

# Detailed Bill Summary

**SECTION 1 of the bill – Findings**

**Corresponds with version \R**

**SECTION 2 of the bill - Provides the framework for the bill**

**Sec. 21.54.200: Establishes the health care program**

This section lays out what the legislation will accomplish.

- it ensures that all state residents can afford quality health coverage that suits their particular needs
- it requires that health coverage is meaningful, as discussed later in AS 21.54.250
- it reduces unsustainable health care cost increases, through encouraging primary care and prevention
- it centers on consumer choice by providing a framework for competition, where insurance plans must compete to acquire and retain customers

**Sec. 21.54.210: Establishes the Alaska Health Care Board**

This section establishes the Alaska Health Care Board under the Division of Insurance. The board will have 13 voting members, and will include:

- one insurance producer licensed to do business in the state
- one representative from a health insurance company licensed in Alaska
- one representative that works for a large business
- one representative that works for a small business
- two representatives from Alaska hospitals
- one representative of a labor organization
- two licensed Alaska physicians
- two consumer advocates
- one registered nurse
- the commissioner of Health and Social Services, or their designee

Each member, except the commissioner, serves a 3 year term and are subject to appointment and reappointment by the Governor. Members will be entitled to standard per diem and transportation costs under AS 39.20.180. The board will select a chair and a vice chair, and a majority of the board will be considered a quorum for transacting business.

**Sec. 21.54.220: Defines the powers and duties of the Alaska Health Care Board**

The board oversees two of the main elements in this bill: the health care Clearinghouse and the health care fund, the function of which are described in later sections of the bill.

In particular, the board will:

- ensure that a variety of plans are available in the clearinghouse, where individuals make plan selections based on their personal needs
- help educate the public about different plan options, and ensure that residents are enrolled in a health benefit plan
- establish enrollment criteria and procedures for individuals, and provide for an annual open season when customers can change their plan selections.

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In particular, the board will (*continued*):

- The board will hear complaints or objections to decisions made by the program or clearinghouse. Individuals who feel aggrieved by a decision of the board are entitled to a hearing
- Establish criteria and implement the voucher system, which will be discussed in a later section
- Ensure that plans protect individuals from severe financial hardship in times of medical need

### **Sec. 21.54.230: Alaska Health Care Clearinghouse**

The health care clearinghouse will be the ‘place’ where Alaskans are connected up with private health plans that suit their needs. The clearinghouse will disseminate information about health insurance and the plans that are ‘certified’ to fulfill the essential health care services criteria, as defined later in the bill.

The Clearinghouse will be the place where individuals with health care vouchers make plan selections and are connected up with quality insurance products.

### **Sec. 21.54.240: Establishes the Voucher system, and includes the individual responsibility clause**

This section ensures that all Alaskans can afford quality health coverage. It begins in (a) with the individual responsibility clause, which requires that all Alaskans have health coverage that provides essential health care services. This requirement will only affect those who don’t currently have coverage: (1) – (8) outline specific examples of individuals who will be exempt from the individual responsibility clause. Excepted from the requirement are individuals who receive benefits under employer plans or publicly funded programs, including IHS recipients. In addition, individuals who have objections to the requirement to have health coverage on religious grounds can apply to be exempt from the individual responsibility clause.

Subsections (b) through (e) describe the sliding scale voucher system which makes health coverage affordable for all legal residents. Sliding scale vouchers are issued to individuals in households based on the federal government’s federal poverty level criteria (FPL), which sets a poverty line annually based on household size. This year the FPL has been set at \$13,000 of gross income a year for an individual, or \$26,500 per year for a family of four.

Subsection (c) provides a guarantee that anyone who falls below the federal poverty line won’t have to pay for health coverage.

Subsection (d) provides vouchers, on a sliding scale, to individuals in households that earn between 100% and 300% of the FPL. Using the numbers from above, this means that an individual who earns between \$13,000 and \$39,000 a year or a family of four that has a household income between \$26,500 and \$79,500 will be eligible for a sliding scale voucher that makes health insurance affordable. The amount of these vouchers will be set by the board, and will vary, with more assistance going to those who earn less.

Subsection (e) requires that all individuals over 300% of the FPL acquire health coverage. While these individuals will not receive needs based vouchers, they will be eligible to receive specified beneficiary vouchers, which are discussed in a later section of the bill.

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Subsection (b) provides larger vouchers to individuals who only qualify for ACHIA coverage, making the cost of coverage equal to that available in the normal market. These vouchers will be issued to people who earn up to 450% of the FPL.

Subsection (f) ensures that only legal residents of Alaska receive needs based vouchers.

Subsection (g) clarifies that an individual who is eligible for health coverage funded by a source other than the health care clearinghouse won't receive needs based vouchers to make insurance affordable.

### **Sec. 21.54.250: Defines essential health care services**

This section defines the benefits that all health insurance plans sold through the clearinghouse must include.

Insurance plans will include coverage for:

- preventative and primary care
- emergency services
- inpatient services and hospital treatment
- ambulatory patient services
- prescription drug coverage
- mental health services

### **Sec. 21.54.260: Relates to employer provided health coverage**

(a) and (b) are included to make it clear that nothing in this legislation changes employer based health coverage for companies that elect to provide it.

(c) and (d) relate to the employer levy, which ensures that all employers contribute to the health of employees around the state. This tax is only levied against employers who don't offer health coverage, and the amount depends on the number of employees who lack health coverage and are required to attain it under this legislation. For businesses that pay below \$500,000 gross annually to employees that are required to participate, no levy will be charged. For businesses with \$500,000 to \$1 million a year in gross payroll to employees required to participate in the plan, the levy will be 1% of gross payroll. For \$1 million or greater, the levy will be 2%. If an employer either a) offers to pay 33% of premium costs or b) successfully enrolls 25% of employees in an employer sponsored plan they will be exempt from this tax. In addition, if an employer establishes a so-called 'Section 125' cafeteria plan that allows employees to purchase health coverage with pre-federal tax dollars, the employer will be exempt from this levy.

### **Sec. 21.54.270: Relates to the structure of insurance plans available in the clearinghouse**

This section requires that plans provide coverage for essential health care services, as described in 21.54.250.

(b) in this section mandates that an insurance company not turn down an individual looking for coverage.

Subsection (c) makes clear that health insurance plans can have varied levels of deductibles, co-pays, co-insurance and out of pocket maximums. They can include high deductible health care plans, and benefit levels can be different for in network and out of network providers. In addition, this subsection encourages lower

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cost plans that are especially designed for young adults, ages 18-30, which have different terms than are found in normal plans.

Subsection (d) increases the length of time that a child must be covered under a clearinghouse plan to 25 years of age, or until 2 years after the dependent no longer resides with the family.

Subsection (e) borrows language from Alaska's small group health insurance law that limits the length of time a preexisting condition limitation can be imposed on new enrollees to a maximum of 12 months. It also only allows a two year look back for determining when preexisting conditions exist.

Subsection (f) requires insurers to give credit for prior coverage when determining preexisting condition exclusion periods on newly issued health insurance plans sold through the clearinghouse.

### **Sec. 21.54.280: Establishes the Alaska Health Fund and Specified Beneficiary vouchers**

The health fund is established as a separate trust fund of the state, and will include:

- state money and appropriations
- federal money, pursued through a variety of routes including 1115a waivers
- employer levy established in 21.54.260
- health care premiums received and appropriated to the fund
- money from any source that is given with purposes consistent with the purpose of the program

(b) establishes specified beneficiary vouchers, which gives an employer, employers or individuals the ability to contribute to the health premium of a given individual, through a voucher.

### **Sec. 21.54.290: Disputes and appeals**

This section gives an individual the opportunity for a hearing if they are denied health coverage by a certified plan, or if a plan fails to deliver essential health care services. In addition, if a person feels adversely affected or aggrieved by a decision of the board or clearinghouse, they have the right to a hearing.

### **Sec. 21.54.300: Reporting**

This section provides for an annual report by the health care board that includes statistics relating to how the health reform program is performing. In addition, the board will also give an evaluation and recommendations on a variety of important health reform topics, including the use of electronic health records, S-CHIP, the effect of mandated benefits, prescription drug bargaining, ways to maximize federal health care dollars, recruitment and retention of medical professionals, evidenced based treatment procedures, Medicaid effectiveness/expansions and more.

### **Sec. 21.54.310: Regulations**

This section requires that the board establish regulations under the Administrative Procedure Act.

**The remainder of the bill deals with definitions, transitional provisions and effective dates.**

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