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Referred: Finance

1 IN THE SENATE

BY THE HEALTH, EDUCATION AND
SOCIAL SERVICES COMMITTEE

2 HOUSE CS FOR CS FOR SPONSOR SUBSTITUTE FOR SENATE BILL NO. 227 (HESS)

3 IN THE LEGISLATURE OF THE STATE OF ALASKA

4 ELEVENTH LEGISLATURE - SECOND SESSION

5 A BILL

6 For an Act entitled: "An Act relating to the health of residents of the
7 state, and providing for an effective date."

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

9 * Section 1. AS 21 is amended by adding a new chapter to read:

10 CHAPTER 50. COMPREHENSIVE HEALTH CARE PLANS.

11 Sec. 21.50.010. INDIVIDUAL AND GROUP COMPREHENSIVE HEALTH CARE
12 PLANS. (a) A carrier offering individual health insurance in the state
13 shall, as a condition of transacting health insurance, make an indi-
14 vidual comprehensive health care plan described in AS 21.50.020 avail-
15 able to each resident of the state who is not eligible for Medicare. An
16 individual shall have a choice of the low option, the middle option, or
17 the high option deductible described in AS 21.50.020(b). Individual
18 comprehensive health care plans may be made available through partici-
19 pation in the Health Reinsurance Association in accordance with AS 21.-
20 50.030 or a residual market association, in accordance with AS 21.50.-
21 040. The premium charged for a plan which is not insured by or through
22 an association may not exceed the premium which is applicable through
23 participation in an association. The premium charged for a plan insured
24 by or through an association is the premium established for the particu-
25 lar classification under that association.

26 (b) Each carrier offering group health insurance in the state
27 shall, as a condition of transacting health insurance, make a group
28 comprehensive health care plan described in AS 21.50.020 available to
29 every resident employer of three or more eligible employees. An em-

1 ployer shall have the choice of the low option, the middle option, or
2 the high option deductible described in AS 21.50.020(b). Group comp-
3 rehensive health care plans may be made available to resident employers
4 of between three and 25 eligible employees through participation in the
5 Health Reinsurance Association under AS 21.50.030 or the residual market
6 association under AS 21.50.040. The premium charged for a plan on
7 groups of between three and 25 eligible employees which is not insured
8 by or through an association may not exceed the premium which is appli-
9 cable through participation in an association. The premium charged for
10 a plan which is insured by or through an association is the premium
11 established for that particular classification under that association.

12 (c) A carrier required to offer a comprehensive health care plan
13 may also offer other plans of health insurance not meeting the require-
14 ments of this chapter which it is authorized to transact.

15 (d) This chapter does not require a carrier to make coverage
16 available under a group or individual comprehensive health care plan to
17 a person or group already covered under a comprehensive health care
18 plan.

19 Sec. 21.50.020. MINIMUM STANDARD BENEFITS. (a) Individual and
20 group comprehensive health care plans shall include minimum standard
21 benefits described in this section. Except as provided in (b) and (c)
22 of this section, minimum standard benefits are benefits, including
23 coverage for catastrophic illness, with a lifetime maximum of \$1,000,000
24 per insured person for reasonable charges or, when applicable, the
25 allowance agreed upon between a provider and a carrier for charges
26 actually incurred for the following health care services rendered to an
27 insured person covered by a plan for the diagnosis or treatment of
28 nonoccupational disease, injury, or condition;

29 (1) hospital services;

1 (2) professional services other than services for mental or
2 dental conditions which are rendered by

3 (A) a physician or at his direction; or

4 (B) by a registered nurse;

5 (3) the diagnosis or treatment of mental conditions as de-
6 fined by the director during the year by one or more physicians on other
7 than an inpatient basis or, at their direction, by their staffs of
8 registered nurses, up to a yearly maximum benefit of \$1,000;

9 (4) legend drugs requiring a physician's prescription;

10 (5) services of a skilled nursing facility for not more than
11 120 days in a calendar year if the services begin within 14 days follow-
12 ing a confinement of at least three consecutive days in a hospital for
13 the same condition;

14 (6) home health agency services, as defined by the director,
15 up to a maximum of 180 visits in a calendar year

16 (A) if the services begin within seven days following
17 confinement in a hospital or skilled nursing facility for at least
18 three consecutive days for the same condition; or

19 (B) if an insured person is diagnosed by a physician as
20 terminally ill with a prognosis of six months or less to live;
21 services under this paragraph may include medical social services
22 not to exceed \$200 in a calendar year;

23 (7) use of radium or other radioactive materials;

24 (8) oxygen;

25 (9) anesthetics;

26 (10) non-dental prosthesis;

27 (11) rental of durable medical equipment which has no personal
28 use in the absence of the condition for which it is prescribed;

29 (12) diagnostic x-rays and laboratory tests as defined in

1 regulations of the director;

2 (13) oral surgery for

3 (A) excision of partially or completely unerupted
4 impacted teeth; or

5 (B) excision of a tooth root without the extraction of
6 the entire tooth;

7 (14) services of a licensed physical therapist, rendered under
8 the direction of a physician;

9 (15) medically necessary transportation as defined in regula-
10 tions of the director; or

11 (16) other medically necessary services in the treatment or
12 diagnosis of an illness or injury as defined in regulations of the
13 director.

14 (b) Minimum standard benefits may include one or more of the
15 following provisions:

16 (1) Subject to (3) of this subsection, a plan may require
17 deductibles. The low option deductible is \$100 per person, the middle
18 option deductible is \$500 per person, and the high option deductible is
19 \$1,000 per person. The amount of the deductible may not be greater when
20 a service is rendered on an outpatient basis than when the service is
21 offered on an inpatient basis. Expenses incurred during the last three
22 months of a calendar year and actually applied to an insured person's
23 deductible for the year shall be applied to the insured person's
24 deductible in the following calendar year. The \$100 maximum, the \$500
25 maximum and the \$1,000 maximum shall be adjusted yearly by the director
26 by regulation to correspond with the change in the medical care
27 component of the consumer price index. The base year for the computa-
28 tion is the first full year of operation of the plan.

29 (2) Subject to the provisions of (3) of this subsection a

1 plan shall require a maximum copayment of 20 percent for charges for all
2 types of health care in excess of the deductible and 50 percent for
3 services listed in (a)(3) of this section in excess of the deductible.

4 (3) The sum of the deductible and copayments required in a
5 calendar year under an option may not exceed a maximum limit of \$1,000
6 per covered individual or \$2,000 per covered family except that (A)
7 covered expenses incurred after the applicable maximum limit has been
8 reached are paid at the rate of 100 percent; and (B) expenses incurred
9 for treatment of mental and nervous conditions may be paid at the rate
10 of 50 percent under (a)(3) of this section. The \$1,000 and \$2,000
11 maximums shall be adjusted yearly by the director to correspond with the
12 change in the medical care component of the consumer price index.

13 (4) The plan may limit lifetime benefits to a maximum of not
14 less than \$1,000,000 per insured person.

15 (5) A plan may not exclude coverage of a preexisting con-
16 dition unless medical advice or treatment was recommended or received
17 within the period of six months immediately before the effective date of
18 coverage. A policy may not exclude coverage for a loss due to pre-
19 existing conditions for a period greater than 12 months following the
20 effective date of coverage. An individual comprehensive health care
21 plan issued as a result of conversion from group health insurance or
22 from a self-insured group shall credit the time covered under the group
23 health insurance toward the exclusion for preexisting conditions.

24 (c) Plans providing minimum standard benefits need not provide
25 benefits for a charge for

26 (1) care for an injury or disease arising out of and in the
27 course of an employment subject to a workers' compensation or similar
28 law;

29 (2) treatment for cosmetic purposes other than surgery for

1 the prompt repair of disfigurement due to illness or accidental injury
2 sustained while covered;

3 (3) travel other than medically necessary transportation as
4 defined by the director;

5 (4) private room accommodations to the extent it is in excess
6 of the institution's most common charge for a semiprivate room;

7 (5) services or articles to the extent that it exceeds the
8 reasonable charge in the locality for the service;

9 (6) services or articles which are determined not to be
10 medically necessary;

11 (7) services or articles the provision of which is not within
12 the scope of the license or certificate of the institution or individual
13 rendering the services or articles;

14 (8) services or articles furnished, paid for or reimbursed
15 directly by or under a law of a government, except as otherwise provided
16 in this chapter;

17 (9) services or articles for custodial care or designed
18 primarily to assist an insured person in meeting his activities of daily
19 living;

20 (10) services which would not have been made if no insurance
21 existed or for which the insured person is not legally obligated to pay;

22 (11) eyeglasses, contact lenses or hearing aids, or the fitting
23 of them;

24 (12) dental care not specifically covered by this chapter; and

25 (13) services of a registered nurse who ordinarily resides in
26 the insured person's home, or who is a member of the insured person's
27 family or the family of the spouse.

28 (d) If an insured person who receives benefits for an injury
29 possesses a right of recovery, a carrier that has paid benefits to or

1 for the insured person is subrogated to a right of recovery to the
2 extent of its payments.

3 (e) A dependent of an eligible employee is eligible for coverage
4 under a group comprehensive health care plan but a group comprehensive
5 health care plan need not include a person covered under another group
6 comprehensive health plan.

7 (f) The director shall adopt regulations concerning coordination
8 of benefits between group comprehensive health care plans and other
9 health insurance plans.

10 Sec. 21.50.030. HEALTH REINSURANCE ASSOCIATION. (a) There is
11 created as a nonprofit legal entity the Health Reinsurance Association.
12 Each insurer and self insurer doing business in the state, as a con-
13 dition to its authority to transact the applicable kinds of health in-
14 surance defined in AS 21.50.100, is a member of the Health Reinsurance
15 Association. The Health Reinsurance Association shall perform its
16 functions under a plan of operation established and approved under (b)
17 of this section and shall exercise its powers through a board of gover-
18 nors established under this section.

19 (b) The board of governors of the Health Reinsurance Association
20 shall consist of seven individuals selected by participating members and
21 subject to approval by the director. The director shall give notice to
22 all members of the time and place of the organizational meeting to
23 select the first board of governors and to organize the association. In
24 determining voting rights at the meeting a member is entitled to vote in
25 person or proxy. The vote shall be weighted based on the net health
26 insurance premium derived from business in the state in the previous
27 calendar year. If the board of governors is not selected within 60 days
28 after notice of the meeting, the director may appoint the board of
29 governors. In approving or selecting members of the board of governors,

1 the director may consider whether all members are fairly represented.
2 Members of the board of governors may be reimbursed from the money of
3 the Health Reinsurance Association for expenses incurred by them as
4 members but are not otherwise entitled to compensation by the associa-
5 tion for their services.

6 (c) The board of governors shall submit to the director a plan of
7 operation for the Health Reinsurance Association to assure the fair,
8 reasonable and equitable administration of the association. The plan of
9 operation becomes effective on approval in writing by the director con-
10 sistent with the date on which the coverage under this chapter must be
11 made available. The director shall, after notice and hearing, approve
12 the plan of operation if the plan is determined to assure the fair,
13 reasonable and equitable administration of the Health Reinsurance Asso-
14 ciation and provide for the sharing of association gains or losses on an
15 equitable proportionate basis. If the board of governors fails to
16 submit a suitable plan of operation within 180 days after its appoint-
17 ment or if at any time the board of governors fails to submit suitable
18 amendments to the plan, the director may, after notice and hearing,
19 adopt a plan or amendments to a plan as are necessary to carry out the
20 provisions of this section. A plan and amendments to a plan continue in
21 force until modified by the director or superseded by a plan or amend-
22 ments submitted by the board of governors and approved by the director.
23 A plan of operation shall, in addition to requirements enumerated in
24 this chapter,

25 (1) establish procedures for the handling and accounting of
26 assets and money of the Health Reinsurance Association;

27 (2) establish regular times and places for meetings of the
28 board of governors;

29 (3) establish procedures for records to be kept of all finan-

1 cial transactions and for the annual fiscal reporting to the director;

2 (4) establish procedures under which selections for the board
3 of governors shall be made and submitted to the director;

4 (5) establish procedures to amend, subject to the approval of
5 the director, the plan of operations;

6 (6) establish procedures for the selection of an administer-
7 ing carrier and set out the powers and duties of the administering
8 carrier;

9 (7) contain additional provisions for the execution of the
10 powers and duties of the Health Reinsurance Association; and

11 (8) establish procedures for the advertisement on behalf of
12 all participating carriers of the general availability of the compre-
13 hensive health care plans under this chapter.

14 (d) The Health Reinsurance Association has the general power and
15 authority granted under the law of the state to a carrier to transact
16 the kinds of health insurance defined under AS 21.50.100 and in addition,
17 may

18 (1) enter into contracts necessary to carry out the pro-
19 visions of this chapter;

20 (2) sue or be sued and may take legal action necessary to
21 recover an assessment for, on behalf of, or against a participating
22 member;

23 (3) take legal action necessary to avoid the payment of
24 improper claims against the Health Reinsurance Association or the
25 coverage provided by or through the association;

26 (4) establish with respect to health insurance provided by or
27 on behalf of the Health Reinsurance Association, appropriate rates,
28 scales of rates, rate classifications and rating adjustments which may
29 not be unreasonable in relation to the coverage provided and the opera-

1 tional expenses of the association not to exceed the limits set under
2 (e)(4) of this section;

3 (5) administer a reinsurance program for participating mem-
4 bers;

5 (6) pool risks among participating members;

6 (7) issue policies of insurance in its own name or on behalf
7 of participating members on an indemnity or provision of service basis
8 providing the coverage required by this chapter;

9 (8) administer separate pools, segregated accounts, or other
10 plans considered appropriate for separate members or groups of members;

11 (9) operate a combination of plans, pools, reinsurance ar-
12 rangements or other mechanisms considered appropriate to accomplish the
13 fair and equitable operation of the Health Reinsurance Association;

14 (10) set limits on the amounts of reinsurance which may be
15 ceded to the Health Reinsurance Association by its members; and

16 (11) appoint from among participating members appropriate
17 committees necessary to provide assistance in the operation of the
18 Health Reinsurance Association.

19 (e) Each member of the Health Reinsurance Association shall par-
20 ticipate in the association under the following provisions of this
21 subsection:

22 (1) A participating member shall determine the particular
23 categories of risks it elects to have written by or through the Health
24 Reinsurance Association.

25 (2) A member may elect to reinsure all the classes of risks
26 in any one or all of the following categories of comprehensive health
27 care coverage under this chapter which it underwrites in the state:

28 (A) individual, excluding group conversion;

29 (B) individual, including group conversion; and

1 (C) groups of between three and 25 employees or members.
2 (3) A member or employer may not select out individual lives
3 from an employer group to be insured by or through the Health Reinsur-
4 ance Association. Members electing to administer risks which are in-
5 sured by or through the Health Reinsurance Association shall comply with
6 the benefit determination guidelines and the accounting procedures
7 established by the association. A risk insured by or through the Health
8 Reinsurance Association cannot be withdrawn by the participating member
9 except under rules established by the association.
10 (4) Rates for coverage issued by or through the Health Rein-
11 surance Association may not be excessive, inadequate or unfairly dis-
12 criminatory. Separate scales of premium rates based on age apply for
13 individual risks and group risks. Rates may be adjusted for area varia-
14 tions in provider costs. Premium rates shall consider the substantial
15 extra morbidity and administrative expenses for association risks,
16 reimbursement or reasonable expenses incurred for the writing of Health
17 Reinsurance Association risks and the level of rates charged by insurers
18 for groups of 10 lives. The rate for a given classification or group
19 may not be more than 125 percent of the average group rate charged for
20 the classification or group at standard risk with similar character-
21 istics under a policy covering 10 lives. All rates shall be promulgated
22 by the Health Reinsurance Association through an actuarial committee
23 consisting of five persons who are members of the American Academy of
24 Actuaries, shall be filed with the director and may be disapproved
25 within 60 days from the filing if the director determines that the rates
26 are excessive, inadequate, or unfairly discriminatory.
27 (f) Following the close of a fiscal year, an administering carrier
28 shall determine the net premiums, reinsurance premiums less administra-
29 tive expense allowance, the expense of administration pertaining to the

1 reinsurance operations of the Health Reinsurance Association and the
2 incurred losses for the year. A net loss shall be assessed to part-
3 icipating members of the Health Reinsurance Association in proportion to
4 their respective shares of the total health insurance premiums earned in
5 the state during the calendar year, or with paid losses in the year,
6 coinciding with or ending during the fiscal year of the association or
7 on another equitable basis provided in the plan of operations. For
8 self-insured members of the Health Reinsurance Association, health
9 insurance premiums earned shall be established by a formula as set by
10 the association and approved by the director. Net gains, if any, shall
11 be held at interest to offset future losses or allocated to reduce
12 future premiums.

13 (g) A net loss to the Health Reinsurance Association represented
14 by the excess of its actual expenses of administering policies issued by
15 the association over the applicable expense allowance shall be separat-
16 ely assessed to participating members who do not elect to administer
17 their plans. Assessments shall be on an equitable formula established
18 by the board of governors.

19 (h) The Health Reinsurance Association shall conduct periodic
20 audits to assure the general accuracy of the financial data submitted to
21 the association and the association shall have an annual audit of its
22 operations by an independent certified public accountant. The annual
23 audit shall be filed with the director for his review and the Health
24 Reinsurance Association is subject to examination by the director under
25 AS 21.06.

26 (i) Policy forms issued by the Health Reinsurance Association
27 shall conform in substance to prototype forms developed by the associa-
28 tion and to the requirements of this chapter and of AS 21.42, AS 21.52,
29 and AS 21.54 and shall be approved by the director. The director may

1 disapprove a form if it contains a provision which is unfair or decep-
2 tive or which encourages misrepresentation of the policy.

3 (j) The Health Reinsurance Association may not issue or reissue
4 comprehensive health care plan coverage for a person who is covered
5 under an individual or group comprehensive health care plan, who is
6 eligible for Medicare, or who is not a resident of this state.

7 (k) Benefits payable under a comprehensive health care plan in-
8 sured by or reinsured through the Health Reinsurance Association are
9 paid net of all other health care benefits paid or payable through
10 another source and net of all health care benefits provided by or under
11 another state or federal law including Title XVIII of the Social
12 Security Act, Medicare but not including Medicaid.

13 (l) No liability and no claim arises against a carrier or its
14 agents or its employees, the Health Reinsurance Association, or the
15 residual market mechanism established under AS 21.50.040, or their
16 agents or employees, or the director for any action taken by the direc-
17 tor in the performance of his duties under this chapter. This subsec-
18 tion does not apply to the obligations of a carrier, a self-insurer, the
19 Health Reinsurance Association or the residual market mechanism for
20 payment of benefits provided under a comprehensive health care plan.

21 (m) A carrier may credit an assessment paid to the Health Re-
22 insurance Association under (f) of this section against its income tax
23 payable under AS 43.20 or its premium tax payable under this title for
24 the year in which the assessment was paid. If a carrier's total assess-
25 ment exceeds its tax liability for the year, the commissioner of revenue
26 shall directly reimburse the carrier in the amount of the excess.

27 **Sec. 21.50.040. RESIDUAL MARKET ASSOCIATION.** (a) A hospital or
28 medical service corporation may elect to meet the obligations of
29 AS 21.50.010 by participating in the Health Reinsurance Association

1 either as a full member or by making comprehensive health care plans
2 available directly through a subscriber contract or combination of
3 contracts or by forming a separate residual market association similar
4 to the Health Reinsurance Association.

5 (b) If a hospital or medical service corporation forms a separate
6 residual market association, the director has the same regulatory powers
7 over the residual market association as he has over the Health Rein-
8 surance Association and the residual market association has the same
9 powers and duties as the Health Reinsurance Association under AS 21.-
10 50.030. Rating classifications under a residual market association
11 established under this section need not be the same as classifications
12 established under the Health Reinsurance Association but rates estab-
13 lished by the residual market association shall be approved by the
14 director. The director may adopt regulations to implement this section.

15 (c) If a hospital or medical service corporation does not partici-
16 pate in the Health Reinsurance Association, it is required to make an
17 individual comprehensive health care plan available to every resident of
18 the state who is not eligible for Medicare and whose coverage under a
19 group or individual contract issued by the hospital or medical service
20 corporation has terminated. The coverage may be made available through
21 a separate residual market association established under this section.

22 (d) A hospital or medical service corporation may credit an assess-
23 ment paid to the residual market mechanism under (a) and (b) of this
24 section against its income tax payable under AS 43.20 or its premium tax
25 payable under this title for the year in which the assessment was paid.
26 If the total assessment of a hospital or medical service corporation
27 exceeds its tax liability for the year, the commissioner of revenue
28 shall directly reimburse the hospital or medical corporation in the
29 amount of the excess.

1 Sec. 21.50.050. POWERS OF DIRECTOR. The director may

2 (1) formulate general policies to advance the purposes of
3 AS 21.50.010 - 21.50.040 and may adopt regulations under AS 21.06.090 to
4 carry out the provisions of AS 21.50.010 - 21.50.040;

5 (2) adopt regulations upgrading minimum benefit standards
6 under AS 21.50.020 as may be appropriate due to inflation or changes in
7 the prevailing standards of the industry;

8 (3) supervise the establishment of the Health Reinsurance
9 Association under AS 21.50.030 or a residual market association under
10 AS 21.50.040;

11 (4) approve the selection of the administering carrier by an
12 association and approve an association's contract with the administering
13 carrier including the comprehensive health care plan coverage and the
14 premiums to be charged;

15 (5) adopt by regulation reasonable limits on administrative
16 expenses of the administering carrier which may be paid from compre-
17 hensive health care plan premiums, and minimum standards for the propor-
18 tion of comprehensive health care plan premiums to be paid out in claims;

19 (6) appoint advisory committees;

20 (7) conduct audits to assure the general accuracy of the
21 financial data submitted by an administering carrier and its associa-
22 tion;

23 (8) contract with the federal government or with another unit
24 of government to ensure coordination of the comprehensive health care
25 plan with other governmental assistance programs;

26 (9) undertake directly or through studies or demonstration
27 programs to develop awareness of the benefits of AS 21.50.010 - 21.50.040
28 so that residents of the state may avail themselves of the health care
29 benefits provided by these sections.

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Sec. 21.50.100. DEFINITIONS. In this chapter,

(1) "association" means the Health Reinsurance Association established under AS 21.50.030 or a residual market association established under AS 21.50.040;

(2) "carrier" means an insurer, hospital service corporation or medical service corporation, or fraternal benefit society;

(3) "comprehensive health care plan" means health insurance which provides the benefits required under AS 21.50.020;

(4) "dependent" means

(A) the spouse of the primary insured;

(B) an unmarried child of the primary insured or of the spouse of the primary insured, who is

(i) under the age of 19 years;

(ii) under the age of 23 years, a full-time student, and chiefly dependent on the primary insured or the spouse of the primary insured for support and maintenance; or

(iii) of any age and by reason of mental retardation or physical handicap is incapable of self-sustaining employment and is chiefly dependent on the primary insured or the spouse of the primary insured for support and maintenance; and

(C) a household member who is chiefly dependent on the primary insured or the spouse of the primary insured for support and maintenance;

(5) "director" means the director of the division of insurance in the Department of Commerce and Economic Development;

(6) "family" means the primary insured and the covered dependents of the primary insured;

(7) "health insurance"

1 (A) means hospital and medical expenses incurred poli-
2 cies written on a direct basis, nonprofit service plan contracts,
3 and self-insured or self-funded employee health benefit plans;

4 (B) does not include accident only policies, disability
5 income policies or casualty insurance coverages subject to regu-
6 lation under AS 21.39;

7 (8) "home health agency" means a public or private agency or
8 a private organization which is primarily engaged in providing skilled
9 nursing services and other therapeutic services and which qualifies
10 under 42 U.S.C. sec. 1395x as a home health agency for the purposes of
11 Medicare;

12 (9) "hospital" means an institution which is primarily en-
13 gaged in providing, by or under the supervision of physicians, diag-
14 nostic and therapeutic services for medical diagnosis, treatment and
15 care or rehabilitation services, to injured, disabled, or sick persons,
16 which qualifies under 42 U.S.C. sec. 1395x as a hospital for the pur-
17 poses of Medicare;

18 (10) "insurer" means an insurance company licensed to transact
19 accident and health insurance business in the state;

20 (11) "medical social services" means services rendered, under
21 the direction of a physician by a qualified social worker holding a
22 master's degree from an accredited school of social work, including but
23 not limited to

24 (A) assessment of the social, psychological and family
25 problems related to or arising out of an insured person's illness
26 and treatment;

27 (B) appropriate action and utilization of community
28 resources to assist in resolving such problems;

29 (C) participation in the development of treatment for

1 the insured person;

2 (12) "physician" means a licensed practitioner of medicine,
3 osteopathy, acupuncture, chiropractic, podiatry, psychology, and, for
4 purposes of oral surgery only, a doctor of dental surgery or a doctor of
5 medical dentistry;

6 (13) "resident employer"

7 (A) means a person, partnership, association, trust,
8 estate, corporation, whether foreign or domestic or the legal
9 representative, trustee in bankruptcy or receiver or trustee of one
10 of these, or the legal representative of a deceased person, in-
11 cluding the state and a municipality of the state which has in its
12 employ one or more individuals during a calendar year;

13 (B) refers only to an employer with a majority of em-
14 ployees employed in the state;

15 (14) "self-insurer"

16 (A) means an employer or an employee welfare benefit
17 fund or plan which provides payment for or reimbursement of the
18 whole or a part of the cost of covered hospital or medical expenses
19 for covered individuals;

20 (B) does not include an employee welfare benefit fund or
21 plan established before January 1, 1981, by an organization which
22 is exempt from federal income taxes under the provisions of sec-
23 tion 501 of the Internal Revenue Code and amendments to it except
24 an organization described in section 501(c)(15) of the Internal
25 Revenue Code;

26 (15) "skilled nursing facility" means an institution which is
27 primarily engaged in providing skilled nursing care and related services
28 to patients who require medical or nursing care or rehabilitation ser-
29 vices, and which qualifies as a skilled nursing facility under 42 U.S.C.

1 sec. 1395x for the purposes of Medicare;

2 (16) "totally disabled" means, with respect to a dependent,
3 the inability of the dependent because of an injury or disease to engage
4 in substantially all of the normal activities of persons of the same age
5 and sex in good health.

6 * Sec. 2. AS 21.84.590 is amended by adding a new paragraph to read:

7 (10) AS 21.50.

8 * Sec. 3. AS 21.87.340 is amended by adding a new paragraph to read:

9 (17) AS 21.50.

10 * Sec. 4. AS 39.30.090(1) is amended to read:

11 (1) A group insurance policy shall provide one or more of the
12 following benefits: life insurance, accidental death and dismemberment
13 insurance, weekly indemnity insurance, hospital expense insurance,
14 surgical expense insurance, dental expense insurance, audio-visual
15 insurance, alcoholism and drug dependency insurance, or other medical
16 care insurance.

17 * Sec. 5. AS 39.30 is amended by adding a new section to read:

18 Sec. 39.30.092. COVERAGE FOR ALCOHOLISM AND DRUG DEPENDENCE. (a)

19 The group insurance policy required by AS 39.30.090(1)

20 (1) shall provide coverage for alcoholism and drug dependence
21 to include

22 (A) inpatient detoxification benefits for not less than
23 14 days of benefit each calendar year in a state-approved treatment
24 facility or licensed hospital; payment of institutional and profes-
25 sional benefits shall be equal to and payable as any other covered
26 condition, except a covered condition which, by the terms of the
27 policy, has an internal restriction;

28 (B) inpatient treatment coverage benefits for not less
29 than 30 days of benefit each calendar year in a state-approved

1 treatment program; payment of institutional and professional bene-
2 fits shall be at the same level as any other covered condition,
3 except a covered condition which, by the terms of the policy, has
4 an internal restriction; and

5 (C) outpatient treatment coverage benefits of not less
6 than 30 visits each calendar year if treatment is provided by a
7 licensed physician, state-approved treatment program, or state-
8 certified professional substance abuse counselor; coverage shall
9 include individual, family or group therapy; benefits shall be paid
10 at not less than 75 percent of the usual, customary and reasonable
11 charge for a medical procedure, treatment or service in the geo-
12 graphic area;

13 (2) may not exclude dependents otherwise covered and may not
14 limit coverage for alcoholism or drug dependence because of age, sex or
15 state of illness;

16 (3) may not apply preexisting or named condition exclusions
17 to deny coverage for alcoholism or drug dependence; and

18 (4) may require a physician's certification of necessity as a
19 condition of payment for alcoholism or drug dependence treatment.

20 (b) The provisions of this section apply to group health insurance
21 contracts and group service or indemnity type contracts issued to pro-
22 vide coverage for employees of the state and may apply to contracts for
23 the benefit of employees of other participating governmental units only
24 if the governing body of the governmental unit elects to have the provi-
25 sions apply.

26 (c) In (a) of this section,

27 (1) "alcoholism" means an illness or condition characterized
28 by the habitual lack of self control in the use of alcoholic beverages,
29 or use of alcoholic beverages to the extent that health is substantially

1 impaired or endangered, or social or economic function is substantially
2 disrupted;

3 (2) "drug dependence" means the condition of being physically
4 or psychologically addicted to an opiate, opiate derivative, tranquil-
5 izer, amphetamine, barbiturate, or similar substance, but excluding
6 nicotine, caffeine and alcohol;

7 (3) "state" means any state in the United States and includes
8 the District of Columbia.

9 * Sec. 6. AS 39.30.100 is amended to read:

10 Sec. 39.30.100. DEFINITIONS. In AS 39.30.090 - 39.30.100 [AS 39.-
11 30.090]

12 (1) "eligible employee" means

13 (A) an employee who has served in permanent full-time or
14 part-time employment with the same governmental unit for 30 days or
15 more, except an emergency or temporary employee, and

16 (B) an elected or appointed official of a governmental
17 unit, effective upon taking the oath of office;

18 (2) "governmental unit" means the state, a borough, municipal
19 corporation, or other political subdivision of the state, and the North
20 Pacific Fishery Management Council;

21 (3) "insurance", "insurance carrier" and "insurance policy"
22 include health care services, health care service contractors and con-
23 tracts.

24 * Sec. 7. The provisions of secs. 4 - 6 of this Act apply to group poli-
25 cies or contracts which provide coverage under AS 39.30.090 - 39.30.100 and
26 which are delivered, issued for delivery, or renewed in this state after the
27 effective date of this Act. A policy or contract providing coverage for
28 eligible employees in this state delivered, issued for delivery, or renewed
29 after the effective date of this Act provides the minimum coverage required

1 by this Act even if the language of the policy or contract does not so
2 specifically provide.

3 * Sec. 8. AS 47.05 is amended by adding new sections to read:

4 Sec. 47.05.070. MEDICAL ASSISTANCE BY INSURANCE OR SERVICE CON-
5 TRACTS. (a) The commissioner shall use available medical assistance
6 funds to purchase and pay premiums on policies of insurance or pay the
7 expenses on health maintenance organization service contracts or medical
8 or hospital service contracts that provide one or more of the medical
9 services available under state medical assistance programs.

10 (b) The policy of insurance or the contract must by its terms
11 guarantee

12 (1) to provide the medical services allowed under state law;

13 (2) to provide medical services under policies of insurance
14 or contracts in compliance with applicable laws and regulations;

15 (3) to provide the statistical data, records, and reports
16 relating to the provision, administration, and costs of providing
17 medical services as required by the commissioner.

18 Sec. 47.05.080. CONTRACTS WITH DIRECT PROVIDERS OF CARE AND
19 SERVICE. (a) The commissioner may enter into nonexclusive contracts
20 under which funds available for medical assistance may be administered
21 and disbursed by the contractor to direct providers of medical and
22 remedial care and services available under medical assistance for
23 services rendered and supplies furnished by them.

24 (b) A contract under this section shall

25 (1) oblige the contractor to make payments under the contract
26 promptly and not later than 30 days after receipt of the proper evidence
27 of the claim; and

28 (2) provide data, records, and reports required by the com-
29 missioner.

1 Sec. 47.05.090. IMPLEMENTATION. The commissioner shall implement
2 the provisions of AS 47.05.070 - 47.05.090 when the commissioner
3 determines that comparable benefits are available at equal or less cost
4 than direct payments by the department to the providers of medical
5 assistance.

6 Sec. 47.05.100. INTERIM PAYMENT. The department may make an
7 interim payment before receipt of billing for service to providers who
8 serve a large volume of state medical assistance clients under regula-
9 tions of the department.

10 Sec. 47.05.110. INTEREST ON LATE PAYMENTS. When presented by a
11 provider of medical services with a clean claim, the state shall pay

12 (1) interest at the rate of one percent per month when
13 payment is delayed more than 30 days after presentation of the clean
14 claim;

15 (2) interest at the rate of two percent per month when
16 payment is delayed more than 90 days after presentation of the clean
17 claim; and

18 (3) a full months interest entitlement if the claim is not
19 paid by the 15th day of a calendar month.

20 Sec. 47.05.120. DEFINITIONS. In AS 47.05.070 - 47.05.120

21 (1) "clean claim" means a claim for payment which can be
22 processed without obtaining additional information from the provider of
23 the service or from a third party; it includes a claim with errors
24 originating in the department's claims processing system, but does not
25 include claims from a provider who is under investigation for fraud or
26 abuse, or a claim under review for medical necessity;

27 (2) "commissioner" means the commissioner of health and
28 social services;

29 (3) "department" means the Department of Health and Social

1 Services;

2 (4) "medical assistance" means Medicaid (AS 47.07), general
3 relief medical (AS 47.25.120), catastrophic illness (AS 47.03), and
4 crippled children's and maternal and child health programs (AS 18.05.-
5 010).

6 * Sec. 9. AS 47.07.020(b) is repealed and re-enacted to read:

7 (b) Residents of the state for whom the Social Security Act allows
8 optional medical coverage qualifying for federal financial participation
9 are eligible for medical assistance.

10 * Sec. 10. AS 47.07.030 is repealed and re-enacted to read:

11 Sec. 47.07.030. MEDICAL SERVICES TO BE PROVIDED. Medical services
12 to be offered to eligible persons include services eligible for federal
13 financial participation under Title XIX of the federal Social Services
14 Act.

15 * Sec. 11. AS 47.25.120 is amended to read:

16 Sec. 47.25.120. ELIGIBILITY FOR ASSISTANCE. Financial assistance
17 may be given under AS 47.25.120 - 47.25.300 [, SO FAR AS PRACTICABLE
18 UNDER THE CONDITIONS IN THIS STATE,] to

19 (1) a needy person who is eligible under the regulations of
20 the department; and

21 (2) a medically needy person whose income is less than the
22 medically needy income standard or who has incurred medical expenses
23 which equal or exceed the difference between the person's monthly in-
24 come and the medically needy income standard; the medically needy in-
25 come standard is 150 percent of the current Federal Community Services
26 Administration poverty income guidelines for Alaska (45 C.F.R.,
27 sec. 1060.2).

28 * Sec. 12. AS 47.07.020(d) is repealed.

29 * Sec. 13. Sections 1 - 7 and 9 - 12 of this Act take effect January 1,

1 1981.

2 * Sec. 14. Sections 8, 13, and 14 of this Act take effect July 1, 1980.

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