

Quality Health Insurance for Alaskans Act of 2018
A BILL BY INITIATIVE

“An Act relating to health insurance”

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

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

- (a) **SHORT TITLE.** This Act may be known as the “Quality Health Insurance for Alaskans Act of 2018.”

- (b) **FINDINGS AND PURPOSE.**
 - (1) The People of the State of Alaska find that it is of paramount importance that all individuals residing within our State have access to affordable, high-quality health care.
 - (a) Alaskans with preexisting conditions should have the same access to health coverage as healthy Alaskans, and should not be denied coverage or charged higher insurance premiums based on their medical conditions.
 - (b) Young Alaskans should be allowed to stay on their parents’ health care plans until age 26.
 - (c) Alaskans should have access to comprehensive medical services through their health insurance plans, and insurance companies should not be allowed to eliminate essential health benefits, such as maternity care, prescription drugs, and hospitalizations, in order to save money and increase their profits.
 - (d) Without limits on the co-payments, deductibles, and other costs that insured Alaskans must pay for medical services, Alaskans may forgo necessary care or be vulnerable to financial distress and medical bankruptcy.
 - (e) Alaskans who contract serious illnesses, like cancer or Alzheimer’s, or are the victims of violence or a serious accident, should not lose their insurance because their illness or injuries are severe and they exceed an annual or lifetime cost limit on their health coverage.
 - (f) Experts agree that preventive health care does more to keep people healthy and reduce health care costs than anything else we can do. It’s in all Alaskans’ best interests that preventive care is covered, without co-payments, by all insurance plans.
 - (g) Alaskans nearing retirement age should have access to affordable health insurance, and no Alaskan should be discriminated against based on their age or gender when buying health insurance.
 - (h) Alaskans with private insurance should have access to a summary of benefits that is clear and understandable.
 - (2) The purpose of this Act is to ensure that high-quality comprehensive health insurance is made available and affordable on a non-discriminatory basis to all who are not otherwise eligible for state- or federally funded health care. This Act

guarantees benefits and protections for Alaskans covered by private insurance plans to ensure that state residents continue to have quality insurance coverage.

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

Chapter 98. Individual and Group Health Insurance Reforms

Sec. 21.98.010. Guaranteed issuance of coverage in the individual and group market.

- (a) Subject to subsections (b) through (e), a health care insurer that offers health insurance coverage in the individual or group market in the State of Alaska may not deny coverage to any employer or individual in the applicable market in Alaska that applies for such coverage.
- (b) A health care insurer covered by subsection (a) may restrict enrollment to open and special enrollment periods, which shall be designated by the director.
 - (i) Open enrollment periods shall occur on at least an annual basis.
 - (ii) The director shall designate special monthly enrollment periods, which shall apply to all coverage offered through a State Exchange, for all categories of persons eligible for such enrollment periods under 42 U.S.C. §18031(c)(6)(D), as that provision existed on January 1, 2017, including those defined in 25 U.S.C. §1603(13).
- (c) A health care insurer that offers health insurance coverage in the group or individual market through a network plan may
 - (i) in the group market, limit the employers who may apply for such coverage to those with eligible individuals who live, work, or reside within the network plan's service area; and
 - (ii) within the service area of such plan, deny coverage to otherwise eligible employers and individuals upon demonstrating, in accordance with regulations promulgated by the director pursuant to this subsection, that
 - (A) it lacks the capacity to deliver adequate services to any additional enrollees due to its obligations to existing group contract holders and enrollees; and
 - (B) it is denying coverage on a non-discriminatory basis, without regard to the claims experience or any health status factors of such individuals or such employers and their employees and their employees' dependents.
- (d) A health care insurer may deny health insurance coverage in the group or individual market upon demonstrating, in accordance with regulations that the director shall promulgate pursuant to this subsection, that
 - (i) it does not have the financial reserves necessary to underwrite additional coverage; and
 - (ii) it is denying coverage on a non-discriminatory basis, without regard to the claims experience or any health status factors of such individuals or such employers and their employees and their employees' dependents.

- (e) Upon denying health insurance coverage pursuant to subsections (c)(ii) or (d), a health care insurer is prohibited from offering coverage in the group or individual market for a period of 180 days after the date such coverage is denied.

Sec 21.98.020. Guaranteed renewability of coverage.

- (a) Subject to subsection (b), each health care insurer that offers health insurance coverage in the individual or group market shall renew or continue in force such coverage at the option of the plan sponsor or the individual, as applicable.
- (b) A health care insurer may decline to renew or may discontinue health insurance coverage offered in the group or individual market only if such nonrenewal or discontinuance is based on one or more of the grounds for exception described in 42 U.S.C. §§300gg-2(b) through (d), as those provisions existed on January 1, 2017, i.e., nonpayment of premiums, fraud, violation of participation or contribution rates, termination of coverage, movement outside the service area, cessation of association membership, or an issuer's discontinuance of all coverage in the individual or group market.

Sec. 21.98.030. Prohibition of preexisting condition exclusions or other discrimination based on health status.

- (a) A health care insurer offering group or individual health insurance coverage may not impose any preexisting condition exclusion with respect to such plan or coverage.
- (b) For purposes of this section, the term "preexisting condition exclusion" means a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for such coverage, regardless of whether any medical advice, diagnosis, care, or treatment was recommended or received before such date.

Sec. 21.98.040. Dependent coverage for individuals to age 26.

- (a) A health care insurer offering group or individual health insurance that provides dependent coverage of children shall continue to make such coverage available for an adult child until the child turns 26 years of age. Such dependent coverage shall be made available regardless of the child's
 - (i) marital, student, or employment status;
 - (ii) financial dependency on the primary subscriber or any other person;
 - (iii) residency with the primary subscriber or any other person;
 - (iv) residency within the network service area;
 - (v) eligibility for other coverage; or
 - (vi) any combination of such factors.
- (b) The terms of dependent coverage as described in subsection (a) may not vary based on the dependent child's age.

Sec. 21.98.050. Guaranteed essential health benefits coverage.

- (a) A health care insurer that offers health insurance coverage in the individual or small group market shall ensure that such coverage includes, at a minimum, the essential health benefits defined in subsection (b), and complies with the requirements of the federal Mental Health Parity and Addiction Equity Act of 2008 and with the versions of 42 U.S.C. §300gg-26(a) and 42 U.S.C. §18022(b) in effect on January 1, 2017.

(b) Essential health benefits shall mean those benefits defined as such by the United States Secretary of Health and Human Services pursuant to 42 U.S.C. §18022(b) (as that provision existed on January 1, 2017), at any time on or after January 1, 2017, as well as any additional benefits defined as such by the Secretary of the Alaska Department of Health and Social Services pursuant to this section within the following general categories:

- (i) Ambulatory patient services;
- (ii) Emergency services;
- (iii) Hospitalization;
- (iv) Maternity and newborn care;
- (v) Mental health and substance use disorder services, including behavioral health treatment;
- (vi) Prescription drugs;
- (vii) Rehabilitative and habilitative services and devices;
- (viii) Laboratory services;
- (ix) Preventive and wellness services and chronic disease management; and
- (x) Pediatric services, including oral and vision care.

Essential health benefits shall include, at a minimum, all items and services covered by Alaska's 2017 "EHB Benchmark Plan," as designated pursuant to 45 C.F.R. §156.100. In defining additional essential health benefits pursuant to this section, the Commissioner of the Alaska Department of Health and Social Services shall comply with the federal Mental Health Parity and Addiction Equity Act of 2008 as set forth in the version of 42 U.S.C. §300gg-26(a) in effect on January 1, 2017, and shall apply the criteria set forth in the version of 42 U.S.C. §18022(b)(4) in effect on January 1, 2017.

- (c) For each health plan that a health insurer offers in this State, the health insurer shall offer a corresponding child-only plan providing the same coverage in which the only enrollees are individuals who, as of the beginning of a plan year, have not attained the age of 21.
- (d) Nothing in this section shall prevent the sale of stand-alone dental benefit plans, provided such plans cover any pediatric dental services defined as essential health benefits as set forth in subsection (b).
- (e) Nothing in this section shall be construed to supersede any other state law requiring coverage of additional items or services. Compliance with this section shall not exempt a health care insurer from providing coverage for all other items and services required under AS 21.07.020 and chapter 42 of this title.

Sec. 21.98.060. Limits on out-of-pocket expenses.

- (a) The total annual cost sharing, or out-of-pocket expenses (including co-payments, coinsurance, deductibles, other similar charges, and any other expenditure required of an insured for qualified medical expenses within the meaning of 26 U.S.C. §223(d)(2), as it existed on January 1, 2017), for essential health benefits coverage under a health plan may not exceed the dollar amounts in effect under 42 U.S.C. §18022(c) as of January 1, 2017, and shall comply with the requirements of the federal Mental Health Parity and Addiction Equity Act of 2008 as set forth in the version of 42 U.S.C. §300gg-26(a) in effect on January 1, 2017.
- (b) The State of Alaska has the responsibility to take necessary action to preserve its individual health insurance market and access to affordable coverage for people of all

income levels, including the provision of income-based assistance that makes the cost of coverage affordable to middle- and low-income residents.

- (c) For purposes of this section, “essential health benefits” has the meaning given in AS 21.98.050.

Sec. 21.98.070. No lifetime or annual limits on essential health benefits.

- (a) A health care insurer offering group or individual health insurance coverage may not establish aggregate lifetime or annual limits on the dollar value of essential health benefits that can be recovered for any participant or beneficiary, regardless of whether such benefits are provided in-network or out-of-network.
- (b) For purposes of this section, “essential health benefits” has the meaning given in AS 21.98.050.

Sec. 21.98.080. No cost-sharing for preventive health services.

- (a) A health care insurer offering group or individual health insurance coverage shall, at a minimum, provide coverage for all of the following items and services, and may not impose any cost sharing requirements, such as a co-payment, co-insurance, or deductible, with respect to such items and services:
 - (i) preventive items or services having an “A” or “B” rating by the United States Preventive Services Task Force, at any time on or after January 1, 2017;
 - (ii) immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention at any time on or after January 1, 2017;
 - (iii) with respect to infants, children, and adolescents, preventive care and screenings provided for in the Health Resources and Services Administration-supported comprehensive guidelines at any time on or after January 1, 2017;
 - (iv) with respect to women, such additional preventive care and screenings provided for in the Health Resources and Services Administration-supported Women’s Preventive Services Guidelines at any time on or after January 1, 2017; and
 - (v) any additional preventive items or services so designated by the Secretary of the Alaska Department of Health and Social Services as necessary to ensure that effective preventive care and services are made available and affordable to all Alaska residents.

This subsection shall be construed broadly to require coverage, and prohibit cost sharing requirements, for the most inclusive set of items and services.

- (b) Nothing in this section shall be construed to prohibit a health care insurer from providing coverage for services in addition to those required by subsection (a).
- (c) The coverage required by subsection (a) shall be provided for plan or policy years that begin on or after the date that is one year after the date the relevant recommendation or guideline is issued.
- (d) The director is authorized to adopt regulations setting forth a religious accommodation exemption from the requirements of this section. Any such exemption shall be no broader than necessary to avoid the infringement of constitutional rights.

Sec. 21.98.090. Rating restrictions.

- (a) The premium rate charged by a health care insurer for health insurance coverage offered in the individual or small group market may vary based only on the following factors:
 - (i) whether such plan or coverage covers an individual or family;
 - (ii) the geographic rating area, as established in accordance with subsection (b)(i);
 - (iii) age, except that such rate may not vary by more than 3 to 1 for adults aged 21 and older, as established in accordance with subsection (b)(ii); and
 - (iv) tobacco use, except that such rate may not vary by more than the ratio in effect for that plan on January 1, 2017 or the maximum ratio set forth in 42 U.S.C. §300gg(a)(1)(A)(iv) as of January 1, 2017, whichever is lower.
- (b) The director shall promulgate regulations establishing the following:
 - (i) one or more geographic rating areas within the State of Alaska for purposes of subsection (a)(ii); and
 - (ii) The permissible age bands for rating purposes under subsection (a)(iii).
- (c) With respect to family coverage under health insurance coverage, the rating variations permitted under subsections (a)(iii) and (a)(iv) shall be applied based on the portion of the premium that is attributable to each covered family member.
- (d) This section shall also apply to any health care insurer that offers coverage in the large group market through a State Exchange.

Sec. 21.98.100. Transparency.

A health plan and health insurer offering health insurance coverage in the individual or group market shall provide to applicants and covered individuals a summary of benefits and coverage explanation that accurately describes the benefits and coverage under the applicable plan or coverage in compliance with the standards promulgated by the United States Secretary of Health and Human Services pursuant to the version of 42 U.S.C. §300gg-15(a) through (d) and 45 CFR 147.200 in effect on January 1, 2017.

Sec. 21.98.110. Grandfathered health plan coverage.

- (a) “Grandfathered health plan coverage” shall have the meaning given in the version of 45 C.F.R. 147.140 in effect on January 1, 2017.
- (b) Sections 21.98.010, 21.98.020, 21.98.030, 21.98.050, 21.98.060, 21.98.070 insofar as it relates to annual dollar limits only, 21.98.080, and 21.98.090 shall not apply to grandfathered health plan coverage in the individual market.
- (c) Sections 21.98.010, 21.98.020, 21.98.050, 21.98.060, 21.98.080, and 21.98.090 shall not apply to grandfathered health plan coverage in the group market.

Sec. 21.98.120. Definitions.

In this chapter,

- (1) “aggregate lifetime limit” has the meaning given in AS 21.54.500;
- (2) “annual limit” has the meaning given in AS 21.54.500;
- (3) “beneficiary” has the meaning given in AS 21.54.500;
- (4) “director” means the director of the Division of Insurance;
- (5) “group health insurance coverage” means, in connection with a group health plan, health insurance coverage offered in connection with such plan;
- (6) “group health plan” means an employee welfare benefit plan (as defined in section 3(1) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. §1002(1)) to the extent that the plan provides medical care (including items and services paid for as

medical care) to employees (including both current and former employees) or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise;

- (7) “group market” has the meaning given in AS 21.54.500;
- (8) “health care insurer” has the meaning given in AS 21.54.500;
- (9) “health insurance coverage” means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health care insurer;
- (10) “health status factor” has the meaning given in AS 21.54.500;
- (11) “individual health insurance coverage” means health insurance coverage offered to individuals in the individual market, but does not include short-term limited duration insurance;
- (12) “individual market” has the meaning given in AS 21.51.500;
- (13) “large employer” has the meaning given in AS 21.54.500;
- (14) “network plan” has the meaning given in AS 21.54.500;
- (15) “participant” has the meaning given in AS 21.54.500;
- (16) “plan” and “health plan” mean “health care insurance plan” as defined in AS 21.54.500;
- (17) “plan sponsor” has the meaning given in AS 21.54.500;
- (18) “small employer” has the meaning given in AS 21.54.500;
- (19) “small group market” means the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by a small employer;
- (20) “State Exchange” means an American Health Benefit Exchange established by Alaska pursuant to 42 U.S.C. §18031.

Sec. 21.98.130. Repeal of conflicting state law

All statutory provisions and parts of statutory provisions in conflict with the provisions of this chapter are superseded by this act.

***Section 3.** AS 21 is amended as follows to achieve consistency with Section 2 of this Act:

***Section 3.1.** AS 21.51.020 is amended to read:

Sec. 21.51.020. Scope, Format of Policy

A policy of health insurance may not be delivered or issued for delivery to a person in this state unless it otherwise complies with this title, and complies with the following:

- (1) the entire money and other considerations must be expressed in the policy;
- (2) the time the insurance takes effect and terminates must be expressed in the policy;
- (3) it must insure only one person, except that a policy may insure, originally or by subsequent amendment, upon the application of an adult member of a family, who shall be considered the policyholder, any two or more eligible members of that family, including husband, wife, dependent children, or any children under a specified age, which may not [EXCEED] **be less than 26** [25] years, and any other person dependent on the policyholder;

(4) the style, arrangement, and over-all appearance of the policy must give no undue prominence to any portion of the text, and every printed portion of the text of the policy and of endorsements or attached papers must be plainly printed in light-faced type of a style in general use, the size of which must be uniform and not less than 10 point with a lower case unspaced alphabet length not less than 120 point; in this paragraph, text includes all printed matter except the name and address of the insurer, name or title of the policy, the brief description, if any, and captions and subcaptions;

(5) the exceptions and reductions of indemnity must be set out in the policy and, other than those contained in AS 21.51.040--21.51.260, must be printed, at the insurer's option, either included with the benefit provision to which they apply, or under an appropriate caption such as "Exceptions," or "Exceptions and Reductions," except that if an exception or reduction specifically applies only to a particular benefit of the policy, a statement of the exception or reduction must be included with the benefit provision to which it applies;

(6) each form, including riders and endorsements, must be identified by a form number in the lower left-hand corner of the first page;

(7) the policy may not contain a provision making a portion of the charter, rules, constitution, or bylaws of the insurer a part of the policy unless the portion is set out in full in the policy; this paragraph does not apply to the incorporation of, or reference to, a statement of rates or classification of risks, or short-rate table filed with the director.

***Section 3.2.** AS 21.51.250 is amended to read:

Sec. 21.51.250. Illegal occupation

There may be a provision as follows:

"Illegal Occupation: The insurer shall not be liable for a loss to which a contributing cause was the insured's commission of or attempt to commit a felony or to which a contributing cause was the insured's being engaged in an illegal occupation, except to the extent coverage is required under AS 21.98.050 through AS 21.98.080."

***Section 3.3.** AS 21.51.260 is amended to read:

Sec. 21.51.260. Intoxicants and narcotics

There may be a provision as follows:

"Intoxicants and Narcotics: The insurer shall not be liable for a loss sustained or contracted in consequence of the insured's being intoxicated or under the influence of a narcotic unless administered on the advice of a physician, except to the extent coverage is required under AS 21.98.050 through AS 21.98.080."

***Section 3.4.** AS 21.51.405(a) is amended to read:

Sec. 21.51.405. Rate requirements; filings; regulations

(a) Rates charged for a health insurance policy may not be excessive, inadequate, or unfairly discriminatory. Rates charged for a health insurance policy may vary based only on the factors described in AS 21.98.090.

***Section 3.5.** AS 21.56.120 is repealed and reenacted to read:

Sec. 21.56.120. Premium Rate Restrictions; Disclosures; Reports; Confidentiality

(a) A premium rate for a health care insurance plan subject to this chapter is subject to the following provisions:

- (1) rates charged for a health insurance policy may vary based only on the factors described in AS 21.98.090;
- (2) a premium rate for a health care insurance plan shall comply with the requirements of this section;
- (3) a small employer insurer shall
 - (A) apply rating factors, as described in AS 21.98.090, 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 care insurance plans; and
 - (B) treat all health care insurance plans issued or renewed in the same calendar month as having the same rating period;
- (4) for the purposes of this subsection, a health care insurance plan that contains a restricted provider network may not be considered similar coverage to a health care insurance plan that does not use a restricted provider network if the restriction of benefits to network providers results in substantial differences in claim costs;
- (5) a small employer insurer may not use case characteristics, other than those factors described in AS 21.98.090.

(b) In connection with the offering for sale of a health care insurance plan to a small employer, a small employer insurer shall, as part of its solicitation and sales materials, disclose in a manner understandable by the average small employer and sufficient to reasonably inform small employers of their rights and obligations under the health care insurance plan

- (1) the extent that premium rates for a specified small employer are established or adjusted based on the factors permitted by this section; and
- (2) the provisions of the health care insurance plan
 - (A) concerning the small employer insurer's right to change premium rates and factors that affect changes in premium rates;
 - (B) relating to renewability of policies and contracts;
 - (C) relating to any preexisting condition provision; and
 - (D) concerning the benefits and premiums available under all health care insurance plans for which the small employer qualifies.

(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 AS 21.54.100--21.54.500 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) the director may use the information or other discovered information in a judicial or administrative proceeding.

(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 chapter and with the requirements of AS 21.98.090, including ensuring that differences in rates charged for health care insurance 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 care insurance plans.

(e) In determining the premium rates for a small employer covered under an association health insurance policy authorized under AS 21.54.060(a)(6), a small employer insurer may not use the claims experience of the small employer while the employer was covered under another health insurance policy and may use only that underwriting information obtained through the insurer's normal application process for new small employer groups that are not written under the association plan.

***Section 3.6.** 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 21.07;

(4) AS 21.09, except AS 21.09.090;

(5) AS 21.18.010;

(6) AS 21.18.030;

(7) AS 21.18.040;

(8) AS 21.18.080 - 21.18.086;

(9) AS 21.36;

(10) AS 21.42.110, 21.42.345-21.42.395;

(11) AS 21.51.120 and 21.51.400;

(12) AS 21.51.405;

(13) AS 21.53;

(14) AS 21.54;

(15) AS 21.56;

(16) AS 21.69.400;

- (17) AS 21.69.520;
- (18) AS 21.69.600, 21.69.620, and 21.69.630;
- (19) AS 21.78;
- (20) AS 21.96.060;
- (21) AS 21.97;[].
- (22) AS 21.98.

***Section 3.7.** AS 21.51.270, 21.54.110, and 21.56.160 are repealed.

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

SEVERABILITY. Under AS 01.10.030, if any provision of this Act, or the application of it to any person or circumstance, is held invalid, the remainder of this Act and the application to other persons or circumstances are not affected.