STATE

HOSPITAL & NURSING HOME

ASSOCIATION

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

Re: Support SB 242
Health Insurance Small
Employers

Dear Senator Sturgulewski:

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

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

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

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

Sincerely,

Harlan R. Knudson
President/CEO

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

319 SEWARD STREET #11 • JUNEAU, AK 99801 • (907) 586-1790 • FAX (907) 463-3573

NFIB Alaska

National Federation of Independent Business

FAX COVER SHEET

DATE: 4/7/92

NUMBER OF PAGES: 2 6
(Including this page)

TO: Melissa

COMPANY: Senator Sturgulewski's Office

FAX NO. 465-3810

FROM: Rosa

FAX NO: (907) 789-3433

If this message is not received correctly
please call (907) 789-4278

MESSAGE: I have the flu & may not be able to attend the Senate HESS hearing in the morning. Therefore, I would appreciate you including my letter in the Committee members meeting folders.

Thanks!

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

The Guardian of Small Business

NFIB Alaska

National Federation of
Independent Business

April 7, 1992

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

RE: SB 242: Health Insurance for small employers.

Dear Senator Collins:

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

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

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

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

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

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

1991

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

Yes 72.2% No 17% Undecided 10.8%

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

Yes 50.2% No 19.3% Undecided 30.5%

1989

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

Yes 8% No 87% Undecided 5%

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

Sincerely,

Resa Jerrel

Resa Jerrel
State Director

Enclosure

cc: Senate Health, Education and
Social Services Committee

AlaskaBusiness

MONTHLY

28

38

54

FEATURES

DEPARTMENTS

Cover photo: © 1991 Chris Arend. The Alaska Zoo's Annabelle paints with nontoxic acrylics. David Hall, elephant trainer and painting coach, holds a framed painting.

12-1991

EALTH CARE

posed Legislation

lieve the plan would saddle business with the enormous costs of fixing the nation's health care ills. Among the legislation's critics are the U.S. Chamber of Commerce, the Health Insurance Association of America and organizations representing small business.

They charge that the bill, which would impose a government mandate for employers to purchase health insurance, would promise far more than could be delivered at the predicted costs. The proposed solution has been dubbed by its detractors a "play-or-pay" system because all employers would have to provide full-time and part-time workers and their dependents with private health insurance or pay a payroll tax to fund a government program that would provide coverage.

Several provisions in the legislation are aimed at making the program acceptable to small companies – by definition, those having fewer than 100 workers. Those provisions include a phase-in period of up to five years, determined by the number of employees, before small businesses are required to provide or contribute to coverage for workers; special treatment for new small businesses and for small businesses that have not previously provided coverage; the creation of federal standards for the small-group health insurance market; and tax revisions that would allow 100 percent deductibility for health insurance premiums by the self-employed and would establish a 25-percent tax credit for certain qualifying low-profit firms.

Alaska Business Monthly sought unsuccessfully to find an Alaskan spokesperson to defend the mandated health care bill. Several Alaskans, however, criticize the legislation. The following two viewpoint articles represent pro and con arguments. Also, on the next page, you'll find a capsulization of the bill presented in the "Executive Summary" prepared for the bill's introduction.

By Judith Fuerst Griffin

NO

By Resa Jerrel

As state director of the National Federation of Independent Business, Resa Jerrel represents the interest of small-business owners before the Alaska Legislature and coordinates grass-roots lobbying activities of the organization's 5,200 members. Jerrel previously has been director of governmental relations for Associated General Contractors of Alaska and administrative assistant to the Alaska Senate Resources Committee.

Millions of Americans do not have health insurance, and many among this group are small-business owners and their employees. In Alaska, it is estimated that 90,000 people are uninsured or underinsured. For small firms, the cost of health insurance and the lack of availability of group health plans are the two major stumbling blocks to health insurance coverage.

It comes as no surprise, then, that finding a way to provide health insurance for these uninsured is on the minds of members of Congress. What is surprising is how some lawmakers want to address the problem.

One proposal now being touted on Capitol Hill is Senate Bill 1227. This plan would require businesses to provide health insurance to their workers or pay a hefty payroll tax – the "play or pay" proposal. The taxes levied on business would go into a pool to cover the costs of a federally subsidized Medicare-type health plan. Under the proposal, businesses that do not offer health insurance would be saddled with a payroll tax increase of as much as 8 percent. This tax almost certainly would have to rise to keep up with skyrocketing health costs. The cost to business owners and other taxpayers is estimated at $6 billion for the first year alone.

A "play or pay" program is in reality a tax on labor. Already 37 to 50 cents of every dollar in pay goes toward mandated programs such as workers' compensation, unemployment insurance and social security. Any government policy that mandates small-business owners to cover their employees – regardless of cost or profitability – will cause small-business failures, changes in employment policies, higher unemployment and higher product costs to consumers. The proposal allows no flexibility and it would increase the cost of health insurance. It would inhibit small firms from increasing wages, as well as from expanding other benefits, production capacity and staff.

Employees benefit much more when small firms are encouraged to provide flexible fringe benefits, rather than being forced into offering a one-size-fits-all benefit package. Competitiveness of small firms is enhanced through increased flexibility and improved ability to fashion benefit plans to meet employee needs.

Further, according to a study prepared for the NFIB Foundation, the research affiliate of the National Federation of Independent Business, this proposal will produce an effect directly opposite what supporters seek. According to the study, instead of encouraging small-business owners to offer health insurance, the "play or pay" approach will create incentives for many to pay the tax instead of paying for health insurance out of their own pockets. The result: The amount of money required to operate the program will be significantly larger than what the added payroll taxes will generate.

The incentive to pay the tax rather than purchase a health insurance plan will be especially attractive to small businesses that hire unskilled and part-time workers. For example, a business with 10 workers who earn $9 an hour and two part-time workers earning $6.50 an hour could cut the cost of health care in half by paying the tax and dropping the employees' private health insurance.

At the present time, small-business employers pay at least 20 percent more for the same health insurance coverage as larger companies. Under the

continued on page 19

YES *continued from page 16*

health insurance will be eligible to receive health benefits through AmeriCare.

AmeriCare is a dramatically new public program. Federal standards will be set for eligibility, benefits and reimbursement. The legislation also includes a number of provisions that are intended to provide financial assistance to small businesses in the form of tax credits to help them adjust to the new requirements.

In addition, this legislation includes a provision to reform the small-group insurance market. This reform is critical to small businesses that currently cannot afford insurance or whose employees are excluded from coverage because of pre-existing conditions.

The legislation also recognizes that the federal and state governments must share the burden in reforming the health care system and assuring access to care for all of our citizens. Even under the best-case scenario, not all Americans will have access to employer-based health insurance.

If this legislation is to accomplish our goal of providing quality, affordable health care for all Americans, it must have as its underlying foundation meaningful cost containment. The cost-containment provisions included in this bill will result in significant reductions in the rate of increases throughout the system. The establishment of a National Health Care Expenditure Board and state consortia are the linchpin of cost-containment provisions that are estimated to save nearly $80 billion over five years.

Reforming the health care system will be difficult. While most of us believe there is a serious problem, few can agree on the solution. A perfect solution does not exist. Some argue that the United States should adopt a Canadian model of national health insurance. Others argue that tax incentives to businesses with no requirement to provide coverage are the answer.

The legislation we are introducing today represents a compromise between those two views, keeping in mind our own traditions and values as Americans. Our nation's health care system is on the critical list. I believe the time to act is now. If we do not work together to control the soaring costs of health care and to provide care for millions of Americans now not covered or at risk of losing their coverage, we will all fall victim to the collapse of the system. ❖

NO *continued from page 17*

proposal, small-business employees could very well receive greater benefits under the federally subsidized program.

Facing the prospect of health care costs rising faster than employee wages, small-business owners may find that the "play or pay" proposal offers a more financially attractive health package. They may decide it is cheaper to pay the tax and get better health coverage.

If the "play or pay" proposal becomes law, this plan effectively will mark the beginning of a federal takeover of private health insurance. This will lead to a nationalized, Medicare-type public insurance system with uncontrolled health care costs.

Small-business owners fear a national health insurance system. They remember the efficiency of the U.S. Postal Service, the compassion of the Internal Revenue Service, the demeanor of Occupational Safety and Health Administration inspectors, and Pentagon prices. Small-business owners put their faith in the private-sector free-market system, which can and does deliver better quality and efficiency than any government agency.

Once the machinery is put in motion and the majority of smaller firms opt to pay rather than play, the advocates of a national health plan will have the excuses they have been looking for to take over the health care needs of Americans. The prospect is not a pleasant one to contemplate. Small-business owners believe a true free-market approach is a much better idea.

With more then 5,200 members, the Juneau-based National Federation of Independent Business/Alaska is the state's largest small-business advocacy organization. NFIB/Alaska draws its members from all walks of commercial life: from family farms to neighborhood retailers, from independent manufacturers to doctors and lawyers, from wholesalers to janitorial service firms.

Each year NFIB/Alaska polls its diverse membership on a variety of issues. The federation uses the poll results to form its legislative agenda, lobbying in support of positions approved by majority vote. In 1989 NFIB/Alaska asked its members: Should legislation be enacted requiring employers to provide basic health-care insurance coverage for their employees? Eighty-seven percent of the responding members were opposed to the idea. ❖

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

ALASKA
★STATE★
CHAMBER
OF COMMERCE

April 7, 1992

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

Dear Senator Sturgulewski:

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

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

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

Sincerely,

Tom E. Roy
President

NATIONAL ACADEMY FOR STATE HEALTH POLICY

PORTLAND, MAINE

Access and the Uninsured:

A Guide for States

Patricia A. Butler, J.D.
Boulder, Colorado

Elizabeth H. Kilbreth, Associate Director
Human Services Development Institute
Edmund S. Muskie Institute of Public Affairs
University of Southern Maine

Members, Steering Committee on the Uninsured
National Academy for State Health Policy

April, 1991

With Support from the Health Resources and Services Administration, DHHS, and
The Pew Charitable Trusts, Philadelphia, Pennsylvania

The highest rated group within an insurer's small employer line of business cannot be given rates more than 20 percent above the average of all the groups within that line of business. In **New York**, insurance regulation limits rate increases for health risk factors to 50 percent above what would otherwise be charged. These limitations attempt to prevent the use of exorbitant rate quotes as a way of effectively terminating some small groups. It may also provide some cross-subsidization among sub-groups, keeping premium costs somewhat more equitable across the market.

Limiting renewal rate increases

New York precludes using claims experience as a factor in setting rates until the group life years have reached fifty. In other words, a group of ten persons could not be experience rated until after its fifth year with a carrier while a group of twenty-five could be experience-rated after two years. In addition, New York prohibits the use of claims experience in establishing renewal rates if evidence of insurability was used in determining the initial premiums (or in determining whether or not to underwrite the group). Thus insurers in New York have a choice between initial medical underwriting or using claims experience for renewal rates (with a maximum mark-up of 50 percent).

Comprehensive Small Group Market Reform Proposals

Concerned with the dysfunctions of the small group market, both HIAA and NAIC have developed or are developing comprehensive proposals designed to substantially increase availability of coverage, stabilize premium rates and distribute risk more broadly. These proposals combine guaranteed issue and renewal, continuity of coverage provisions, underwriting, and rating reforms, and reinsurance mechanisms designed to protect insurers from losses and small group pools from significant and rapid deterioration. **Connecticut** has already enacted parts of these recommendations.

Proposed Underwriting and Rating Reforms

The HIAA and NAIC proposed reforms have several features in common. Both advocate whole group coverage (an insurer cannot deny coverage for an individual within an applicant group), both guarantee renewability (an insurer cannot drop a group at the end of a contract period, due to claims experience), and both advocate guaranteed continuity of coverage (with no newly imposed waiting periods) within the group market for the individual or group that changes policies. Under the terms of these proposals, an insurer could refuse to renew coverage only in cases of non-payment of premium, fraud, where a firm's size drops below eligibility levels, or if a firm is no longer conducting the same business as at the time of coverage. As is currently the case in Connecticut, North Carolina and Maine, coverage would become a transportable benefit, from group plan to group plan.

Both proposals also place limits on discretionary rating practices, but differ somewhat in the specifics of their recommendations. Under the HIAA proposal, insurers could vary by as

much as 35 percent from a mid-point, the rates offered to demographically and geographically similar groups, based on underwriting criteria. Insurers could vary rates by industry type but not by more than 15 percent from a mid-point rate (see example, Footnote 2, page 65). NAIC recommends a 25 percent rate band for groups with similar case characteristics and a 20 percent variation between different classes of business. Class of business distinctions under the NAIC proposal are allowed for lines of business acquired from other carriers, multiple employer associations, guarantee issue groups, and products sold by distinct marketing and sales representatives or organizations. Both proposals also place limits on the increase at renewal allowed for claims experience, basically allowing 15 percent on top of general inflation and any changes due to benefit modification.

In addition to these rating restrictions, the NAIC proposal precludes a number of practices that might allow an insurer to "game" the proposed system. Under this proposal, the insurer could not transfer a group involuntarily from one class of business to another. Similarly, the insurer could not offer a transfer to some groups within a class unless a similar offer was made to all groups, without regard to claims experience, health status or demographics. If an insurer drops a line of business, it cannot establish a new line for five years without prior approval from the insurance commissioner; and it cannot transfer some groups from the defunct line without offering similar coverage to all groups within that line. This proposal, in other words, precludes practices that allow insurers to weed out or differentially rate the groups with the worst experience, except within the range established by law.

Risk Distribution Proposals

To offset the potential risk associated with these reforms, HIAA has proposed a reinsurance arrangement that would protect individual insurers and spread the risk associated with the voluntary small group market broadly across the industry. A reinsurance organization would be established in which memberships would be mandatory for all insurers doing business in a state. Through this mechanism, insurers (not employers or individuals) would purchase reinsurance either for entire groups deemed to be high risk, or for individuals within groups. Premiums for groups would be capped at 150 percent of average market premiums and at 500 percent for individuals. Like state high risk pools, the premiums would not be expected to cover the claims experience of the reinsurance program, and additional funding would be secured through a proportional assessment (of four percent of premiums collected) on all carriers in the small group market, and if necessary to meet the pool's fiscal requirements, a one percent assessment on other health insurance plans.

The purchase of reinsurance would be negotiated between the primary insurer and the reinsurance organization. The high risk individual would maintain the same benefits through the same policy as the rest of his/her employment group (and not be required to purchase a separate policy through the High Risk Organization as is the case with current state High Risk Pools). Further, insurers could not pass through the entire cost of the reinsurance in

the form of premium increases to the affected individual or group, but rather would be limited to the 35 percent or 25 percent rating band ceiling described above.

NAIC is currently studying five different risk distribution strategies. Two of these strategies would be coupled with guaranteed issue requirements (i.e. insurers would be required to write policies for all applicants within eligible categories, without regard to health status). The proposals under study include: prospective reinsurance where, like the HIAA proposal, high risk groups are initially identified through medical underwriting and reinsurance is purchased through the pool; retrospective reinsurance where the pool provides stop-loss coverage of claims above a certain amount; an allocation model where high risk groups would be equitably distributed among carriers; a pooled employee option where small groups would be aggregated into benefits programs and treated as a single group for insurance purposes (like a multiple employer trust); and a designated carrier option where, like current state high risk programs, a designated insurer would administer a coverage program for high risk groups under contract to the reinsurance program.

No state has adopted either of these reform packages wholesale. However, **Connecticut** included many features from these proposals in its comprehensive health care access legislative package enacted in 1990. Encompassed in Connecticut's law are guaranteed issue provisions, guaranteed renewability, limitations on pre-existing conditions with continuity of coverage in successor plans, and required whole group coverage. Connecticut has also limited rating bands based on medical underwriting and claims experience with limits similar to the HIAA proposal. A phase-in period is allowed for existing coverage policies. In keeping with the recommendations from the HIAA, Connecticut has created a reinsurance program with mandatory participation by all insurers in the state. Insurers contribute to pool losses through a five percent assessment on their small group premiums. This assessment, if insufficient, can be supplemented by an assessment on all health benefit premiums generated in the state.

Connecticut has supplemented this small group market reform with special coverage programs for currently uninsured and low-wage small firms. Each insurer participating in the small group market is required to offer "special health care plans", designed to make transitional affordable coverage available to currently uninsured small businesses (see description, Chapter VII). Connecticut is also using the reinsurance organization to administer an even lower cost coverage plan to small businesses with ten or fewer employees, the majority of whom have wages below 200 percent of the poverty level.

Mandatory Community Rating

The rating reforms proposed by the Associations and adopted in Connecticut may broaden availability, stabilize premiums and slightly narrow the variation in price in the small group market. These proposals, however, continue to allow substantial variation in premium rates.

None does away with age/sex rating bands.[1] And even for persons with similar age/sex characteristics, the range between lowest and highest allowable rates (taking into account allowable variation for industry classification and risk characteristics) is substantial.[2] The combination of these factors can result in maintaining prohibitive differences in rates for older men or women, particularly those with prior health problems or employed in "hazardous" industries.

An alternative model for comprehensively restructuring the small group market is under consideration in at least three states (**New York, Maine** and **Vermont**). These proposals suggest that differential rating based on any factors other than geographic location be eliminated altogether and that denial of coverage based on health status be banned in the small group and individual market. Under these proposals, all insurers in the market would face similar risks because no one carrier would be in a position to screen out bad risks. The claims experience of all individuals and groups would be pooled and all would receive similar rate increases.

This guaranteed issue, community-rating model is currently found only among some Blue Cross/Blue Shield plans and some federally qualified HMOs, where it is fast disappearing. Those plans that have guaranteed issue or community-rated in the past had pools that deteriorated and required substantial increases in premiums when faced with the competition of screened, low-risk groups that could offer advantageous rates.

The argument put forward with these new proposals is that with "a level playing field", no one insurer should experience pool deterioration, and equity in cost of coverage would be maintained in the small group market.

Community rating is attractively uncomplicated. It eliminates the need for costly and administratively cumbersome medical underwriting and complex actuarial rate adjustments among different lines of business. Some argue that it also accomplishes a socially desirable goal of broadly distributing health care costs across a large population base without penalizing individuals for their health status, age or sex.

The major concern regarding community rating is that the premium necessary to cover the claims experience of the community pool, including all those with expensive health

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[1]Typically, a healthy fifty year old man may be charged double the premium of a healthy twenty-five year old man in manually rated policies, and a woman will have premiums 40 percent higher than a man of the same age - in a plan without maternity coverage.

[2]An example of possible premium spread among individuals with similar case characteristics under HIAA's proposal is as follows: Allowable variation in monthly premium based on industry classification (15 percent variation) - low, $127.50; midpoint, $150.00; high, $172.50. Highest possible premium (35 percent above high risk business group midpoint) - $232.87. Lowest possible premium (35 percent below low risk business group midpoint) - $82.87. Spread between lowest premium and highest premium among individuals with similar case characteristics - 280 percent.

conditions, would be very high, encouraging the young and healthy to go without coverage. In other words, the community pool might suffer the same deterioration experienced by individual insurers who have not aggressively applied medical underwriting criteria. In a voluntary market, where individuals and employer groups can choose whether or not to purchase coverage or to self-insure, it is difficult to assure broad participation with a costly product.

These concerns are real, although it is difficult to predict with any accuracy the likely impact of either the rating reforms proposed by the Associations or the community-rating proposals. Since all these proposals remove barriers to potentially high cost users, the median coverage cost under each plan is likely to rise, driving some from the market. It is unclear how many currently insured will drop out of the system when faced with price increases, especially if lower cost coverage is not available elsewhere.

HIAA and some of the other state-specific proposals suggest counter-balancing these potential increases in cost with reductions in the scope of benefits as a means of lowering premiums. The pros and cons of benefit reductions are discussed in Chapter VII. Some of the proposals are also coupled with mechanisms that shift some of the costs of the small group market more broadly across the insured population, such as the HIAA model's proposed assessment of all insurance carriers to fund the reinsurance program. One proposal in Maine contains a feature that would entitle any carrier offering a guaranteed issue, community-rated product in the small group market to a substantial hospital discount on all claims generated by their small group line of business. Since the hospital losses for these discounted services would be passed on to other hospital payors, this feature would constitute an indirect assessment on all other insurers and payors.

Whatever the mechanism - reduced benefits, a reinsurance program, a hospital discount, employer tax credits or direct subsidies - states may want to consider ways of linking reforms of the small group market to strategies designed to bring down insurance prices. The "no-cost" options available to states may not be no cost after all.

Chapter VII Private Sector Initiatives

Introduction

Private health care providers have traditionally responded to the needs of uninsured and low income people throughout the country. Hospitals, physicians, and other practitioners render millions of dollars of charity care to individual patients (Fraser, 1988). In some communities medical societies or non-profit clinics have organized formal private sector referral networks. These programs often coordinate with local government and public health activities. In the last few years some insurance carriers have developed innovative programs in several states that either directly fund children's health care or make lower-priced health insurance available to small firms. In most cases these programs developed independent of any public involvement but some were fostered or enhanced by public funding or regulation. As discussed in Chapter IV, Blue Cross plans with "open enrollment" (i.e. guaranteed issue without medical underwriting) and the high risk pools financed by assessments on insurers and HMOs without a tax credit also represent ways the private sector finances health care for people who would otherwise be uninsured. For example, Blue Cross of California recently began voluntarily accepting one small group previously rejected due an to employee medical condition for every five standard groups, at rates 30 percent higher than standard groups.

The private sector is also responding, independent of public initiatives, to the need for lower cost insurance products. These efforts are for the most part directed toward alternative benefit configurations, increasing cost sharing and eliminating some "non-basic" services, such as mental health.

States have responded to these initiatives in a variety of ways, ranging from regulatory changes to encourage such developments, to the initiation of public/private partnerships (eg. **Michigan**'s Medicaid/Blue Cross children's plan, Chapter II), to some instances of resistance to relaxing mandated benefits.

Blue Cross "Caring Foundation" Plans

Following the 1985 example of Blue Cross of Western **Pennsylvania**, Blue Cross Associations in ten other states have developed private sector programs to subsidize outpatient health services for low income children (Appendix, Table A). These programs, which look like "insurance" to enrollees, but which are generally treated by regulatory agencies as charity care programs, vary slightly but generally serve children under age 19 in families ineligible for Medicaid but with incomes under the federal poverty level. Most programs cover only completely uninsured children, not children whose insurance has high deductibles or does not cover well child care (although as noted in Chapter II, about 30 percent of the children enrolled in **Minnesota**'s Child Health Plan have group insurance but need supplemental coverage for ambulatory care). As Medicaid eligibility has recently increased, some of the Caring Foundation programs have raised eligibility standards to 133