Introduced: 4/29/88 5-2186A
Referred: Health, Education and Social Services, Labor and Commerce and Finance

1 IN THE SENATE BY THE JUDICIARY COMMITTEE

2 SENATE BILL NO. 520

3 IN THE LEGISLATURE OF THE STATE OF ALASKA

4 FIFTEENTH LEGISLATURE - SECOND SESSION

5 A BILL

6 For an Act entitled: "An Act relating to health insurance; and providing
7 for an effective date."

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

9 * Section 1. LEGISLATIVE FINDINGS AND INTENT. (a) The legislature
10 finds that
11 (1) the access of residents of the state to basic health care
12 services is a natural, essential, and unalienable right that is protected
13 by art. VII, sec. 4, of the Constitution of the State of Alaska;
14 (2) within the state many people lack access to basic health
15 care services because they are not able to purchase health care insurance
16 at a reasonable price or because they are restricted from purchasing health
17 insurance by the practices of the insurance industry;
18 (3) lack of access to health care negatively affects the health
19 status of the uninsured in the state by the delay or lack of medical treat-
20 ment, thereby increasing the incidence of disease and illness in the state;
21 (4) the cost of providing hospital care to the uninsured is a
22 burden on the taxpayers and certain businesses in the state;
23 (5) most businesses in the state assist their employees in the
24 purchase of health care insurance and that many other businesses are pre-
25 cluded from providing such assistance because of economic and cost con-
26 cerns;
27 (6) the inability of certain businesses to offer health insur-
28 ance benefits to their employees is a hindrance to their ability to compete
29 for capable employees in the labor market and therefore has a negative

1 economic impact on the state.

2 (b) It is the intent of the legislature to promote the accessibility 3 of health care services for all its citizens, a public purpose for which 4 money may be expended.

5 * Sec. 2. AS 18 is amended by adding a new chapter to read:

6 CHAPTER 21. HOSPITAL INSURANCE.

7 ARTICLE 1. DISABILITY INSURANCE.

8 Sec. 18.21.010. SERVICES AT ACUTE HOSPITALS. (a) Payment for 9 services provided by acute hospitals shall be established by the 10 commission for each acute hospital at a percentage of approved charges 11 determined under (b) and (c) of this section except where the services 12 are rendered under a selective product contract.

13 (b) For each acute hospital for each fiscal year, the commission 14 shall establish the percentage of charges to be paid to each hospital 15 as equal to Medicaid payments for that fiscal year as determined in 16 the final settlement for the hospital, divided by Medicaid approved 17 charges for the hospital for that fiscal year. Medicaid approved 18 charges for inpatient services shall be calculated by dividing 19 Medicaid actual inpatient charges for that fiscal year by the same 20 fiscal year's ratio of actual non-Medicare gross inpatient service 21 revenue divided by approved non-Medicare gross inpatient service 22 revenue unadjusted for compliance. Medicaid approved charges for 23 outpatient services shall be considered equal to Medicaid actual 24 charges for outpatient services for that fiscal year. A percentage 25 computed under this subsection shall be adjusted under (c) of this 26 section. Notwithstanding this section, in establishing rates of 27 payment for services provided by hospitals, the commission shall take 28 into account the special circumstances of disproportionate share 29 hospitals by adjusting the rates of payment in a manner to relieve the

1 disproportionate burden of free care given by hospitals.
2 (c) Notwithstanding any other provision of law, payments to
3 acute hospitals shall, in the aggregate, not exceed an amount that
4 conforms to an upper limit requirement imposed by title XIX of the
5 Social Security Act and defined by relevant provisions of the regu-
6 lations adopted by the health care financing administration. Before
7 the commencement of each fiscal year, the commission shall determine
8 an applicable upper limit requirement imposed by federal law. In the
9 event that the limit is exceeded, the commission shall adopt regu-
10 lations that specify the manner by which hospitals' percentage rates
11 of payment shall be adjusted so that social security payments to acute
12 hospitals do not exceed the upper limit.
13 (d) For hospitals that have earned deficit revenue for the
14 fiscal year and whose approved fiscal year revenue was adjusted upward
15 as a result of the deficit, an adjustment shall occur at the end of
16 the fiscal year to allow the hospital to pay the state an amount equal
17 to the percentage share of the upward adjustment, multiplied by the
18 percentage of charge calculated under (b) of this section.
19 (e) If the social security payment methodology set out in this
20 section is not approvable by the health care financing administration,
21 the commission is authorized and directed to modify the methodology as
22 may be required to secure health care financing administration ap-
23 proval; however, the modified methodology shall have results as com-
24 parable as possible to those of the methodology prescribed in title
25 XIX of the Social Security Act.
26 Sec. 18.21.020. MEDICARE SHORTFALL ASSISTANCE FUND. (a) There
27 is established a separate fund to be known as the Medicare shortfall
28 assistance fund. The purpose of this fund is to provide compensation
29 to acute hospitals for shortfalls in Medicare payments resulting from

1 annual changes in Medicare rates that are less than the rate of in-
2 flation as measured by the health care financing administration market
3 basket projection. For purposes of calculating shortfalls, each
4 year's prospective payment system rate shall be compared to the pro-
5 spective payment system rate that was effective for the hospital in
6 the hospital's previous fiscal year. In calculating prospective
7 payment system rates, all adjustment factors shall be included. The
8 Alaska Hospital Association shall annually submit to the Rate-setting
9 Commission a plan for the calculation of the shortfall and the dis-
10 tribution of money from the fund. The amount available for distribu-
11 tion from the fund shall not exceed $50,000,000 for each year.
12 (b) The commissioner of revenue shall receive and be the custo-
13 dian of funds appropriated for the Medicare shortfall assistance fund.
14 The funds shall be distributed under methods and procedures adopted by
15 the Rate-setting Commission giving weight to the plan submitted by the
16 Alaska Hospital Association.
17 Sec. 18.21.030. ANNUAL REPORT. Every acute hospital shall file
18 with the commission within 90 days after the beginning of the fiscal
19 year and at least once during the fiscal year, as required by the
20 commission, a summary of revenue, costs and statistical information
21 the commission requires in order to document the relationship of
22 actual non-Medicare gross inpatient service revenue to approved non-
23 Medicare gross inpatient service revenue, so that the commission may
24 determine the extent to which excess revenue or deficit revenue was
25 generated for the fiscal year. For this purpose, excess revenue for
26 each fiscal year shall equal the amount by which actual non-Medicare
27 gross inpatient service revenue exceeds approved non-Medicare gross
28 inpatient service revenue for the fiscal year, and deficit revenue
29 shall equal the amount by which approved non-Medicare gross inpatient

1 service revenue exceeds actual approved non-Medicare gross inpatient
2 service revenue for the fiscal year.
3 Sec. 18.21.040. ACUTE HOSPITAL CHARGES. Every acute hospital
4 shall establish its charges under the provisions of this chapter. The
5 charges established by an acute hospital for health care services
6 rendered shall be uniform for all patients receiving comparable ser-
7 vices.
8 Sec. 18.21.050. PATIENT CARE COSTS. In addition to the other
9 adjustments required in this chapter, the patient care costs of cer-
10 tain hospitals shall be adjusted as follows:
11 (1) for fiscal years 1989, 1990, and 1991, the patient care
12 costs of certain hospitals shall be adjusted to incorporate a low base
13 cost adjustment under the distribution methodology set out under
14 AS 18.21.130 - 18.21.230; the commission shall ensure that the sum of
15 all individual hospital adjustments under this paragraph shall in-
16 crease the projected payments from purchasers and third-party payors
17 who pay on the basis of charges and a hospital service corporation by
18 $55,000,000 for fiscal year 1988; and by $40,000,000, multiplied by
19 one plus the fiscal year 1989 inflation adjustment under AS 18.21.-
20 060(d), for fiscal year 1990; and
21 (2) for fiscal years 1990, 1991, and 1992, the patient care
22 costs of certain hospitals shall be adjusted to incorporate a prospec-
23 tive payment system price reduction adjustment made under a distribu-
24 tion methodology adopted by the Rate-setting Commission giving weight
25 to the plan submitted by the Alaska Hospital Association; the purpose
26 of the adjustment shall be to compensate acute hospitals for those
27 shortfalls in Medicare payments for which the hospitals are not com-
28 pensated; the distribution plan shall identify every hospital that is
29 to receive this adjustment and shall specify, for each hospital, an

1 amount of projected net patient service revenue that is to be received
2 from a hospital service corporation and purchasers and third-party
3 payors who pay on the basis of charges; the distribution plan shall be
4 submitted to the commission by September 1 of each year and the com-
5 mission shall verify that the sum of all individual hospital adjust-
6 ments shall increase the projected payments from purchasers and
7 third-party payors who pay on the basis of charges and a hospital
8 service corporation by an amount not to exceed $20,000,000 each year.
9 Sec. 18.21.060. ACUTE HOSPITAL PATIENT COSTS. For fiscal year
10 1988, patient care costs for each acute hospital shall be determined
11 under the following provisions and calculations:
12 (1) the fiscal year 1988 total patient care costs shall
13 include the following provisions:
14 (A) all hospital agreement 29 base year adjustments
15 and exceptions shall be included at the amount approved or au-
16 dited by the commission as of December 11, 1988, except that
17 where a formal settlement agreement was executed between Blue
18 Cross and the hospital before December 11, 1988, the amounts
19 included in the settlement shall be the amounts included in this
20 adjustment;
21 (B) absent a commission approved amount as of
22 December 11, 1988, the amount to be included shall be that amount
23 formally recommended for approval by Blue Cross and included as
24 an adjustment to the appropriate year's hospital agreement 29
25 year end maximum allowable cost report or as formally agreed to
26 in writing by Blue Cross and the hospital as of April 1, 1989; no
27 other adjustment may be made;
28 (C) all hospital agreement 30 recurring base year
29 adjustments and exceptions approved by the commission; the

1 commission shall resolve all outstanding hospital agreement 30
2 base year adjustments and exceptions; hospitals shall retain the
3 right to appeal commission disallowances of hospital agreement 30
4 exceptions and base year adjustments;
5 (D) the commission shall complete all outstanding
6 audits as of September 1, 1989; the 1988 maximum allowable cost
7 shall be adjusted to reflect the effects of all resolved audits;
8 hospitals shall retain the right to appeal audit adjustments;
9 (E) fiscal year 1988 total patient care costs as
10 calculated under hospital agreement 30 schedule A.O. line 12 of
11 year-end per-review filing and as adjusted by the provisions
12 stipulated in (A) - (D) of this paragraph shall be further ad-
13 justed by subtracting lines 9, 10, and 11 of schedule A.O., as
14 adjusted; this result multiplied by 94-12/100 percent shall
15 constitute fiscal year 1987 maximum allowable costs;
16 (2) the maximum allowable costs shall be further adjusted
17 in a manner to provide that the projected payments of a hospital
18 service corporation and purchasers and third-party payors who pay on
19 the basis of charges will include the amount of net revenue adjust-
20 ment, if any, provided in this chapter;
21 (3) the fiscal year 1988 maximum allowable costs shall be
22 further adjusted by adding or subtracting, as appropriate, one-half of
23 the difference between the inpatient services volume allowance pro-
24 vided in line eight of schedule A.O. of the 1988 year-end filing
25 per-review appendix D maximum allowable cost report and a revised
26 inpatient services volume allowance calculated on the basis of formu-
27 las contained in hospital agreement 30, but utilizing a marginal cost
28 allowance of 100 percent; both the original fiscal year 1988 inpatient
29 services volume allowance and the revised fiscal year 1988 inpatient

1 services volume allowance shall be calculated using a conversion
2 program that corrects for inconsistencies resulting from coding and
3 grouper changes between fiscal year 1985 and fiscal year 1988;
4 (4) fiscal year 1988 maximum allowable costs as adjusted
5 under (1) - (4) of this section shall then be multiplied by the fiscal
6 year 1989 inflation adjustment; the inflation adjustment shall be
7 equal to the sum of: (A) the composite inflation factor calculated in
8 accordance with the methodology described in hospital agreement 30
9 utilizing May inflation projections, or February inflation projections
10 in the case of hospitals with fiscal years ending June 30, and (B)
11 2/100; revenue attributable to the 2/100 shall provide for certain
12 wage increases for technicians, nurses, nursing aides, orderlies, and
13 attendants; carry forward of underprojections or overprojections from
14 the preceding year shall not be included;
15 (5) the fiscal year 1987 maximum allowable costs, as ad-
16 justed under (2) - (4) of this section, shall be further adjusted, if
17 necessary, to increase them to an amount equal to fiscal 1988 maximum
18 allowable costs determined under (1) of this section multiplied by a
19 factor of one and 46/1000;
20 (6) fiscal year 1988 maximum allowable costs determined
21 under (4) or (5) of this section, as applicable, shall be further
22 adjusted by incorporating a 1989 volume adjustment that shall be
23 calculated in accordance with the following conditions:
24 (A) all inpatient and outpatient volume adjustments
25 shall utilize the same statistics as were utilized in hospital
26 agreement 30 to measure volume changes and shall be computed on a
27 cost base that has been adjusted for the level of productivity
28 included in the last year of hospital agreement 30;
29 (B) the inpatient, routine outpatient, surgical day

1 care, and emergency service volume adjustments shall be calculated on the basis of a marginal cost allowance of 100 percent and there shall be no corridors applied;

4 (C) the outpatient ancillary service volume adjustments shall be calculated on the basis of a marginal cost allowance of 60 percent and there shall be no corridors applied;

7 (D) in determining the inpatient volume allowance for fiscal years 1989 - 1992, the statistical base shall be case-mix adjusted discharges, including all transfers of inpatients from an acute hospital to another facility; the commission shall ensure that the changes in volume are calculated in such a way as to accurately adjust for any coding and grouper changes that have been implemented; and to accurately account for discharges assigned a zero weight under the New Jersey weighting system; adjustments may take one or more than one of the following forms but shall not be limited to the options outlined: (i) restatement of all fiscal years into a form consistent with the coding principles and grouper utilized in fiscal year 1985 or 1988; (ii) restatement of the rate year into a form consistent with the coding principles and grouper utilized in the year preceding the rate year; (iii) restatement of the rate year and year preceding the rate year to account for any updates made by the state of New Jersey in its weighting system which more appropriately reflect the coding principles and grouper being utilized; and (iv) development by Blue Cross and the Alaska Hospital Association of weights for discharges assigned a zero weighting under the New Jersey system; in carrying out its rights and responsibilities granted under this paragraph, the commission must inform hospitals by no later than April 30, of the rate year, how the

1 change in case-mix adjusted discharges is to be measured for that
2 year; the determination shall be made only after a series of
3 public hearings has taken place and the commission shall consider
4 the comments of all interested parties in making its final deter-
5 mination; if Blue Cross and the Alaska Hospital Association have
6 failed to agree on a methodology for deriving weights for dis-
7 charges assigned a zero weighting by June 30 of the rate year,
8 hospitals may submit individual methodologies to the commission
9 for approval and subsequent incorporation;
10 (7) fiscal year 1988 maximum allowable costs as adjusted
11 under (6) of this section shall be further adjusted by adding fiscal
12 year 1989 depreciation, amortization, interest, determination of need
13 capital cost and other capital costs defined under hospital agreement
14 30; the fiscal year 1989 dollar amount of the depreciation, amortiza-
15 tion, interest, determination of need capital costs, and other capital
16 costs that was subject to productivity adjustment in the last year of
17 hospital agreement 30 shall be multiplied by 94 and 12/100 percent;
18 the remaining fiscal year 1989 dollar amount shall be allowed in full;
19 the sum of the productivity adjusted portion and the amount allowed in
20 full shall be the adjustment;
21 (8) the fiscal year maximum allowable costs shall be fur-
22 ther adjusted by adding any incremental costs incurred subsequent to
23 October 1, 1988, associated with government-mandated requirements
24 mandated subsequent to October 1, 1987, and approved by the commis-
25 sion; for purposes of this paragraph, "government-mandated require-
26 ments" means the incremental costs for each acute care hospital re-
27 sulting from its compliance with any governmental requirement whether
28 established by statute, regulation, or governmental ordinance and
29 shall be allowed on the basis of incurred costs;

1 (9) the fiscal year 1988 adjusted maximum allowable costs
2 shall be further adjusted by adding any incremental operating costs
3 associated with approved determination of need projects; the costs
4 shall be subject to commission approval under criteria utilized during
5 the term of hospital agreement 30; in addition, in the case of the
6 department of mental health's approved special projects, the maximum
7 allowable costs shall be further adjusted by an amount, to be de-
8 termined by the commission, that will provide an incentive for hos-
9 pitals to undertake the projects, provided that the incentive adjust-
10 ment shall in no case exceed 10 percent of incremental operating
11 costs;
12 (10) the fiscal year 1988 maximum allowable costs shall be
13 further adjusted to incorporate actual malpractice costs, and sick,
14 vacation, and earned time accruals, that are applicable in accordance
15 with provisions contained in hospital agreement 30; the fiscal year
16 1989 dollar amount of actual malpractice costs and sick, vacation, and
17 earned time accruals that was subject to productivity adjustment in
18 the last year of hospital agreement 30 shall be multiplied by 94 and
19 12/100 percent; the remaining fiscal year 1989 dollar amount shall be
20 allowed in full; the sum of the productivity adjusted portion and the
21 amount allowed in full shall be the adjustment;
22 (11) fiscal year 1988 maximum allowable costs, as adjusted
23 under (1) - (10) of this section shall constitute fiscal year 1989
24 patient care costs for purposes of determining fiscal year 1989 ap-
25 proved gross patient service revenue under this chapter;
26 (12) each acute hospital that receives an adjustment under
27 (2) or (3) of this section shall expend a sufficient portion of its
28 fiscal year 1989 approved gross patient service revenue upon expendi-
29 tures in the six nonmanagement labor categories designated under

1 schedule C.1.0. of appendix D of hospital agreement 30 to ensure that
2 the hospital will not be subject to a labor cost recovery under this
3 chapter.
4 Sec. 18.21.070. INPATIENT VOLUME DECLINE ADJUSTMENT. (a)
5 Except as provided in AS 18.21.210, a hospital that had an inpatient
6 volume decline of 20 percent or more from fiscal year 1985 through
7 fiscal year 1987 and which operated at an occupancy rate of 50 percent
8 or less in fiscal year 1988, shall not be entitled to the adjustment
9 described in AS 18.21.050(1) or (2) or to the adjustment described in
10 AS 18.21.060(5). For the purposes of this section, volume decline
11 shall be measured using case-mix adjusted discharges calculated in the
12 same manner as in AS 18.21.060(5), and occupancy rate shall be mea-
13 sured using total fiscal year 1988 patient days for all services
14 divided by the number of licensed end beds multiplied by 365. Li-
15 censed beds shall be calculated by taking the number of end beds as
16 reported in Rate-setting Commission form 403, schedule III, column 4,
17 line 14 and subtracting any beds reduced or converted by any determi-
18 nation of need approved or on file as of January 1, 1989, and further
19 subtracting any beds temporarily removed from service if the removal
20 has been granted by the Department of Health and Social Services,
21 under licensure regulations for hospitals, and if the removal was
22 effective before October 1, 1988. Occupancy rate shall be calculated
23 by taking the total patient days as reported to the Rate-setting
24 Commission and dividing by the product of end beds, as hereinbefore
25 described, times 365 expressed as a percentage.
26 (b) Except as provided in AS 18.21.210, an institution that
27 experienced an occupancy rate of 40 percent or less in fiscal year
28 1988 shall not be entitled to the adjustment described in AS 18.21.-
29 050(1) or (2) or to the adjustment described in AS 18.21.060(5).

1 Occupancy rate shall be measured as described in (a) of this section.
2 (c) Notwithstanding this section, the following types of hos-
3 pitals shall be entitled to the adjustments described in AS 18.21.-
4 050 - 18.21.060, regardless of their rates of volume decline or occu-
5 pancy:
6 (1) a sole community provider;
7 (2) a specialty hospital; or
8 (3) a comprehensive cancer center.
9 Sec. 18.21.080. ACUTE CARE PATIENT COSTS. For fiscal year 1990,
10 patient care costs for each acute hospital shall be determined in
11 accordance with the following provisions:
12 (1) fiscal year 1989 adjusted prior year costs for each
13 acute hospital shall be adjusted to reflect the incremental costs of
14 prior year recurring determination of need exceptions that represent
15 full year costs;
16 (2) fiscal year 1989 adjusted prior year costs shall be
17 further adjusted in such a manner as to ensure that the projected
18 payments of a hospital service corporation and third-party payors who
19 pay on the basis of charges will include the amount of net revenue
20 adjustment, for fiscal year 1990, if any, under AS 18.21.050(1) and
21 (3);
22 (3) fiscal year 1989 adjusted prior year costs shall be
23 further adjusted by adding or subtracting, as appropriate, one-half of
24 the difference between the inpatient services volume allowance and the
25 revised inpatient services volume allowance calculated under AS 18.-
26 21.060(3), multiplied by the fiscal year 1989 inflation adjustment as
27 determined under AS 18.21.070(3);
28 (4) fiscal year 1989 adjusted prior year costs, as adjusted
29 under (1) - (3) of this section, shall then be multiplied by the

1 fiscal year 1990 inflation adjustment; the inflation adjustment shall
2 be equal to the sum of: (A) the composite inflation factor calculated
3 in accordance with the methodology described in hospital agreement 30
4 utilizing May inflation projections, or February inflation projections
5 in the case of hospitals with fiscal years ending June 30, and (B)
6 1/100; revenue attributable to said 1/100 shall provide for certain
7 wage increases for technicians, nurses, nursing aides, orderlies, and
8 attendants; carry forward of underprojections or overprojections from
9 the preceding year shall not be included;
10 (5) fiscal year 1989 adjusted prior year costs shall be
11 further adjusted in such a manner as to ensure that the projected
12 payments of a hospital service corporation and purchasers and third-
13 party payors who pay on the basis of charges will include the amount
14 of net revenue adjustment, if any, under AS 18.21.060(2);
15 (6) fiscal year 1989 adjusted prior year costs as adjusted
16 under (1) - (5) of this subsection, shall be further adjusted by
17 incorporating a 1990 volume adjustment that shall measure volume
18 changes between fiscal year 1990 and 1991 and that shall be calculated
19 under AS 18.21.070(6);
20 (7) the fiscal year 1990 adjusted prior year costs shall be
21 further adjusted by adding fiscal year 1990 depreciation, amortiza-
22 tion, interest, determination of need capital costs and other capital
23 costs defined under hospital agreement 30; the fiscal year 1990 dollar
24 amount of the depreciation, amortization, interest, determination of
25 need capital costs, and other capital costs that was subject to pro-
26 ductivity adjustment in the last year of hospital agreement 30 shall
27 be multiplied by 94 12/100 percent; the remaining fiscal year 1990
28 dollar amount shall be allowed in full; the sum of the productivity
29 adjusted portion and the amount allowed in full shall be the

1 adjustment;

2 (8) fiscal year 1989 adjusted prior year costs shall be
3 further adjusted by adding any incremental costs associated with
4 government-mandated requirements as defined in AS 18.21.079(8);

5 (9) fiscal year 1989 adjusted prior year costs shall be
6 further adjusted by adding any incremental operating costs associated
7 with approved determination of need projects implemented in fiscal
8 year 1990; the costs shall be subject to commission approval under
9 criteria utilized during the term of hospital agreement 30; in addi-
10 tion, in the case of the Department of Health and Social Services
11 approved special projects, the maximum allowable costs shall be fur-
12 ther adjusted by an amount, to be determined by the commission, that
13 will provide an incentive for hospitals to undertake the projects,
14 provided that the incentive adjustment shall in no case exceed 10
15 percent of incremental operating costs;

16 (10) fiscal year 1989 adjusted prior year costs shall be
17 further adjusted to incorporate actual fiscal year 1990 malpractice
18 costs, and sick, vacation, and earned time accruals that are applica-
19 ble in accordance with provisions contained in hospital agreement 30;
20 the fiscal year 1990 dollar amount of actual malpractice costs and
21 sick, vacation, and earned time accruals that was subject to produc-
22 tivity adjustment in the last year of hospital agreement 30 shall be
23 multiplied by 94 12/100 percent; the remaining fiscal year 1990 dollar
24 amount shall be allowed in full; the sum of the productivity adjusted
25 portion and the amount allowed in full shall be the adjustment;

26 (11) each acute hospital shall report to the commission its
27 actual expenses during fiscal years 1988 and 1989 for each of the six
28 nonmanagement labor categories so designated under schedule C.1.O. of
29 appendix D of hospital agreement 30;

1 (12) fiscal year 1989 adjusted prior year costs, as adjusted
2 under (1) - (10) of this subsection, shall constitute fiscal year 1990
3 patient care costs for purposes of determining fiscal year 1990 ap-
4 proved gross patient service revenue under AS 18.21.100;
5 (13) each acute hospital that receives an adjustment under
6 (1) or (2) of this subsection shall expend a sufficient portion of its
7 fiscal year 1990 approved gross patient service revenue upon expendi-
8 tures in the six nonmanagement labor categories to ensure that the
9 hospital will not be subject to a labor cost recovery under AS 18.-
10 21.090.
11 Sec. 18.21.090. FUTURE ACUTE CARE PATIENT COSTS. (a) For
12 fiscal year 1991 patient care costs for each acute hospital shall be
13 determined in a manner consistent with AS 18.21.080(1) and (4) - (13).
14 Fiscal year 1991 approved revenue of any hospital that received an
15 adjustment under AS 18.21.070(2) or (3), or 18.21.080(2) or (3) shall
16 be further adjusted by subtracting a labor cost recovery, if any. The
17 labor cost recovery shall be determined as follows:
18 (1) the fiscal year 1990 actual expenses for each of the
19 six nonmanagement labor categories designated under schedule C.1.0. of
20 appendix D of hospital agreement 30 shall be adjusted by subtracting
21 the product of the inflation adjustments associated with the cat-
22 egories under AS 18.21.070(3) and 18.21.080(3), and multiplied by the
23 percentage of total gross patient service revenue attributable to
24 purchasers and third-party payors who pay on the basis of charges and
25 a hospital service corporation; the results shall then be summed for
26 all six such categories;
27 (2) the fiscal year 1988 actual expenses for the sum of the
28 six nonmanagement labor categories shall be adjusted by adding 80
29 percent of the net revenue received from purchasers and third-party

1 payors who pay on the basis of charges and a hospital service corpo-
2 ration due to adjustments made under AS 18.21.070(2) and (3), and
3 18.21.080(2) and (3);
4 (3) subtract the amount calculated in (1) of this sub-
5 section from the amount calculated in (2) of this subsection;
6 (4) if the amount calculated in (3) of this subsection is
7 positive, a labor cost recovery shall be applicable; the labor cost
8 recovery shall be the lesser of the amount in (3) of this subsection
9 or 80 percent of the net revenue received from purchasers and third-
10 party payors who pay on the basis of charges and a hospital service
11 corporation as a result of adjustments made under AS 18.21.070(2) and
12 (3), and 18.21.080(2) and (3);
13 (5) fiscal year 1991 approved revenue shall be adjusted in
14 a manner to ensure that the projected payments of purchasers and
15 third-party payors who pay on the basis of charges and a hospital
16 service corporation are reduced by the amount of the labor cost recov-
17 ery, if any, calculated under (4) of this section.
18 (b) The commission may waive any or all of the labor cost recov-
19 ery under (a)(1) - (5) of this section, upon request for any hospital
20 that demonstrates that the recovery would inappropriately penalize the
21 hospital and its nonmanagement employees, because the hospital's fail-
22 ure to expend sufficient amounts for nonmanagement labor expenses to
23 avoid the recovery is the result of staff reductions necessary to
24 accommodate a volume decline or of inability to hire employees due to
25 a shortage of available personnel.
26 (c) Each acute hospital shall report its actual expenses during
27 fiscal years 1988 and 1990 for each of the six nonmanagement labor
28 categories designated under schedule C.1.0. of appendix D of hospital
29 agreement 30.

1 Sec. 18.21.100. HOSPITAL PATIENT COSTS. (a) For fiscal year
2 1992, patient care costs for each hospital shall be determined in a
3 manner consistent with AS 18.21.090(a). Fiscal year 1992 approved
4 revenue of a hospital that received an adjustment under AS 18.21.-
5 080(2) or (3), or 18.21.090(2) or (3), and that was subject to a labor
6 cost recovery under AS 18.21.090 shall be further adjusted to reflect
7 a labor cost recovery, if any. The labor cost recovery shall be
8 determined as follows:
9 (1) the fiscal year 1991 actual expenses for each of the
10 six nonmanagement labor categories designated under schedule C.1.0. of
11 appendix D of hospital agreement 30 shall be adjusted by subtracting
12 the product of: the sum of (A) the inflation adjustments associated
13 with the categories that were provided under AS 18.21.080(3) and
14 18.21.090(3), and (B) the comparable inflation adjustments provided
15 for fiscal year 1991; multiplied by the percentage of total gross
16 patient service revenue attributable to purchasers and third-party
17 payors who pay on the basis of charges and a hospital service corpo-
18 ration; the results shall then be summed for all six categories;
19 (2) the fiscal year 1988 actual expenses for the sum of six
20 nonmanagement labor categories shall be adjusted by adding 80 percent
21 of the net revenue received from purchasers and third-party payors who
22 pay on the basis of charges and a hospital service corporation due to
23 adjustments made under AS 18.21.080(2) and (3), and 18.21.090(2) and
24 (3);
25 (3) subtract the amount calculated in (a)(1)(A) of this
26 section from the amount calculated in (a)(1)(B) of this section;
27 (4) if the amount calculated in (a)(1)(B) of this section
28 is positive, a labor cost recovery shall be applicable; the labor cost
29 recovery shall be the lesser of the amount in (a)(1)(B) or 80 percent

1 of the net revenue received from purchasers and third-party payors who
2 pay on the basis of charges and a hospital service due to adjustments
3 made under AS 18.21.080(2) and (3), and 18.21.090(2) and (3);
4 (5) fiscal 1992 approved revenue shall be adjusted in a
5 manner to ensure that the projected payments of purchasers and third-
6 party payors who pay on the basis of charges and a hospital service
7 corporation are reduced by the amount of the labor cost recovery, if
8 any, calculated under (a)(4) of this section.
9 (b) The commission may waive any or all of the labor cost recov-
10 ery under (a) of this section upon request for any hospital that
11 demonstrates that the recovery would inappropriately penalize the
12 hospital and its nonmanagement employees, because the hospital's fail-
13 ure to expend sufficient amounts for nonmanagement labor expenses to
14 avoid the recovery is the result of staff reductions necessary to
15 accommodate a volume decline or of inability to hire employees due to
16 a shortage of available personnel.
17 Sec. 18.21.110. GROSS PATIENT SERVICE REVENUE. For fiscal years
18 1989 -1992 approved gross patient service revenue shall be calculated
19 in the following manner:
20 (1) each year the malpractice adjustment for medicare short-
21 fall calculated under the principles governing hospital agreement 30
22 shall be added to fiscal year patient care costs as calculated under
23 AS 18.21.060 - 18.21.100;
24 (2) patient care costs for fiscal years 1989 - 1992, as
25 calculated under AS 18.21.060 - 18.21.100 and as adjusted under (1) of
26 this section shall then be multiplied by the proportion of charges
27 attributable to those purchasers and third-party payors who pay on the
28 basis of charges and to a hospital service corporation, excluding
29 those charges associated with free care, bad debt, and services

1 rendered to title XIX recipients; the product shall be known as private sector patient care costs;

3 (3) private sector patient care costs as computed according to (2) of this section shall then be further adjusted for a working capital allowance as computed in accordance with hospital agreement 30, and the sum shall be multiplied by one plus the uniform statewide uncompensated care allowance as computed according to AS 18.21.140; the resulting product shall be termed the private sector liability;

9 (4) the private sector liability as computed according to (3) of this section shall be divided by: (A) the proportion of charges attributable to purchasers and third-party payors who pay on the basis of charges, excluding those charges associated with free care and bad debt services, multiplied by one plus the uniform differential; plus (B) the proportion of charges attributable to a hospital service corporation; the result of this division shall be known as the Blue Cross basis of payment;

17 (5) the Blue Cross basis of payment as calculated in accordance with (4) of this section shall be further multiplied by one plus the uniform differential and the resulting product shall be termed approved gross patient service revenue for fiscal years 1989 - 1992.

21 Sec. 18.21.120. NON-MEDICARE SERVICE REVENUE. For fiscal years 1989 - 1992, approved non-Medicare gross inpatient service revenue shall be calculated as follows:

24 (1) actual gross outpatient service revenue shall be subtracted from approved gross patient service revenue and the resulting difference shall be known as approved gross inpatient service revenue; approved gross inpatient service revenue shall then be multiplied by: (A) the ratio of the percent of actual gross inpatient service revenue attributable to non-Medicare patients to the percent of case-mix

1 adjusted discharges attributal to non-Medicare patients; the calcu-
2 lation shall utilize gross inpatient service revenue and case-mix
3 adjusted discharges for the final six months of the fiscal year begin-
4 ning on October 1, 1984, and the first six months of the fiscal year
5 beginning on October 1, 1985, and shall be further adjusted, if appli-
6 cable, under changes made in accordance with AS 18.21.080(6); and (B)
7 the percent of case-mix adjusted discharges attributable to non-
8 Medicare patients in the rate year;
9 (2) the resultant amount shall be termed the approved
10 non-Medicare gross inpatient service revenue without compliance; how-
11 ever, if an acute hospital appealed the commission's determination of
12 approved gross inpatient service revenue for the acute hospital for
13 the fiscal years beginning October 1, 1983, or October 1, 1984, and
14 the commission affecting the pendency of the appeal ordered the acute
15 hospital to adjust its charges to comply with approved gross patient
16 service revenue and the order affected all or part of the final six
17 months of the fiscal year beginning October 1, 1984, and the first six
18 months of the fiscal year beginning October 1, 1985, and the order of
19 the commission was determined by the division not to have been in
20 accordance with the approved gross patient service revenue determined
21 by the division for the acute hospital, then the calculation of the
22 ratio of the percent of actual gross inpatient service revenue attrib-
23 utable to non-Medicare patients to the percent of case-mix adjusted
24 discharges attributable to non-Medicare patients shall utilize gross
25 inpatient service revenues and case-mix adjusted discharges for the
26 final six months of the fiscal year beginning October 1, 1983, and the
27 first six months of the fiscal year beginning October 1, 1984.
28 Sec. 18.21.130. NON-MEDICARE GROSS REVENUE. Beginning with
29 fiscal year 1989, and for each fiscal year thereafter, approved non-

1 Medicare gross inpatient service revenue, without compliance, shall be
2 adjusted to reflect any deficit or excess revenue earned in the preceding fiscal year; the dollar amount of the deficit or excess revenue
4 shall be multiplied by one plus the average prime interest rate for
5 the preceding fiscal year plus two percent and the product shall be
6 the dollar amount added to or subtracted from approved non-Medicare
7 gross inpatient service revenue, without compliance, and the resultant
8 amount shall be termed approved non-Medicare gross inpatient service
9 revenue.

10 Sec. 18.21.140. ACUTE CARE HOSPITAL DEFICIT. Notwithstanding
11 any other provisions of law, in computing the amount of each acute
12 hospital's deficit or excess revenue in any fiscal year, the commis-
13 sion shall, subject to regulations to be adopted by the commission,
14 increase or decrease a hospital's approved non-Medicare gross inpa-
15 tient service revenue to the extent that it determines that the defi-
16 cit or excess in the hospital's non-Medicare gross inpatient service
17 revenue is attributable to a change from the base period to the fiscal
18 year in the number and type of services provided to non-Medicare
19 patients, as compared to Medicare patients, which change is caused by
20 a change in the relative clinical characteristics and medical needs of
21 non-Medicare and Medicare patients not reflected in the measurement of
22 case-mix adjusted discharges.

23 Sec. 18.21.150. UNCOMPENSATED CARE ALLOWANCE. (a) The uniform
24 statewide allowance for uncompensated care for each hospital for each
25 fiscal year beginning in fiscal year 1989 shall be calculated by the
26 commission by dividing the amount of total private sector liability to
27 the pool for such fiscal year by an amount equal to the sum of: (1)
28 the sum for all acute hospitals of the private sector share of pro-
29 jected patient care costs for the fiscal year; and (2) a working

1 capital allowance specified by the commission for the fiscal year.
2 The amount of total private sector liability to the pool for this
3 purpose shall equal: $325,000,000 for fiscal year 1989; $318,500,000
4 for fiscal year 1990; $312,000,000 for fiscal year 1991; and
5 $312,000,000 minus the amount appropriated by the state for the fiscal
6 year for coverage of hospitalization expenses of recipients of bene-
7 fits under AS 21.55 for fiscal year 1992.
8 (b) Prior to the beginning of each hospital fiscal year, the
9 commission shall, using the most appropriate and accurate data avail-
10 able, estimate the uniform allowance for statewide uncompensated care.
11 These estimates shall be updated, on a timely basis, as significant
12 new information becomes available. The commission shall supply these
13 data and estimates promptly to the Disability Insurance Authority and
14 shall audit the accounts of hospitals with respect to receipts and
15 liabilities for uncompensated care in accordance with standards adopt-
16 ed by the authority.
17 Sec. 18.21.160. INTERIM PAYMENT RATE. For fiscal years 1989 -
18 1992, the interim rate of payment by a nonprofit hospital service
19 corporation to acute hospitals shall be at the level of billed charges
20 multiplied by the ratio of: (1) one; to (2) the sum of one plus the
21 uniform differential.
22 Sec. 18.21.170. LOW COST HOSPITAL ADJUSTMENT. Notwithstanding
23 any other provisions of law, the commission shall identify low cost
24 acute hospitals and shall allow each hospital the low cost hospital
25 adjustment provided under AS 18.21.180 - 18.21.250.
26 Sec. 18.21.180. CALCULATION OF LOW COST ADJUSTMENT. (a) Each
27 hospital's qualification for a low cost hospital adjustment shall be
28 determined by:
29 (1) dividing 1986 adjusted patient days into noncapital

1 expense for each hospital, to derive its 1986 noncapital costs per
2 adjusted patient day;
3 (2) calculating two standard deviations below the median of
4 all hospitals' noncapital costs per adjusted patient day;
5 (3) assigning each hospital an increasing positive or
6 increasing negative Arabic number depending on its rank above or below
7 the second standard deviation from the median calculated under (2) of
8 this section;
9 (4) dividing 1986 adjusted admissions into noncapital costs
10 for each hospital to derive its 1986 noncapital costs per adjusted
11 admission;
12 (5) calculating two standard deviations below the median of
13 all hospitals' 1986 noncapital costs per adjusted admissions;
14 (6) assigning each hospital an increasing positive or
15 increasing negative Arabic number depending on its rank above or below
16 the second standard deviation from the median calculated under (5) of
17 this subsection;
18 (7) for each hospital sum the positive and negative Arabic
19 numbers assigned by (3) and (4) of this subsection to derive its
20 aggregate ranking.
21 (b) Each hospital whose aggregate ranking of 1986 noncapital
22 costs per patient day and 1986 noncapital costs per adjusted admission
23 is less than zero, shall be determined to be entitled to a low cost
24 hospital adjustment.
25 Sec. 18.21.190. NONCAPITAL COST ADJUSTMENT. Each hospital
26 entitled to a low cost hospital adjustment whose greater individual
27 negative ranking is for 1986 noncapital costs per adjusted patient
28 day, as assigned under AS 18.21.180(a)(3), the low cost hospital
29 adjustment shall be the lesser of the noncapital cost per adjusted

1 patient day recovery or the revenue reduction factor under AS 18.21.-
2 210 - 18.21.230.
3 Sec. 18.21.200. ADMISSION RECOVERY FACTOR. Each hospital enti-
4 tled to a low cost hospital adjustment whose greater individual nega-
5 tive ranking is for 1986 noncapital costs per adjusted admission, as
6 provided under AS 18.21.180(a)(6), the low cost hospital adjustment
7 shall be the lesser of the cost per adjusted admission recovery or the
8 revenue restoration factor provided for under AS 18.21.220 - 18.21.-
9 230.
10 Sec. 18.21.210. ADJUSTED PATIENT DAY FACTOR. The noncapital
11 cost per adjusted patient day recovery shall be calculated separately
12 for each hospital whose low cost hospital adjustment is subject to
13 AS 18.21.190. For each such hospital the noncapital cost per adjusted
14 patient day recovery shall be equal to the difference between the 1986
15 noncapital costs per adjusted patient day for all hospitals calculated
16 under AS 18.21.180(2), less the 1986 noncapital costs per adjusted
17 patient day for the individual hospital, calculated under AS 18.21.-
18 180(1), multiplied by the individual hospital's 1986 adjusted patient
19 days. The amount so calculated shall be increased or decreased by the
20 percentage change reported for the Consumer Price Index (ALL URBAN) -
21 Medical Care Services for New England - Data Resources, Inc., Health
22 Care Cost - Regional Forecast between the last amount reported for
23 1986 and the amount reported and projected through fiscal year 1988 by
24 Data Resources, Inc.
25 Sec. 18.21.220. ADMISSION RECOVERY ADJUSTMENT. The noncapital
26 cost per adjusted admission recovery shall be calculated separately
27 for each hospital whose low cost hospital adjustment is subject to
28 AS 18.21.190. For each hospital the noncapital cost per adjusted
29 admission recovery shall be equal to the difference between the 1986

1 noncapital cost per adjusted admission calculated under AS 18.21.-
2 180(5) less the 1986 noncapital costs per adjusted admission for the
3 individual hospital, calculated under AS 18.21.180(4), multiplied by
4 the individual hospital's 1986 adjusted admissions. The amount cal-
5 culated shall be increased or decreased by the percentage change
6 reported for the Consumer Price Index (ALL URBAN) - Medical Care
7 Services for New England - Data Resources, Inc., Health Care Cost -
8 Regional Forecast between the last amount reported for 1986 and the
9 amount reported and projected through fiscal year 1989 by Data Re-
10 sources, Inc.
11 Sec. 18.21.230. REVENUE RESTORATION FACTOR. Each hospital's
12 revenue restoration factor shall be calculated by:
13 (1) dividing revenue charged by the hospital to each of its
14 payors by total hospital patient care related revenue;
15 (2) multiplying each payor specific revenue to total reve-
16 nue percentage by a related fiscal year 1984 payor productivity per-
17 centage of two percent for Medicare; zero percent for Blue Cross; two
18 percent for Medicaid; and 1 4/10 percent for all other payors;
19 (3) summing the percentages derived under (2) of this
20 section to derive the 1984 hospital specific revenue restoration
21 percentage;
22 (4) dividing revenue charged by the hospital to each of its
23 payors by total hospital patient care related revenue;
24 (5) multiplying each payor specific revenue to total reve-
25 nue percentage by a related fiscal year 1985 payor productivity per-
26 centage of: four percent for Medicare; zero percent for Blue Cross;
27 four percent for Medicaid; and zero percent for all other payors;
28 (6) summing the percentages derived under (5) of this
29 section to derive a hospital specific 1985 revenue restoration

1 percentage;

2 (7) dividing revenue charged by the hospital to each of its
3 payors by total hospital patient care related revenue;

4 (8) multiplying each payor specific revenue to total reve-
5 nue percentage by a related fiscal year 1986 productivity percentage
6 of: four percent for Medicare; two percent for Blue Cross; six percent
7 for Medicaid; and two percent for all other payors;

8 (9) summing the percentages derived under (8) of this
9 section to derive a hospital specific 1986 revenue restoration per-
10 centage;

11 (10) dividing revenue charged by the hospital to each of its
12 payors by total hospital patient care related revenue;

13 (11) multiplying each payor specific revenue to total reve-
14 nue percentage by a related fiscal year 1987 productivity percentage
15 of: two percent for Blue Cross; three percent for Medicaid; and two
16 percent for all other payors;

17 (12) summing the percentages derived under (11) of this
18 section to derive a hospital specific 1987 revenue restoration per-
19 centage;

20 (13) the 1988 revenue restoration percentage shall be the
21 same calculation as provided for by (11) of this section, except that
22 the productivity percentage for Medicaid shall be two percent;

23 (14) summing the revenue restoration percentages for 1984 -
24 1988 calculated under (3), (6), (9), (12), and (13) of this section to
25 derive an aggregate hospital specific restoration percentage; and

26 (15) multiplying the aggregate hospital specific restoration
27 percentage by the amount of maximum allowable costs reported by each
28 hospital; the amount calculated shall constitute each hospital's
29 revenue restoration factor and shall be increased or decreased by the

1 percentage change reported for the Consumer Price Index (ALL URBAN) - Medical Care Services for New England - Data Resources, Inc., Health Care Cost - Regional Forecast between the last amount reported for 1986 and the amount reported and projected through fiscal year 1989 by Data Resources, Inc.

6 Sec. 18.21.240. NET REVENUE CALCULATION. The commission shall provide that the low cost hospital adjustment shall be included within any allowance of gross revenue, charges, costs, maximum allowable costs, reasonable financial requirements, rates, prices or the like so that each hospital, in addition to any other allowance that are permitted by law, receives net revenue which reflect its low cost adjustment.

13 Sec. 18.21.250. REGULATIONS. The commission shall adopt regulations to implement AS 18.21.130 - 18.21.240. At a minimum the regulations shall set out the low cost hospital adjustment due to each hospital. All data and computation for the low cost hospital adjustments shall be published no later than 21 days before the public hearing.

19 Sec. 18.21.260. CANCER CENTER REVENUE ADJUSTMENT. (a) For fiscal years 1989 - 1992, a comprehensive cancer center may, at its option, elect to establish prospectively and retrospectively, its approved gross patient service revenue, Blue Cross rate of payment and compliance with approved gross patient service revenue in the following manner:

25 (1) determining the sum of the comprehensive cancer center's noncapital inpatient and outpatient costs, in accordance with the principles of reimbursement for provider costs under 42 U.S.C., sec. 1395, and the Medicare provider reimbursement manual, as projected prospectively and reported retrospectively by the comprehensive

1 cancer center and as verified by audit; add depreciation and interest
2 and working capital; multiply the resulting amount by one plus the
3 uniform statewide uncompensated care allowance;
4 (2) multiplying the total amount computed in (1) of this
5 subsection by 107 percent to yield the approved gross patient service
6 revenue for the applicable fiscal year;
7 (3) reflecting any excess or deficit revenue earned in any
8 fiscal year in the approved gross patient service revenue of the
9 subsequent fiscal year.
10 (b) If a comprehensive cancer center chooses to compute its
11 gross patient service revenue in accordance with (a)(1) - (3) of this
12 section, a nonprofit hospital service corporation shall pay the com-
13 prehensive cancer center the lower of reasonable costs, that shall be
14 defined as the total costs computed under (a) (1) - (3) of this sec-
15 tion, or charges.
16 (c) A comprehensive cancer center must elect to have its pay-
17 ments governed by this section, or payments to the comprehensive
18 cancer center shall be governed by AS 18.21.130 - 18.21.210.
19 Sec. 18.21.270. ACUTE HOSPITAL CONVERSION BOARD. (a) There is
20 established within the Department of Health and Social Services an
21 Acute Hospital Conversion Board. The board consists of the commis-
22 sioner of health and social services, who shall serve as the chairman,
23 the chairman of the Rate-setting Commission, and the commissioner of
24 the Disability Insurance Authority. The board shall administer the
25 provisions of this section concerning the closing of acute hospitals
26 or their conversion to other health, rehabilitative, or public pur-
27 poses. The board shall provide assistance to acute hospitals in the
28 identification and development of alternative financial resources and
29 site uses, and in the expedition of state regulatory processes. The

1 board shall advise the division of employment security, and any other
2 appropriate agencies or institutions regarding the need for reemploy-
3 ment training incentive programs for employees of acute hospitals
4 whose employment is or will be terminated because of the closing or
5 conversion of an acute hospital. The board shall further have the
6 authority to assist any closing or converting hospital in any other
7 manner necessary and appropriate to ensure an orderly transition,
8 including, but not limited to, ensuring that the hospital's obliga-
9 tions for any bonds issued and for other short and long-term debt are
10 met.
11 (b) An acute hospital that applies to the board shall qualify
12 for relief under this section upon certifying to the board, with any
13 supporting documentation that the board may require:
14 (1) that it intends to cease operation as an acute hospital
15 by closing, by converting to another health, rehabilitative, or other
16 public purpose, or by ceasing to admit or care for patients in its
17 medical-surgical, pediatric, obstetric, and maternity beds, no later
18 than 12 months following the certification; or
19 (2) that there is substantial doubt concerning whether the
20 hospital will be able to continue as a going concern.
21 (c) Within 30 days of the receipt of certification, the board
22 shall appoint a community need determination committee to study the
23 alternative needs of the community served by the hospital. The com-
24 mittee shall consist of a trustee of the hospital, a representative of
25 the municipality in which the hospital is located, a physician with
26 privileges at the hospital, a local representative of the elderly, a
27 local member of the business community, a member of a collective
28 bargaining unit of the hospital, a nurse employed at the hospital, and
29 a member of a regional health planning agency serving the community,

1 if any. The committee shall hold a public hearing within 60 days of
2 its appointment to determine the needs of the community for alterna-
3 tive health, rehabilitative and other public uses of the hospital
4 facility. A report on the hearing shall be filed with the board.
5 (d) In the case of a hospital certifying its intention to close
6 or convert:
7 (1) notwithstanding any other provisions of law, the board,
8 if satisfied with the documentation provided, shall increase the
9 amount of the hospital's patient care costs as determined under
10 AS 18.21.130 - 18.21.210 for its final 12 months of operation a an
11 acute hospital to the extent necessary to allow for an orderly transi-
12 tion for the patients and employees of the hospital; the board may
13 also, to the extent necessary to make the closure or conversion finan-
14 cially feasible, permanently forgive any outstanding compliance
15 liability;
16 (2) the board may exempt a closing or converting hospital
17 or any hospital undertaking to purchase or merge with the closing or
18 converting hospital from AS 18.20.140 with regard to any substantial
19 change in services proposed as a result of the closing or coverting
20 hospital's cessation of operation as an acute hospital; provided,
21 however, that the board approves the proposal under this section and
22 that the final outcome of the exempted proposal shall be a net re-
23 duction in the number of medical-surgical, pediatric, obstetric and
24 maternity beds equal to the number of beds contained in the closing or
25 converting hospital; the board shall consider the report of the commu-
26 nity need determination committee established under (c) of this sec-
27 tion in determining whether to approve the hospital's proposal for a
28 change in services; the board shall approve the proposal only if it
29 finds that the proposed service will meet an identified health care

1 need in the community; provided, however, that any proposal that is
2 not approved or disapproved within 90 days of its submission shall be
3 considered approved for purposes of this section and shall be exempt
4 from the provisions of AS 18.20.140.
5 (e) In the case of a hospital certifying substantial doubt about
6 its ability to continue as a going concern, notwithstanding AS 18.21,
7 the board may increase the amount of the hospital's patient care costs
8 as determined under AS 18.21.170 - 18.21.210, subject to the following
9 conditions and limitations:
10 (1) the board may approve an increase only if it determines
11 that
12 (A) without rates of payment greater than those
13 permitted under AS 18.21, the hospital will be unable to
14 continue to admit or care for patients in its medical-
15 surgical, pediatric, obstetric and maternity beds; and
16 (B) that the unavailability of the beds would neces-
17 sarily seriously jeopardize the health and well-being of a sig-
18 nificant number of persons;
19 (2) when making the determination required in (1)(A) of
20 this subsection, the board shall identify all feasible alternative
21 methods for relieving the hospital's financial distress, including but
22 not limited to changes in the hospital's management personnel, expense
23 reductions, closure of under-utilized or nonessential services, and
24 merger and consolidation of services with neighboring hospitals;
25 (3) when making the determination required by (1)(B) of
26 this subsection, the board shall at a minimum, consider the report of
27 the community need determination committee established under (c) of
28 this section;
29 (4) any increase shall be for a period of time to be

1 specified by the board; the duration shall be the minimum necessary to
2 enable the continued availability of essential medical-surgical,
3 pediatric, obstetric and maternity beds, and shall not be indefinite;
4 (5) the amount of the increase shall be the minimum neces-
5 sary to enable the continued availability of essential medical-surgi-
6 cal, pediatric, obstetric and maternity beds; in its determination of
7 the amount, the board shall assume implementation of all feasible
8 alternative methods identified under (1) of this subsection, under the
9 plan of action established under (6) of this subsection;
10 (6) an increase made under this subsection shall be contin-
11 gent on the hospital's agreement to and continuing compliance with a
12 plan of action approved by the board; the plan of action shall specify
13 the steps to be taken to make the hospital financially viable and able
14 to provide essential services to its community; the steps shall in-
15 clude all necessary changes in the hospital's management personnel and
16 all feasible alternative methods identified under (2) of this sub-
17 section;
18 (7) the board shall make an increase subject to additional
19 reasonable terms and conditions that it considers necessary and appro-
20 priate.
21 (f) An acute care hospital that qualifies for and receives
22 relief under this section shall give its employees at least 90 days
23 prior written notice of the termination of their employment, the
24 notice to be given in a form and manner prescribed by the board and to
25 include at least the following: notice of their right to continued
26 health benefits under statute or an applicable collective bargaining
27 agreement; and notice of the availability of the comprehensive job
28 placement and reemployment training program.
29 (g) In carrying out its duties under this section, the board

1 shall seek the advice of an advisory council consisting of the follow-
2 ing members: one representative each designated by the Alaska Hospi-
3 tal Association, the Alaska Nurses' Association, and Blue Cross, Inc.;
4 a representative of a collective bargaining unit for hospital workers;
5 and one representative each, to be appointed by the board, of the
6 following: large teaching hospitals, community hospitals, large
7 businesses, small businesses, commercial insurance companies, and
8 health care consumers.
9 Sec. 18.21.280. APPLICABILITY. Notwithstanding any other pro-
10 visions of this chapter, all costs and charges for patients who are
11 residents of other countries shall be exempted from the limitations
12 imposed by this chapter. A hospital shall be allowed to impose a
13 surcharge on the normal charges that would otherwise be allowed under
14 this chapter for residents of other countries. The surcharge may not
15 be included in the calculation of gross patient service revenue. The
16 normal charge and the patient discharge statistics shall otherwise be
17 included under the provisions of this chapter. Blue Cross and the
18 Alaska Hospital Association shall submit a supplemental schedule to
19 the commission for approval.
20 Sec. 18.21.290. STUDENT DISABILITY INSURANCE. (a) Every full-
21 time and part-time student enrolled in a public or independent insti-
22 tution of higher education located in the state shall participate in a
23 qualifying student disability insurance program. An institution may
24 elect to allow students to waive participation in its student disabil-
25 ity insurance program or any part of it; provided, however, that an
26 institution permitting a waiver shall require students waiving par-
27 ticipation to certify in writing before an academic year in which they
28 will not participate in the institution's plan that they are partic-
29 ipating in a disability insurance program having comparable coverages.

1 (b) The Disability Insurance Authority, with the advice and
2 consent of the Board of Regents, shall issue regulations to define
3 qualifying student disability insurance programs, to establish proce-
4 dures to monitor compliance, and to implement the provisions of this
5 section.
6 (c) Each public and independent institution of higher education
7 shall submit an annual report to the Disability Insurance Authority
8 detailing its procedures for complying with the provisions of this
9 section; provided, however, that before the implementation of this
10 section the authority and the Board of Regents shall submit a report
11 to the legislature that analyzes the number of students lacking dis-
12 ability insurance, the costs of the requirements of this section to
13 the students and the public and independent institutions of higher
14 education, and a proposed method for meeting the costs.
15 (d) A public or independent institution of higher education
16 failing to carry out its responsibilities under this section shall pay
17 a penalty per student for every day during which the failure contin-
18 ues, equal to the penalty per employee per day imposed upon noncomply-
19 ing employers. Any institution that relies in good faith on state-
20 ments by students relative to their disability insurance status may
21 not be held liable for a penalty or for failure to comply with the
22 provisions of this section caused by misstatements of that student.
23 Sec. 18.21.900. DEFINITIONS. In this chapter
24 (1) "acute hospital" means a hospital licensed under
25 AS 18.20.040 that contains a majority of medical-surgical, pediatric,
26 obstetric, and maternity beds as defined by the department;
27 (2) "approved gross inpatient service revenue" means in any
28 fiscal year the total approved gross patient service revenue as de-
29 fined in this chapter less actual gross outpatient service revenue for

1 that year;

2 (3) "case mix" means the description and categorization of
3 a hospital's patient population according to relevant criteria ap-
4 proved by the commission and includes primary and secondary diagnoses,
5 primary and secondary procedures, illness severity, patient age, and
6 source of payment;

7 (4) "case mix adjusted discharges" means the sum of the
8 cost weights of each discharge as stipulated in the current hospital
9 agreement, and as adjusted for coding and grouper changes in order to
10 ensure comparability between years;

11 (5) "charge" means the amount to be billed or charged by a
12 hospital for each specific service within a revenue center;

13 (6) "commission" means the Rate-setting Commission estab-
14 lished under this chapter;

15 (7) "community health centers" means health centers operat-
16 ing in conformance with the requirements of sec. 330 of United States
17 P.L. 95-626, as amended by P.L. 97-35 and includes all community
18 health centers that file cost reports as requested by the commission;

19 (8) "comprehensive cancer center" means the hospital of any
20 institution so designated by the national cancer institute under the
21 authority of P.L. 92-218, sec. 408(a)(b) and 42 U.S.C., organized
22 solely for the treatment of cancer, and offered exemption from the
23 Medicare diagnosis related group payment system under 42 C.F.R., sec.
24 405.475(f);

25 (9) "disproportionate share hospital" means an acute hospi-
26 tal that exhibits a payor mix where a minimum of 68 percent of the
27 acute hospital's gross patient service revenue was attributable to
28 title XVIII and title XIX of the federal Social Security Act and local
29 and state government subsidy and free care and bad debt;

1 (10) "Department of Health and Social Services approved
2 special project" means an approved determination of need project
3 providing psychiatric services for voluntary and involuntary inpa-
4 tients in need of intensive, 24 hours a day psychiatric and nursing
5 care and supervision in a secure setting, that will primarily serve
6 recipients of benefits under title XIX and other public assistance
7 programs and that is subject to an agreement between the provider of
8 services and the Department of Health and Social Services; provided
9 the agreement shall include provisions whereby the department will
10 fully control admission to and discharge from the services;
11 (11) "eligible person" means a person who qualifies for
12 financial assistance from a governmental unit in meeting all or part
13 of the cost of general health supplies care, social, rehabilitative,
14 or educational services and accommodations;
15 (12) "fiscal year" means the twelve-month period in which a
16 hospital keeps its accounts and that ends in the calendar year by
17 which it is identified; however, acute hospitals with fiscal years
18 ending June 30 shall be governed in each fiscal year by the provisions
19 of this chapter applicable to the immediately preceding fiscal year,
20 and any reference to a particular fiscal year in this chapter shall be
21 adjusted accordingly where appropriate for those hospitals;
22 (13) "general health supplies, care, social, rehabilitative,
23 or educational services and accommodations" means all supplies, care,
24 and services of medical, optometric, dental, surgical, podiatric,
25 psychiatric, therapeutic, diagnostic, rehabilitative, educational,
26 supportive or geriatric nature, including inpatient and outpatient
27 hospital care and services, and accommodations in hospitals, sana-
28 toria, infirmaries, convalescent and nursing homes, rest homes, facil-
29 ities established, licensed, or approved by the state and similar

1 institutions including those providing treatment, training, instruction, and care of children and adults;

3 (14) "governmental unit" means the state, any department, agency, board, or political subdivision of the state;

5 (15) "gross patient service revenue" means the total dollar amount of a hospital's charges for services rendered in a fiscal year;

7 (16) "hospital" means a hospital licensed under AS 18.20.040 and any psychiatric facility licensed by the state;

9 (17) "hospital agreement" means an agreement between a nonprofit hospital service corporation and a subscriber approved by the commission;

12 (18) "Medicaid costs" means reimbursable costs included in the basis of payment as calculated under the hospital agreement then in effect, exclusive of any costs attributable to: free care and bad debt expense or, in a hospital fiscal year beginning on or after October 1, 1986, the uniform allowance for the statewide uncompensated care pool as calculated under this chapter, price level depreciation in excess of historical cost depreciation, and costs of revaluation of assets associated with a transfer of ownership occurring on or after July 18, 1985, that exceed those permitted by sec. 2314 of P.L. 98-369;

22 (19) "nonacute hospital" means a hospital that is not an acute hospital;

24 (20) "non-Medicare gross inpatient service revenue" means gross inpatient service revenue less gross inpatient service revenue associated with title XVIII patients;

27 (21) "patient" means a natural person receiving health care services from a hospital;

29 (22) "provider of health care services" means a person,

1 corporation, partnership, governmental unit, state institution, or
2 other entity that furnishes general health supplies, care, social,
3 rehabilitative, or educational services and accommodations to an
4 eligible person;
5 (23) "purchaser" means a natural person responsible for
6 payment for health care services rendered by a hospital;
7 (24) "purchasers and third-party payors who pay on the basis
8 of charges" means purchasers and third-party payors excluding: title
9 XVIII and title XIX, other government payors, and nonprofit hospital
10 service corporations to the extent that payments by the corporation
11 are reduced by the uniform differential;
12 (25) "revenue center" means a functioning unit of a hospital
13 that provides distinctive services to a patient for a charge;
14 (26) "sole community provider" means an acute hospital that
15 qualifies as a sole community provider under Medicare regulations;
16 (27) "specialty hospital" means an acute hospital qualifying
17 as exempt from the Medicare prospective payment system regulations or
18 an acute hospital that limits its admissions to patients under active
19 diagnosis and treatment of eyes, ears, nose and throat, or to children
20 or patients under obstetrical care;
21 (28) "state institution" means a hospital, sanatorium,
22 infirmary, clinic, and other facility owned, operated, or administered
23 by the state, that furnishes general health supplies, care, social,
24 rehabilitative, or educational services and accommodations;
25 (29) "third-party payor" means an entity, including, title
26 XVIII and title XIX programs, insurance companies, health maintenance
27 organizations, and nonprofit hospital service corporations, but does
28 not include a purchaser, responsible for payment, either to the pur-
29 chaser or the hospital, for health care services rendered by a

1 hospital;

2 (30) "uniform differential" means 75/1000.

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

4 CHAPTER 55. STATE DISABILITY INSURANCE.

5 ARTICLE 1. DISABILITY INSURANCE AUTHORITY.

6 Sec. 21.55.010. CREATION; PURPOSE. (a) The Disability Insur-
7 ance Authority is established.

8 (b) The purpose of the authority is to provide, on a basis
9 calculated to reduce or contain the costs of the program, a program of
10 insurance coverage for health care services for persons in the state
11 who are not otherwise eligible for or covered by a health insurance
12 plan, a self-insurance health plan, a medical assistance program, or
13 any other plan or program that provides for payment by a third-party
14 payor for health care services.

15 (c) The authority is a public corporation of the state. The
16 authority is an instrumentality of the state in the Department of
17 Commerce and Economic Development but has a legal existence indepen-
18 dent of and separate from the state and has continuing succession
19 until its existence is terminated by law.

20 Sec. 21.55.015. DIRECTORS. (a) The authority is governed by a
21 board of five directors. The directors shall be the commissioner of
22 commerce and economic development, the commissioner of health and
23 social services, the director of the division of insurance, a rep-
24 resentative of the insurance industry appointed by the governor, and a
25 representative of health care providers, appointed by the governor.

26 (b) All directors serve for three-year terms. A vacancy in a
27 directorship shall be filled in the same manner as the original ap-
28 pointment but only for the unexpired term.

29 (c) The directors must be residents of the state and shall

1 comply with the requirements of AS 39.50 (Conflict of Interest). The
2 directors of the authority serve without compensation, but are enti-
3 tled to travel and per diem expenses authorized by law for state
4 boards and commissions under AS 39.20.180.
5 Sec. 21.55.020. ORGANIZATION. The board shall appoint a commis-
6 sioner of the authority who shall serve at the pleasure of the board
7 and may be removed by the board at any time. The commissioner shall
8 have educational qualifications and administrative and other experi-
9 ence that the board determines to be necessary for the performance of
10 the duties of commissioner. The commissioner shall appoint and may
11 remove agents and subordinate officers that the commissioner considers
12 necessary and may establish divisions and subdivisions within the
13 authority that the commissioner considers appropriate. The position
14 of commissioner shall be in the exempt service.
15 Sec. 21.55.030. STAFF. The commissioner shall appoint a person
16 to serve as deputy commissioner of the authority. The deputy commis-
17 sioner shall perform the duties that the commissioner determines and
18 shall, in the case of a vacancy in the office of commissioner and
19 during the commissioner's absence or disability, exercise the powers
20 and perform the duties of the office of the commissioner. The deputy
21 commissioner shall have educational qualifications and administrative
22 and other experience that the commissioner determines to be necessary
23 for the performance of the duties of deputy commissioner. The posi-
24 tion of deputy commissioner shall be in the exempt service.
25 Sec. 21.55.040. GENERAL POWERS. The authority may
26 (1) make, amend, and repeal regulations for the management
27 of its affairs;
28 (2) make contracts and execute all instruments necessary or
29 convenient for carrying out its business;

1 (3) acquire, own, hold, dispose of, and encumber personal
2 property and lease real property in the exercise of its powers and the
3 performance of its duties;
4 (4) enter into agreements or transactions with a federal,
5 state, or municipal agency, or other public institution, or with a
6 private individual, partnership, firm, corporation, association, or
7 other entity;
8 (5) manage the hospital uncompensated care pool established
9 under AS 21.55.130 in conjunction with the rate-setting commission;
10 (6) establish advisory boards to expand the participation
11 in its decisions and to draw on the experience of representatives from
12 all aspects of the health care financing field, including, but not
13 limited to, providers, consumers, third-party payors, businesses,
14 unions, and academicians;
15 (7) procure insurance in connection with its duties in the
16 amounts and from insurers as may be necessary or desirable;
17 (8) provide a health insurance program through the purchase
18 of health insurance plans from the private sector, including managed
19 health care plans; provided that the financial assumptions underlying
20 these purchasing arrangements shall be made on an actuarially sound
21 basis;
22 (9) design and revise a basic schedule of health care
23 services that enrollees in the health insurance program shall be
24 entitled to receive, covered services to include those that are typi-
25 cally included in employer sponsored health benefit plans in the
26 state; the authority may adopt schedules of covered health care ser-
27 vices that differ from the basic schedule and that apply to specific
28 classes of enrollees;
29 (10) establish a schedule of premium contributions,

1 copayments, coinsurance, and deductibles to be paid by enrollees in
2 its health insurance program, including reduced premiums based on a
3 sliding fee, and other fees and revise them from time to time, subject
4 to the approval of the division of insurance; the schedule shall
5 provide for enrollees to pay 100 percent of the premium contributions
6 if their income substantially exceeds the nonfarm poverty guidelines
7 of the United States Office of Management and Budget;
8 (11) maintain a prudent level of reserve funds to protect
9 the solvency of the trust funds of the authority; and
10 (12) conduct studies concerning the status of health care
11 access in the state, including the impact on consumers and businesses
12 of the various programs established under this chapter.
13 Sec. 21.55.050. ADVISORY BOARDS. The authority may establish
14 advisory boards that it considers necessary to advise it in matters
15 relating to the functions, duties, and powers set out in this chapter,
16 and shall establish advisory boards to
17 (1) advise the authority relative to small business access
18 to affordable health care; the board shall consist of nine members
19 appointed by the commissioner, five of whom shall represent small
20 businesses, one of whom shall be an agent or broker of health insur-
21 ance, one of whom shall represent a hospital service corporation, one
22 of whom shall represent a health insurance company, and one of whom
23 shall represent a health maintenance organization; the board shall
24 meet from time to time and shall advise the commissioner on all mat-
25 ters concerning small businesses for which the department is author-
26 ized to establish programs, and shall review menu or cafeteria plans;
27 (2) advise the authority on matters relative to the unin-
28 sured; the board shall consist of nine members appointed by the com-
29 missioner, three of whom shall be consumer representatives, one of

1 whom shall be an organized labor representative, one of whom shall be
2 a hospital representative, one of whom shall be a community health
3 center representative, one of whom shall be a physician representa-
4 tive, one of whom shall be a health insurance representative, and one
5 of whom shall be a business representative; the board shall advise the
6 authority on all matters relative to the programs of the authority to
7 provide health insurance to the uninsured.
8 ARTICLE 2. STATE DISABILITY INSURANCE PLANS.
9 Sec. 21.55.060. TYPES OF INSURANCE PLANS. The authority shall
10 establish health insurance programs consistent with this chapter to
11 improve the access to health care for all residents of the state who
12 are not covered by a health insurance plan, a self-insurance plan, or
13 a medical assistance program. The authority shall not operate as an
14 insurance company but shall make health insurance plans available to
15 residents of the state through the purchase of health insurance plans,
16 including managed health care plans, from private health insurance
17 companies, a hospital service corporation, a medical service corpora-
18 tion, or health maintenance organizations, and through the brokering
19 of health insurance for employers and consumers of health care ser-
20 vices. The authority shall endeavor to purchase health insurance
21 plans in an economical manner, and shall enroll individuals in managed
22 health care plans when practicable.
23 Sec. 21.55.070. PURCHASE OF INSURANCE. (a) The authority
24 shall, subject to appropriation, negotiate with and purchase, on the
25 terms that it considers to be in the best interest of the authority
26 and its enrollees, from one or more insurance companies, hospital
27 service corporations, medical service corporations, or health mainte-
28 nance organizations, a policy or policies of group general or blanket
29 insurance providing hospital, surgical, medical, and other health

1 insurance benefits covering the following persons:
2 (1) residents of the state, and their dependents, who are
3 not enrolled in a health insurance plan, self-insurance health plan,
4 or medical assistance program;
5 (2) employees and their dependents not eligible for group
6 health insurance partially or fully paid for by employers and who are
7 not enrolled in another health insurance plan, self-insurance health
8 plan, or medical assistance program; and
9 (3) all other residents of the state not enrolled in a
10 health insurance plan, self-insurance health plan, or medical assis-
11 tance program.
12 (b) The authority shall execute all agreements or contracts
13 pertaining to the policies or amendments to them for and on behalf and
14 in the name of the authority. The authority may negotiate a contract
15 for a term not exceeding three years that it considers to be the most
16 advantageous to the authority and its enrollees; the authority shall
17 endeavor to contract with insurance companies, a hospital service
18 corporation, or medical service corporations only for managed health
19 care plans or for health insurance plans that employ other methods to
20 reduce costs of health care services; the authority shall ensure that
21 every enrollee shall have a choice of at least two plans providing
22 health care insurance benefits; and the authority shall also ensure
23 that not more than 30 percent of the enrollees may be enrolled in a
24 health insurance plan of a single health insurance company, hospital
25 service corporation, or health maintenance organization.
26 (c) The authority shall adopt regulations regarding eligibility
27 criteria, enrollment, and termination policies. The authority shall
28 establish procedures by which individuals who participate or are
29 seeking to participate in the health insurance program of the

1 authority may appeal determinations of noneligibility, enrollment, and
2 termination. The authority shall allow, on an annual basis, an oppor-
3 tunity for enrollees to transfer their enrollments among participating
4 health insurance plans.
5 (d) The authority shall establish a schedule of premium contri-
6 butions, copayments, deductibles, or coinsurance amounts to be paid by
7 individual enrollees for a policy purchased by the authority. The
8 schedule shall establish a sliding scale of payments for enrollees
9 based on family income and size and any other factors determined to be
10 relevant or appropriate by the authority; the schedule shall provide
11 for enrollees to pay 100 percent of the premium contributions if their
12 income substantially exceeds the nonfarm poverty guidelines of the
13 United States Office of Management and Budget. The authority shall
14 establish procedures by which an enrollee may appeal the determination
15 of the enrollee's contribution.
16 (e) The authority shall require that an insurance company,
17 hospital service corporation, medical service corporation, or health
18 maintenance organization, that provides health care benefits to en-
19 rollees to establish grievance procedures that are approved by the
20 authority and, in the case of actions taken directly by the authority,
21 the authority shall establish its own grievance procedures. The
22 procedures are exempt from the Administrative Procedure Act (AS 44.-
23 62).
24 (f) Any health insurance plan provided by the authority to its
25 enrollees through a contract with a health insurance company, hospital
26 service corporation, medical service corporation, or health mainte-
27 nance organization, shall provide a reasonable range of health care
28 services to enrollees, shall ensure access to an adequate range of
29 health care providers, and shall include mandated benefits otherwise

1 required by law. Any health insurance plan that constitutes a managed
2 health care plan shall provide, at a minimum, the following benefits:
3 (1) inpatient and outpatient acute hospital services;
4 (2) inpatient and outpatient physician services;
5 (3) diagnostic and screening tests;
6 (4) preventive care;
7 (5) prenatal and well-baby care;
8 (6) medically necessary emergency health services; and
9 (7) all other benefits that health maintenance organiza-
10 tions are required by law to provide.
11 Sec. 21.55.080. PHASE-IN INITIATIVES. (a) The authority shall,
12 subject to appropriation, establish phase-in initiatives on a region-
13 al, statewide, or population basis that shall be designed to test the
14 relative advantages and disadvantages of alternative methods of pro-
15 viding health insurance plans, particularly managed health care plans,
16 to persons lacking health insurance. Phase-in initiatives shall be
17 established through contracts with health insurance companies, hospi-
18 tal service corporations, medical service corporations, or health
19 maintenance organizations. The authority shall utilize phase-in
20 initiatives as part of a plan to provide health insurance to the
21 uninsured on an orderly and gradual basis. Phase-in initiatives shall
22 be funded for a period not to exceed two years; an initiative found by
23 the authority to be an efficient and effective method of providing
24 health care services to the uninsured may be funded by the authority
25 on a permanent basis, under the provisions of AS 21.55.070.
26 (b) The authority may include in a phase-in-initiative any of
27 the persons eligible for coverage in a health insurance program au-
28 thorized by this chapter as well as persons eligible for Medicare and
29 Medicaid programs. The authority shall

1 (1) test several alternative methods of providing health
2 care to the uninsured, including the utilization of preferred provider
3 arrangements established by health insurance companies;
4 (2) establish phase-in initiatives in different regions of
5 the state and in urban and rural settings; and
6 (3) perform a study of the effectiveness of the various
7 phase-in initiatives.
8 (c) The authority shall require that a health insurance plan,
9 including a managed health care plan, with which it contracts under
10 this section must submit annually to the authority a report of the
11 demographics and utilization patterns of the enrollees.
12 Sec. 21.55.090. SMALL BUSINESS INSURANCE. (a) The authority
13 shall establish programs to enable small businesses to purchase health
14 insurance for their employees at rates that are as equivalent as
15 possible to the rates at which large employers can purchase health
16 insurance. Programs shall include the following:
17 (1) the study of the insurance market and the practices of
18 insurance companies, hospital service corporations, medical service
19 corporations, and health maintenance organizations, to determine the
20 causes of the relative unavailability of health insurance plans for
21 small businesses and of disproportionate health insurance premium
22 costs for small businesses and to recommend and develop initiatives
23 and strategies to improve the availability and reduce the relative
24 cost of health insurance for small businesses;
25 (2) the establishment of phase-in initiatives to broker
26 health insurance transactions between small businesses and health
27 insurance companies, hospital service corporations, medical service
28 corporations, and health maintenance organizations;
29 (3) the awarding of technical assistance grants to private

1 organizations to assist them to act as brokers on behalf of small
2 businesses seeking to procure health insurance plans;
3 (4) the establishment of a small business health insurance
4 pool for businesses consisting of six or fewer full-time equivalent
5 employees, for the purpose of purchasing health insurance plans for
6 employees and their dependents of businesses in the pool, and the
7 study of the expansion of the pool to cover small businesses of up to
8 10 full-time equivalent employees; not more than 30 percent in the
9 aggregate of the employees may be enrolled in a health insurance plan
10 of a single health insurance company, hospital service corporation, or
11 health maintenance organization;
12 (5) the evaluation of the effectiveness of the initiatives
13 of the authority and tax incentives in reducing the cost of health
14 insurance to small businesses and the impact of voluntary incentives
15 on the number of small businesses offering health insurance to their
16 employees; and
17 (6) the management of the health insurance hardship trust
18 fund to protect certain businesses from being overburdened by the
19 required contributions.
20 (b) The Small Business Advisory Board shall establish criteria
21 to assess and evaluate the incentives and mechanisms created in this
22 chapter for small businesses concerning voluntary participation in a
23 universal health insurance program. The results of the assessment and
24 evaluation shall be reported annually to the authority no later than
25 March 1 with recommendations for changes to assure the effectiveness
26 of the voluntary incentives.
27 Sec. 21.55.100. SMALL BUSINESS POOL INSURANCE. (a) The author-
28 ity shall, subject to appropriation, establish a small business health
29 insurance pool program by negotiation with private third-party payors,

1 and purchase, on terms that it considers to be in the best interest of
2 the authority and its enrollees, from one or more insurance companies,
3 hospital service corporations, medical service corporations, or health
4 maintenance organizations, a policy of group general or blanket insur-
5 ance providing hospital, surgical, medical, and other health insurance
6 benefits covering persons who are the employees and their dependents
7 of small businesses in which the number of full-time equivalent em-
8 ployees does not exceed six.

9 (b) The authority shall execute all agreements or contracts
10 pertaining to pool policies or amendments to them in the name of the
11 authority. The authority may negotiate a contract for a term not
12 exceeding three years that the authority considers to be the most
13 advantageous to the authority and the eligible small business employ-
14 ees; the authority shall endeavor to purchase health insurance plans
15 in an economical manner and shall enroll individuals in managed health
16 care plans whenever practicable; the authority shall ensure that every
17 enrollee shall have a choice of at least two policies providing health
18 care insurance benefits. The authority shall adopt regulations re-
19 garding eligibility criteria, enrollment, and termination policies.

20 (c) The authority shall

21 (1) allow, on an annual basis, an opportunity for enrollees
22 to transfer their enrollments among participating health insurance
23 plans; and

24 (2) establish a schedule of premium contributions, co-
25 payments, deductibles, or coinsurance amounts to be paid by eligible
26 small businesses and individual enrollees; the schedule shall provide
27 for enrollees to pay 100 percent of the premium contributions if their
28 income substantially exceeds the nonfarm poverty guidelines of the
29 United States Office of Management and Budget.

1 Sec. 21.55.110. HARDSHIP INSURANCE PROGRAM. (a) The authority
2 shall, subject to appropriation, establish a health insurance hardship
3 program to assist employers severely impacted by the medical security
4 contribution. The program shall provide assistance to employers
5 (1) who are small businesses; and
6 (2) for whom the medical security contribution exceeds five
7 percent of the employer's gross revenue; the assistance shall reduce
8 the employer's medical security contribution to an amount equal to
9 five percent of the employer's gross revenues.
10 (b) The commissioner may transfer amounts from the medical
11 security trust fund to the health insurance hardship trust fund only
12 upon a finding by the rate review board established under this chapter
13 that there is a surplus in the medical security trust fund and that
14 the transfer would be in the best interest of the employers of the
15 state.
16 Sec. 21.55.120. UNINSURED AND UNDERINSURED PROGRAM. The author-
17 ity shall establish a continuing program of investigation and study of
18 the uninsured and underinsured in the state. The authority shall
19 examine
20 (1) the impact of the lack of adequate health insurance on
21 residents in the state, including the effects of Medicare cutbacks and
22 medex premium increases on poor and near-poor elders and the problems
23 of persons, particularly children, with disabilities who have diffi-
24 culty obtaining adequate health insurance coverage; the study shall
25 document the impact and shall develop recommendations and proposals to
26 remedy the situation; and
27 (2) the overall impact of programs developed by the author-
28 ity and the Department of Health and Social Services on the uninsured,
29 the underinsured, and the role of employers in assisting their

1 employees in affording health insurance.

2 Sec. 21.55.130. UNCOMPENSATED CARE POOL. (a) The authority
3 shall administer an uncompensated care pool consisting of the revenue
4 produced by the uniform statewide allowance for uncompensated care
5 included in gross patient service revenue of acute hospitals appropri-
6 ated for the pool under this section. The hospital's liability to the
7 pool shall equal the product of the uniform statewide allowance for
8 uncompensated care times the sum of the hospital's private sector
9 share of projected patient care costs for the fiscal year, and a
10 working capital allowance specified by the commission for the fiscal
11 year. The liability of the pool to the hospital shall equal the
12 lesser of:

13 (1) the reimbursable uncompensated care costs of the hospi-
14 tal for that fiscal year; or

15 (2) the maximum reimbursable uncompensated care costs of
16 the hospital for that fiscal year.

17 (b) The authority shall manage the pool in order to provide for
18 prompt payments to and from hospitals, create a consistent and orderly
19 transfer of funds to and from hospitals, and encourage maximum effi-
20 ciency and appropriateness in the utilization of acute hospital ser-
21 vices. The management shall include the purchase and enrollment of
22 individuals in managed health care plans. For each fiscal year, the
23 authority shall calculate the net liability of each acute hospital to
24 the pool by subtracting from the amount of the liability of the hospi-
25 tal to the pool for the fiscal year the amount of the liability of the
26 pool to the hospital for the fiscal year. The result, if positive,
27 shall be the net hospital liability to the pool, and, if negative,
28 shall be the net liability of the pool to the hospital. The authority
29 shall establish a system of payments by hospitals and by the pool

1 whereby each fiscal year each hospital pays an amount of revenue equal
2 to its net liability to the pool or receives from the pool an amount
3 of revenue equal to the net liability of the pool to the hospital.
4 The system may provide for periodic payments of net liabilities to and
5 from the pool, for the collection and expenditure by the pool of
6 revenue equal to the amounts of hospitals' liabilities to and from the
7 pool, or for any other payment mechanism that the authority finds
8 appropriate to the management of the pool and the financial needs of
9 the hospitals.
10 (c) The authority shall establish an appropriate mechanism for
11 enforcing a hospital's obligation to the pool in the event that a
12 hospital does not make a scheduled payment to the pool. The enforce-
13 ment mechanism may include the assessment of a five percent surcharge
14 on a withheld amount. The authority shall not at any time make pay-
15 ments from the pool for a period in excess of amounts that have been
16 paid into or are available in the pool for the period; the authority
17 may temporarily prorate payments from the pool for cash flow purposes.
18 The authority shall establish a final settlement of the pool for each
19 fiscal year to adjust for audit findings the differences between an
20 interim payment to or from the pool and the actual liability of each
21 acute hospital to the pool or of the pool to the hospital.
22 (d) Not more than $100,000 of the amount paid by the hospitals
23 to the pool may be expended in a fiscal year for the reasonable costs
24 of administering the pool.
25 (e) Subject to the limits contained in this subsection, the
26 revenue in the pool shall be supplemented by an amount appropriated by
27 the state in the event that the total liability of the pool to all
28 hospitals for the fiscal year exceeds the total private sector liabil-
29 ity of the pool for the fiscal year. The total amount of the

1 supplement for a fiscal year shall not exceed the sum of (1) 115
2 percent of the amount of the total liability of the pool to all hos-
3 pitals for the prior fiscal year, minus the total private sector
4 liability for the current year, and (2) 50 percent of an amount by
5 which the total of the liability of the pool to all hospitals for the
6 current fiscal year exceeds 115 percent of the amount of the liability
7 of the pool to all hospitals for the prior fiscal year. The authority
8 may not pay an amount of the liability of the pool to all hospitals
9 that exceeds the sum of the total private sector liability to the pool
10 for the fiscal year and the amount of the state's supplement for the
11 fiscal year under this subsection. The authority shall prorate any
12 resulting shortfall among all hospitals. The authority and the rate-
13 setting commission shall periodically evaluate and shall determine
14 jointly whether a supplement under this subsection is necessary for
15 the fiscal year.
16 (f) Payments by acute hospitals to the pool and state revenue
17 appropriated for the supplement provided in (e) of this section shall
18 be placed in an uncompensated care trust fund established in AS 21.-
19 55.150. Amounts placed in the fund may be expended by the authority
20 for the purposes of the pool, including lawful expenditures for the
21 purpose of reducing hospitals' write-offs for bad debt and free care.
22 (g) The authority shall adopt regulations establishing criteria
23 for hospital credit and collection policies to ensure that hospitals
24 make reasonable efforts to collect payment for hospital services
25 before attributing those services to bad debt or free care. In devel-
26 oping such criteria, the authority shall identify those populations
27 that shall not require collection action. These policies shall be in
28 conformance with applicable credit laws of the state and the United
29 States. The authority shall also adopt regulations necessary to

1 manage the uncompensated care pool under this section, including, but
2 not limited to, regulations (1) providing audit standards for the
3 pool, (2) establishing an enforcement mechanism under (c) of this
4 section, and (3) containing reasonable controls on utilization that
5 include the purchase and enrollment of individuals in managed health
6 care plans and that are consistent with the controls contained in the
7 most current hospital agreement and in regulations under title XVIII
8 of the Social Security Act. Regulations regarding utilization control
9 may be adopted only after a public hearing.

10 ARTICLE 3. TRUST FUNDS.

11 Sec. 21.55.140. MEDICAL SECURITY TRUST FUND. (a) There is
12 established the medical security trust fund. The trust fund shall be
13 administered and expended by the authority. The trust fund consists
14 of money appropriated to the fund; all property and securities ac-
15 quired by and through the use of money belonging to the trust fund and
16 all interest on them; less amounts transferred to the health insurance
17 hardship trust fund under AS 21.55.100; less payments from them for
18 payments to health insurance companies, nonprofit hospital and medical
19 service companies, health maintenance organizations, for refunds or
20 abatements for enrollees or former enrollees. All money appropriated
21 for the use of the authority for the purpose of providing health
22 insurance for the uninsured and all money earned on the amounts in the
23 trust fund shall be deposited or retained in the trust fund.

24 (b) The authority shall establish within the medical security
25 trust fund at least three separate accounts described as follows:

26 (1) an unemployment health insurance contribution account
27 that shall consist of all employer contributions required under this
28 chapter and premiums paid by enrollees that shall be used exclusively
29 for the payments of premiums for health insurance plans provided to

1 persons receiving unemployment compensation;

2 (2) a medical security contribution account that shall
3 consist of all employer contributions required under this chapter,
4 premiums paid by enrollees, other voluntary contributions by other
5 persons or entities, and appropriations from the state that shall be
6 used exclusively for the payments of premiums for health insurance
7 plans provided to eligible employees and their families; and

8 (3) a public sector responsibility account that shall
9 consist of all premiums paid by enrollees, voluntary contributions by
10 other persons and entities, and appropriations from the state that
11 shall be used for payments of premiums for health insurance plans
12 provided to all other residents of the state who lack health insur-
13 ance.

14 (c) Amounts within accounts in the trust fund may not be com-
15 mingled except upon approval of the Rate Review Board and a finding by
16 the board that temporary commingling of the accounts is a short-term
17 measure necessary to ensure the solvency of the trust fund. Amounts
18 so commingled shall be restored to the appropriate account within 90
19 days.

20 (d) The commissioner may requisition from the trust fund amounts
21 that the commissioner considers necessary to meet the current obliga-
22 tions of the authority and estimated obligations for a reasonable
23 future period.

24 Sec. 21.55.150. UNCOMPENSATED CARE TRUST FUND. (a) There is
25 established the uncompensated care trust fund that shall be adminis-
26 tered and expended by the authority. The trust fund consists of
27 appropriations for the purpose of uncompensated hospital care; all
28 property and securities acquired by and through the use of money
29 belonging to the trust fund and all interest on them; less payments

1 from them for the purposes of the pool under AS 21.55.130. All inter-
2 est earned on the amounts in the trust fund shall be deposited or
3 retained in the trust fund.
4 (b) The commissioner may requisition from the trust fund amounts
5 the commissioner determines necessary to meet the current obligations
6 of the authority for the purposes of the trust fund and estimated
7 obligations for a reasonable future period.
8 Sec. 21.55.160. DISABILITY INSURANCE HARDSHIP TRUST FUND. (a)
9 There is established a disability insurance hardship trust fund that
10 shall be administered and expended by the authority. The trust fund
11 consists of appropriations for the purpose of AS 21.55.110; all prop-
12 erty and securities acquired by and through the use of money belonging
13 to the trust fund and all interest on them; all amounts transferred
14 from the medical security fund in accordance with AS 21.55.110; less
15 payments from them for the purposes of the health insurance hardship
16 program. All interest earned on the amounts in the trust fund shall
17 be deposited or retained in the trust fund.
18 (b) The commissioner may expend money from the trust fund as
19 necessary to meet the current obligations of the authority for the
20 purposes of the trust fund and estimated obligations for a reasonable
21 future period.
22 Sec. 21.55.170. TRANSITION. The authority shall provide all
23 residents of the state with access to basic health insurance or
24 managed care at a reasonable cost by March 1, 1993, subject to legis-
25 lative appropriation. To achieve the goal of universal access to
26 health care, the following programs shall be established in accordance
27 with the following schedule:
28 (1) as of April 1, 1989, or as soon as possible thereafter,
29 the authority shall begin the following responsibilities:

1 (A) initiation of a study of the adequacy of health
2 insurance for certain residents of the state under AS 21.55.120;
3 (B) initiation of a study of the relationship of small
4 businesses to the insurance market under AS 21.55.080; and
5 (C) the purchase and enrollment of individuals in
6 managed health care plans under AS 21.55.130;
7 (2) as of July 1, 1989, the following programs shall become
8 effective:
9 (A) the program of supplemental health care coverage
10 to disabled adults;
11 (B) the program of supplemental health coverage to
12 disabled children; and
13 (C) at least two phase-in initiatives to provide
14 health insurance for the uninsured under AS 21.55.070;
15 (3) as of October 1, 1989, the authority shall assume the
16 management of the uncompensated care pool under AS 21.55.130;
17 (4) as of July 1, 1990, the following programs shall become
18 effective:
19 (A) completion of the study authorized in (a)(1)(B) of
20 this section;
21 (B) the small business health insurance pool estab-
22 lished under AS 21.55.080 and other initiatives authorized under
23 AS 21.55.080;
24 (C) the tax credit for businesses providing health
25 insurance to their employees; and
26 (D) additional phase-in initiatives to provide health
27 insurance for the uninsured under AS 21.55.070;
28 (5) on September 1, 1990, the requirement that all college
29 and university students have health insurance shall become effective;

1 (6) on January 1, 1991, the program to provide health
2 insurance to persons receiving unemployment insurance shall become
3 effective; health insurance benefits shall become available to eligi-
4 ble persons as of April 1, 1991; in addition, the authority shall
5 complete the study authorized under (a)(1) of this section;
6 (7) as of January 1, 1992, the state shall reassume the
7 cost of hospital care for general relief recipients;
8 (8) as of July 1, 1992, the authority shall complete the
9 study of the phase-in initiatives as authorized under AS 21.55.070;
10 (9) on January 1, 1993, the program to provide health
11 insurance to employed persons shall become effective; health insurance
12 benefits shall become available to eligible persons as of April 1,
13 1993;
14 (10) as of January 1, 1994, the authority shall complete a
15 study of the impact of the programs authorized or referred to in this
16 chapter on the availability of health care for the uninsured in the
17 state as authorized under AS 21.55.120.
18 Sec. 21.55.180. CONSTRUCTION. Nothing in this chapter may be
19 construed to authorize any person not licensed to practice medicine to
20 exercise any supervision or control over the practice of medicine or
21 the manner in which medical services are provided.
22 ARTICLE 4. MANDATORY CONTRIBUTIONS.
23 Sec. 21.55.190. EMPLOYER CONTRIBUTION. (a) Except as provided
24 in (f) of this section, each employer, except those employers who
25 employ five or fewer employees, shall pay, in the same manner and at
26 the same times as the commissioner prescribes for the contribution
27 required by AS 21.55.120, an unemployment health insurance contribu-
28 tion computed by multiplying the wages paid its employees by 12/100ths
29 of one percent.

1 (b) Each employer, except those employers who employ five or
2 fewer employees, in the same manner and at the same times as the
3 commissioner prescribes for the contribution required by AS 21.55.120,
4 a medical security contribution for each employee computed by multi-
5 plying the wages paid each employee by 12 percent. In this section,
6 "employee" does not include the following employees of any employer:
7 (1) an employee who has been employed by the employer for fewer than
8 90 days from date of hire; (2) an employee who normally works for
9 fewer than 30 hours a week; however, a head of household who has
10 dependent children living at home and is working at least 20 hours a
11 week or an employee having worked at least 520 hours in the previous
12 six months shall be considered to be an employee for the purposes of
13 this section; (3) an employee who is hired to perform a service for a
14 period of less than five months; (4) a seasonal agricultural employee,
15 who for the purposes of this section shall be defined as an individual
16 who is employed in agricultural employment of a seasonal or other
17 temporary nature; and (5) an employee who is covered by a group or
18 nongroup health benefit plan that is financed without participation by
19 the employer, who is enrolled in the Medicare program, or who is
20 covered by a government operated medical assistance program; and
21 provided, further, that an employee covered by a health insurance plan
22 shall be considered to be an employee for the purposes of this sec-
23 tion. Each employee shall be presumed to be an employee as included
24 in this section unless the employer certifies to the commissioner, in
25 the form and manner that the commissioner may require, that the em-
26 ployee should not be included under the provisions of this section.
27 Each employer may require an employee to verify the employee's health
28 insurance status. An employer may not require an applicant for em-
29 ployment to disclose the applicant's health insurance status or the

1 status of the applicant's spouse, dependents, or other family members.
2 An employer may not discriminate against an applicant on the basis of
3 the applicant's health insurance status. A person aggrieved by a
4 violation of this section may institute within three years of the
5 violation a civil action for injunctive relief and any damages thereby
6 incurred. An employer found to be in violation of this section shall
7 pay reasonable attorney fees and court costs incurred in the action as
8 determined by the court.

9 (c) An employer may deduct from the amount owed for each employ-
10 ee under (b) of this section the employer's average expenses per
11 employee for providing health insurance coverage or other health care
12 benefits for each employee, allowable for the current quarter by the
13 Internal Revenue Service as a deductible business expense; however, a
14 nonincorporated employer may deduct from the amount owed for each
15 employee under (b) of this section the employer's average expenses per
16 employee for providing health insurance coverage or other health care
17 benefits for each employee as reported and allowed under regulations
18 adopted by the commissioner; a deduction for an employer may not
19 reduce the contribution for an employee below zero.

20 (d) An unemployment health insurance contribution and a medical
21 security contribution shall be paid to the commissioner under the
22 procedures prescribed by the commissioner. The receipts from the
23 contributions shall be deposited in the general fund. The commis-
24 sioner of administration shall separately account for funds received
25 under this section that are deposited in the general fund. The legis-
26 lature may appropriate the annual estimated balance in the account to
27 the medical security trust fund established under AS 21.55.140.

28 (e) In this section,

29 (1) "wages" does not include that part of remuneration

1 that, after remuneration equal to the medical security wage base with
2 respect to employment with the employer has been paid to an individual
3 during the calendar year, is paid to the individual during the year;
4 including remuneration paid to an individual during the calendar year
5 with respect to employment with a transferring employer;
6 (2) "medical security wage base" means $14,000 for the
7 calendar years 1991 and 1993, and in each subsequent calendar year the
8 medical security wage base shall equal the product of
9 (A) the medical security wage base for the then previ-
10 ous calendar year, and
11 (B) the sum of one and the health insurance inflation
12 rate for the then previous calendar year, as reported by the Rate
13 Review Board established under (h) of this section.
14 (f) This section does not apply to a new employer, as defined
15 under AS 21.55.120, during the first 12 consecutive months specified
16 under AS 21.55.120. During the first calendar year in which this
17 section applies to an employer the employer's unemployment health
18 insurance contribution shall be computed at the rate of 14/100 of one
19 percent multiplied by the wages paid and the employer's medical
20 security contribution shall be computed at the rate of four percent
21 multiplied by the wages paid. During the second calendar year in
22 which this section applies to an employer, the employer's unemployment
23 health insurance contribution shall be computed at the rate of
24 8/100 of one percent multiplied by the wages paid, and the employer's
25 medical security contribution shall be computed at the rate of eight
26 percent multiplied by the wages paid.
27 (g) Except where inconsistent with the provisions of this sec-
28 tion, the terms and conditions of this chapter that are applicable to
29 the payment of and the collection of contributions or payments in lieu

1 of contributions shall apply to the same extent to the payment of and
2 the collection of the unemployment health insurance contribution and
3 the medical security contribution; the contributions may not be cred-
4 ited to the employer's account or the solvency account established
5 under AS 21.55.120.
6 Sec. 21.55.195. RATE REVIEW BOARD. (a) There is established a
7 Rate Review Board composed of the commissioner of administrative, the
8 commissioner of health and social services, and the commissioner of
9 commerce and economic development. The board shall determine the rate
10 of health insurance inflation for the previous year to be applied to
11 the medical security wage base for the subsequent calendar year and
12 shall certify said rate to the commissioner on or before November 30
13 of the year preceding the year to which the medical security wage base
14 is to be applied. This inflation rate shall be the average percentage
15 increase in premiums for accident and sickness insurance policies
16 issued in the state during the then current calendar year over premi-
17 ums for accident and sickness insurance policies issued in the state
18 during the then previous calendar year.
19 (b) On or before November 30 of each year, the commissioner
20 shall certify to the Rate Review Board the estimated costs for the
21 subsequent year of health insurance coverage provided by the authority
22 for individuals and their families who (1) are eligible for the health
23 insurance program established under AS 21.55.030 for individuals
24 receiving unemployment insurance compensation or (2) are eligible for
25 the health insurance program established under AS 21.55.030 for em-
26 ployees. The estimated costs shall be exclusive of amounts to be
27 covered by premiums, copayments, deductibles and coinsurance to be
28 paid by covered individuals and anticipated appropriations. The Rate
29 Review Board shall further adjust the estimated costs to reflect

1 prudent levels of reserves sufficient to carry out the responsibil-
2 ities of the authority for health insurance programs. If in the
3 opinion of the board, the rate of health inflation on the medical
4 security wage base as calculated above would be inadequate to properly
5 fund the health insurance programs, the rate of health insurance
6 inflation shall be appropriately adjusted.

7 (c) An employer who fails to comply with the provisions of this
8 section or AS 21.55.190 shall pay a penalty of not less than $35 for
9 each employee, for every day during which the failure continues, in
10 addition to restitution for amounts owed to the medical security trust
11 fund as a result of the failure to make a correct contribution.
12 Penalties collected under this section shall be deposited in the
13 general fund. An employer, under regulations adopted by the commis-
14 sioner, who relies in good faith on statements by employees relative
15 to their health insurance status, may not be held liable for any
16 penalty or restitution for failure to comply with the provisions of
17 this section caused by misstatements of the employees.

18 (d) An employer notified of a determination of the commissioner
19 that the employer is subject to AS 21.55.190(a) or (b), or notified of
20 a determination of the commissioner that an individual is an employee
21 for the purposes of AS 21.55.190(b) and (c), may request a hearing on
22 the determination. The request for hearing shall be filed within 10
23 days after mailing of the notice of the determination. If a hearing
24 is requested, the commissioner shall give the employer a reasonable
25 opportunity for a fair hearing before an impartial hearing officer.
26 An employer aggrieved by the decision following a hearing may appeal
27 the decision to the superior court.

28 Sec. 21.55.200. MEDICAL ASSISTANCE PROGRAM. (a) The authority
29 shall establish a program of medical care and assistance for pregnant

1 women and infants who are not otherwise eligible for medical assis-
2 tance and who lack private disability insurance coverage or have
3 disability insurance coverage that does not cover all medically neces-
4 sary care covered by the program established by this section. The
5 authority shall furnish medical assistance to each pregnant woman and
6 infant residing in the state in accordance with standards of eligibil-
7 ity established by the authority; provided, however, that the income
8 eligibility standards shall not be less than 200 percent of the non-
9 farm income poverty guidelines defined by the United States Office of
10 Management and Budget.
11 (b) Assistance furnished under this section shall be limited to
12 the following care and services; unless otherwise specified to the
13 contrary payment may not be allowed for inpatient hospitalization:
14 (1) all medically necessary care to maintain health during
15 the course of the pregnancy and delivery, including newborn hospital
16 care;
17 (2) all medically necessary postpartum obstetric and
18 gynecological care;
19 (3) newborn care, including one postpartum pediatric ambu-
20 latory visit; and
21 (4) outreach services designed to identify and encourage
22 the participation of pregnant women and infants in this program.
23 (c) The authority shall ensure that all women who appear to be
24 eligible for medical assistance are assisted in enrolling for the
25 coverage. If a woman receiving services under the program established
26 under this section is found by the Department of Health and Social
27 Services to be eligible for public health services, the department
28 shall pay for the services and shall reimburse the authority for the
29 services; provided that the reimbursements are allowed under title XIX

1 of the Social Security Act.

2 Sec. 21.55.210. PRIMARY CARE PROGRAM. The authority shall
3 establish a program of primary and supplemental medical care and
4 assistance for certain disabled residents of the state who are not
5 eligible for medical assistance under title XIX of the federal Social
6 Security Act. The benefits of the program shall be available to all
7 persons (1) who are not covered for medical costs relative to their
8 disability by an employer's group disability insurance plan, (2) who
9 are not eligible for medical assistance under a work incentive program
10 with federal participation, and (3) who, if not engaged in substantial
11 gainful activity, would meet all eligibility requirements for supple-
12 mental security income under the provisions of title XVI of the Social
13 Security Act at the time of application for the program of medical
14 care and assistance. Subsequent to their enrollment in the program,
15 the disabled residents may continue in enrollment in the program
16 notwithstanding the fact that they no longer meet the financial re-
17 quirements of title XVI in accordance with income requirements estab-
18 lished by the authority. The cost of the program shall be funded, in
19 part, by premium contributions, copayments, and deductibles con-
20 tributed by enrollees according to a sliding scale schedule designed
21 by the authority.

22 Sec. 21.55.220. CHILDREN'S CARE PROGRAM. The authority shall
23 establish a program of medical care and assistance for certain dis-
24 abled children of the state. The benefits of the program shall be
25 available to children who are not eligible for medical assistance
26 programs with federal financial participation and who would meet the
27 disability requirements for supplemental security income under the
28 provisions of title XVI of the Social Security Act. The cost of the
29 program shall be funded, in part, by premium contributions,

1 copayments, and deductibles according to a sliding scale schedule
2 designed by the authority.

3 Sec. 21.55.900. DEFINITIONS. In this chapter

4 (1) "acute hospital" means a hospital that contains a
5 majority of medical-surgical, pediatric, obstetric, and maternity beds
6 as defined by the Department of Health and Social Services;

7 (2) "association" means the Comprehensive Disability Insur-
8 ance Authority created in AS 21.55.010;

9 (3) "bad debt" means an account receivable based on ser-
10 vices furnished to a patient that is

11 (A) regarded as uncollectible, following reasonable
12 collection efforts consistent with the regulations of the depart-
13 ment;

14 (B) charged as a credit loss;

15 (C) not the obligation of a governmental unit or of
16 the federal government or an agency of them; and

17 (D) not free care;

18 (4) "child" means a person who is under 18 years of age;

19 (5) "chronic hospital" means a hospital that is not an
20 acute hospital;

21 (6) "community health center" means an organization that
22 provides primary health care and other health care services in confor-
23 mance with the requirements of sec. 330 of United States P.L. 95-626,
24 as amended by United States P.L. 97-35;

25 (7) "consumer" means a natural person responsible for
26 payment for health care services rendered by a provider;

27 (8) "department" means the Department of Health and Social
28 Services;

29 (9) "dependent" means the spouse and children of an

1 employee if these persons would qualify for dependent status under the
2 Internal Revenue Code or for whom a support order could be granted
3 under chapters 208, 209, or 209c;
4 (10) "employee" means a person who performs services primar-
5 ily in the state for remuneration for an employer; a person who is
6 self-employed is not considered to be an employee;
7 (11) "enrollee" means a person who becomes a member of an
8 insurance program of the authority either individually or as a member
9 of a family;
10 (12) "free care" means a revenue deduction associated with
11 the provision of services to patients who have reasonably been con-
12 sidered financially unable to pay, in whole or in part, for their
13 care, consistent with the regulations of the authority;
14 (13) "health care services" means supplies, care, and ser-
15 vices of medical, surgical, optometric, dental, podiatric, chiro-
16 practic, psychiatric, therapeutic, diagnostic, preventive, rehabilita-
17 tive, supportive, or geriatric nature, including but not limited to,
18 inpatient and outpatient acute hospital care and services, and ser-
19 vices provided by a community health center, by a sanatorium as in-
20 cluded in the definition of "hospital" in title XVIII of the federal
21 Social Security Act and treatment and care compatible with such ser-
22 vices, or by a health maintenance organization;
23 (14) "health insurance company" means a company that engages
24 in the business of health insurance;
25 (15) "health insurance" means the medicare program or an
26 individual or group contract or other plan providing coverage of
27 health care services that is issued by a health insurance company, a
28 hospital service corporation, a medical service corporation, or a
29 health maintenance organization; and includes disability insurance

1 under AS 21.12.050;

2 (16) "health maintenance organization" means a company that
3 provides or arranges for the provision of health care services to
4 enrolled members in exchange primarily for a prepaid per capita or
5 aggregate fixed sum;

6 (17) "hospital" means a hospital licensed by the state;

7 (18) "hospital agreement" means an agreement between a
8 nonprofit hospital service corporation and signatory hospitals ap-
9 proved by the rate-setting commission;

10 (19) "hospital service corporation" means a corporation
11 established for the purpose of operating a nonprofit hospital service
12 plan;

13 (20) "managed health care plan" means a health insurance
14 plan that provides or arranges for, supervises and coordinates health
15 care services to enrolled participants, including plans administered
16 by health maintenance organizations and preferred provider organiza-
17 tions;

18 (21) "maximum reimbursable uncompensated care costs" means
19 the sum of

20 (A) 114 percent multiplied by the projected patient
21 care costs for a hospital service corporation and for purchasers
22 and third-party payors who pay on the basis of charges; and

23 (B) the payments to the title XVIII program made for
24 free care to the acute hospital;

25 (22) "Medicaid program" means medical assistance program
26 administered by the department;

27 (23) "medical assistance program" means the Medicaid pro-
28 gram, the Veterans' Administration health and hospital programs, and
29 any other medical assistance program operated by a governmental unit

1 for persons categorically eligible for such a program;
2 (24) "medical service corporation" means a corporation
3 established for the purpose of operating a nonprofit medical service
4 plan;
5 (25) "Medicare program" means the federal medical insurance
6 program established by title XVIII of the federal Social Security Act;
7 (26) "patient care costs" means reimbursable costs under
8 AS 21.55;
9 (27) "private sector share of projected patient care costs"
10 means the sum of the projected patient care costs of a hospital ser-
11 vice corporation and the projected patient care costs for purchasers
12 and third-party payors who pay on the basis of charges;
13 (28) "provider" means a person, corporation, partnership,
14 governmental unit, state institution, and other entity qualified under
15 the laws of the state to perform or provide health care services;
16 (29) "purchasers and third-party payors who pay on the basis
17 of charges" means purchasers and third-party payors excluding: title
18 XVIII and title XIX, other government payors, and nonprofit hospital
19 service corporations to the extent that payments by such corporations
20 are reduced by the uniform differential;
21 (30) "reimbursable bad debt costs" means the amount of
22 projected patient care costs that are written off as bad debt, net of
23 amounts recovered as a result of collection efforts by the hospital or
24 its agents;
25 (31) "reimbursable free care costs" means the projected
26 patient care costs that are written off as free care, net of any
27 payments for free care;
28 (32) "reimbursable uncompensated care costs" means the sum
29 of reimbursable bad debt costs and reimbursable free care costs;

1 (33) "resident" means a person living in the state as de-
2 fined by the authority by regulation; provided, that the person did
3 not move to the state for the sole purpose of securing health insur-
4 ance under this chapter; provided, further, that confinement of a
5 person in a nursing home, hospital, or other medical institution in
6 the state may not by itself be sufficient to qualify the person as a
7 resident;
8 (34) "self-employed" means a person who is not considered to
9 be an employee and whose primary source of income is derived from the
10 pursuit of a bona fide business;
11 (35) "self-insurance health plan" means a plan that provides
12 health benefits to the employees of a business, that is not a health
13 insurance plan, and in which the business is liable for the actual
14 costs of the health care services provided by the plan plus adminis-
15 trative costs;
16 (36) "small business" means a business, including a business
17 consisting only of the self-employed, in which the total of full-time
18 equivalent employees when averaged on an annual basis does not exceed
19 50;
20 (37) "third-party payor" means an entity including, but not
21 limited to, the Medicaid program, the Medicare program, a health
22 insurance company, a health maintenance organization, a hospital
23 service corporation, a medical service corporation, but not including
24 a consumer responsible for payment to a provider for health care
25 services rendered by a provider.
26 * Sec. 4. AS 21 is amended by adding a new chapter to read:
27 CHAPTER 56. PREFERRED PROVIDER ARRANGEMENTS.
28 Sec. 21.56.010. AUTHORITY TO ENTER ARRANGEMENTS. (a) An orga-
29 nization may enter into a preferred provider arrangement with one or

1 more health care providers upon a determination by the director that
2 the organization and the arrangement comply with the requirements of
3 this chapter and the regulations adopted under this chapter. An
4 organization may not condition its willingness to allow a health care
5 provider to participate in a preferred provider arrangement on the
6 health care provider's agreeing to enter into other contracts or
7 arrangements with the organization that are not part of or related to
8 the preferred provider arrangements.

9 (b) An organization shall submit information concerning a pro-
10 posed preferred provider arrangement to the director for approval
11 under regulations adopted by the director. The information submitted
12 shall include at least the following:

13 (1) a description of the health services and any other
14 benefits to which the covered person is entitled;

15 (2) a description of the locations where and the manner in
16 which health services and other benefits may be obtained;

17 (3) a copy of the evidence of coverage;

18 (4) copies of any contracts with preferred providers; and

19 (5) a description of the rating methodology and rates.

20 (c) A preferred provider arrangement shall contain standards
21 for:

22 (1) maintaining quality health care, including satisfying
23 quality assurance regulations adopted by a state agency;

24 (2) controlling health care costs;

25 (3) assuring reasonable levels of access of health care
26 services and an adequate number and geographical distribution of
27 preferred providers to render those services;

28 (4) assuring appropriate utilization of health care ser-
29 vice; and

1 (5) other areas determined appropriate by the director.

2 Sec. 21.56.020. PREFERRED PROVIDER INCENTIVES. Organizations
3 may offer health benefit plans that provide for incentives for covered
4 persons to use the health care services of preferred providers. A
5 health benefit policy or plan must meet at least the following minimum
6 requirements:

7 (1) benefit levels for health care services rendered by
8 nonpreferred providers shall be at least 80 percent of the benefit
9 levels for services rendered by preferred providers;

10 (2) if a covered person receives emergency care and cannot
11 reasonably reach a preferred provider, payment for care related to the
12 emergency shall be made at the same level and in the same manner as if
13 the covered person had been treated by a preferred provider;

14 (3) a procedure shall be specified for resolving consumer
15 complaints and grievances; and

16 (4) a procedure shall be specified for the disclosure to
17 covered persons of the names of current preferred providers by spe-
18 cialty and geographic area.

19 Sec. 21.56.030. DISCRIMINATION PROHIBITED. An organization may
20 not refuse to enter into a preferred provider arrangement with a
21 health care provider on the basis of religion, race, color, national
22 origin, age, sex, marital status, sexual orientation, or the provid-
23 er's relationships with any other organization. The selection of
24 preferred providers shall be based primarily on cost, availability,
25 and quality of covered services. The terms and conditions offered by
26 an organization that must be met or agreed to by physicians and other
27 professional providers of health care services desiring to enter into
28 a preferred provider arrangement shall be subject to the disapproval
29 of the director if the terms and conditions are not consistent with

1 the purposes, policies, and provisions of this chapter.

2 Sec. 21.56.040. RECORDS REQUIREMENTS. An organization shall
3 maintain financial and utilization records for its preferred provider
4 arrangements and activities in a form separate or separable from the
5 financial and utilization records of other operations and activities
6 carried on by the organization.

7 Sec. 21.56.050. BOND REQUIRED. An organization shall furnish to
8 the director evidence of a surety bond, reinsurance, or other finan-
9 cial resources in an amount satisfactory to the director as a guaran-
10 tee that obligations to covered persons will be performed.

11 Sec. 21.56.060. ANNUAL REPORT. An organization that enters into
12 a preferred provider arrangement shall file annually with the direc-
13 tor, within 120 days of the close of the fiscal year, a report cover-
14 ing the prior fiscal year. The report must include:

15 (1) the number of covered persons under health benefit
16 plans that include preferred provider arrangements;

17 (2) financial and utilization date of health benefit plans
18 that include preferred provider arrangements;

19 (3) a list of preferred providers; and

20 (4) other information that the director may require.

21 Sec. 21.56.070. REGULATIONS AND ENFORCEMENT. In addition to
22 other powers specified in this chapter, the director may, after hear-
23 ing:

24 (1) adopt regulations necessary to the administration and
25 enforcement of this chapter;

26 (2) issue an order requiring any person or organization to
27 cease and desist from violating a provision of this chapter or a
28 regulation, or order of the director;

29 (3) require any person or organization found to have

1 violated a provision of this chapter or a regulation or order to pay a
2 civil penalty not to exceed $10,000 for a single violation; and
3 (4) institute a rehabilitation or liquidation proceeding
4 under AS 21.78.
5 Sec. 21.56.080. LICENSING REQUIREMENTS. An organization that
6 offers or administers a health benefit plan under a preferred provider
7 arrangement. shall be subject to all of the provisions of the orga-
8 nization's licensing statute and any other applicable statutes, in-
9 cluding benefits required to be provided. In connection with any
10 preferred provider arrangement and activities, an organization shall
11 be considered to be an insurance company for the purposes of AS 21.09.
12 Sec. 21.56.090. PREMIUM TAX. (a) Every organization operating
13 a preferred provider arrangement shall annually pay a tax equal to
14 2 28/100th's percent of the gross premiums received during the preced-
15 ing calendar year for coverage of covered persons residing in the
16 state; however, a tax may not be imposed on premiums for Medicare
17 supplemental coverage. In calculating the gross premiums, there shall
18 be deducted any canceled or returned premiums. The tax collected,
19 including interest or penalties, shall be deposited in the general
20 fund.
21 (b) The tax imposed by this section shall be collected and
22 administered by the director. Every organization operating a pre-
23 ferred provider arrangement shall annually, on or before March 15,
24 make a return to the director giving the information that the director
25 may require, for the determination of the tax for the preceding calen-
26 dar year.
27 Sec. 21.56.900. DEFINITIONS. In this chapter
28 (1) "covered person" means a policy holder or other person
29 on whose behalf the organization is obligated to pay for or provide

1 health care services;

2 (2) "covered services" means health care services that the

3 organization is obligated to provide;

4 (3) "emergency care" means covered services delivered to a

5 covered person who has suffered an accidental bodily injury or illness

6 that reasonably requires the beneficiary or insured to seek immediate

7 medical care;

8 (4) "health benefit plan" means the health insurance poli-

9 cy, subscriber agreement, or contract between the covered person and

10 an organization that defines the covered services and benefit levels

11 available;

12 (5) "health care provider" means a provider of health care

13 services licensed in this state;

14 (6) "health care services" means services rendered or

15 products sold by a health care provider within the scope of the pro-

16 vider's license and includes hospital, medical, surgical, dental,

17 vision, and pharmaceutical services or products;

18 (7) "organization" means an insurer authorized to write

19 accident and health insurance in this state, a nonprofit hospital or

20 medical service corporation authorized under AS 21.87, or any other

21 entity approved by the director under this chapter;

22 (8) "preferred provider" means a health care provider or

23 group of health care providers who have contracted to provide spec-

24 ified covered services;

25 (9) "preferred provider arrangement" means a contract

26 between or on behalf of an organization and a preferred provider that

27 complies with all of the requirements of this chapter.

28 * Sec. 5. AS 43 is amended by adding a new chapter to read:

29 CHAPTER 28. DISABILITY INSURANCE CREDIT.

1 Sec. 43.28.010. BUSINESS INSURANCE CREDIT. (a) There is estab-
2 lished a credit for businesses offering disability insurance to their
3 employees.
4 (b) Any business that (1) has one or more full-time equivalent
5 employees unrelated to its owners or partners but no more than 50 such
6 employees calculated on an average annual basis; (2) has not in any
7 one of the preceding three years made an expenditure for the full or
8 partial payment of premiums for a disability insurance plan covering
9 any of its then employees, and (3) makes a disability insurance premi-
10 um expenditure for a disability insurance plan that is available to at
11 least all of its full-time employees, shall be allowed a credit
12 against its income tax due under this title in each of the first two
13 years it makes a disability insurance premium expenditure.
14 (c) The amount of the credit in the first year shall be 20
15 percent of the entire amount of the disability insurance premium
16 expenditure made by the business in the first year and 10 percent of
17 the disability insurance premium expenditure made by the business in
18 the second year. To be eligible to receive the credit, the disability
19 insurance premium expenditure of the business must equal at least 50
20 percent of the total cost of the premiums for the disability insurance
21 plan made available to its employees. In this section,
22 (1) "businesses" means professions, sole proprietorships,
23 trades, or partnerships;
24 (2) "unrelated" means not having the familial relationship
25 of spouse, mother, father, or child.
26 Sec. 43.28.020. CORPORATE INSURANCE CREDIT. (a) There is
27 established a credit for corporations offering disability insurance to
28 their employees. A corporation that
29 (1) has one or more full-time equivalent employees

1 unrelated to its shareholders but no more than 50 such employees
2 calculated on an average annual basis;
3 (2) has not in any one of the preceding three years made an
4 expenditure for the full or partial payment of premiums for a disabil-
5 ity insurance plan covering any of its then employees; and
6 (3) makes a disability insurance premium expenditure for a
7 disability insurance plan that is available to at least all of its
8 full-time employees, shall be allowed a credit against its excise due
9 under this chapter in each of the first two years it makes such a
10 disability insurance premium expenditure.
11 (b) The amount of the credit in the first year shall be 20
12 percent of the entire amount of the disability insurance premium
13 expenditure made by the corporation in the first year and 10 percent
14 of the disability insurance premium expenditure made by the corpo-
15 ration in the second year. To be eligible to receive the credit, the
16 disability insurance premium expenditure of the corporation must equal
17 at least 50 percent of the total cost of the premiums for the disabil-
18 ity insurance plan made available to its employees. In this section,
19 "unrelated" means not having the familial relationship of spouse,
20 mother, father, or child.
21 * Sec. 6. (a) The director to the division of insurance shall conduct
22 a study and examination of nongroup and Medicare supplementary health care
23 programs offered by nonprofit hospital and medical service corporations
24 organized under AS 21.87, by health insurance companies operating under
25 AS 21.09, by preferred provider organizations, by self-insured employee
26 welfare benefit plans, by third-party administrators, and by health claims
27 administration programs.
28 (b) The director shall study the need for, the availability of, the
29 financing for, and supportive governmental incentives available for

1 nongroup and Medicare supplementary health care programs in the state. The
2 director shall conduct an audit of nongroup and Medicare supplementary
3 health care programs offered by nonprofit hospital and medical service
4 corporations. The audits shall determine and examine the losses from 1977
5 through 1987 attributable to the programs and the financial impact of the
6 statutory responsibilities and benefits conferred on the nonprofit hospital
7 and medical corporations.
8 (c) The director may request assistance from other state agencies in
9 the performance of duties imposed under this section. All nonprofit hospi-
10 tal and medical service corporations, health maintenance organizations,
11 health insurance companies, preferred provider organizations, self-insured
12 employee welfare benefit plans, third-party administrators, and health
13 claims administration programs referred to in (a) of this section shall
14 cooperate with and make all information available to the director in the
15 performance of the study and examination. An organization voluntarily
16 providing trade secret or commercial or financial information to the direc-
17 tor may request that the information be maintained as confidential informa-
18 tion by the director. Information provided that is accepted by the direc-
19 tor as confidential may not be considered a public record under AS 09.25.-
20 110 or 09.25.120.
21 (d) The director shall make an interim report on the results of the
22 study and examination to the legislature by July 1, 1989, and shall submit
23 a final report not later than October 1, 1989. All nonprofit hospital and
24 medical service corporations, health maintenance organizations, health
25 insurance companies, preferred provider organizations, self-insured employ-
26 ee welfare benefit plans, third-party administrators, and health claims
27 administration programs shall have an opportunity to review and comment on
28 the interim and final reports 30 days before submission to the legislature.
29 These comments shall be incorporated in the report.

1 * Sec. 7. (a) There is established a Special Commission on Health
2 Insurance Reform. The commission consists of a representative of a non-
3 profit hospital and medical service corporation, a representative of the
4 Department of Law, a representative of health care consumer groups to be
5 appointed by the governor, a representative of health maintenance organiza-
6 tions to be appointed by the governor, and a chairman to be appointed by
7 the governor. The commission shall be appointed within 30 days of the
8 effective date of this section and shall be charged with examining and
9 determining what alternatives, if any, exist to provide citizens of the
10 state with an improved health care delivery and health care insurance
11 system, by improving the competitive environment in the health insurance
12 system, and the affordability and availability of actuarially sound non-
13 group and Medicare supplementary health insurance coverage. The commission
14 shall consult with health care consumer groups regarding the study and
15 examination before undertaking it. The commission shall also study the
16 implications of the provisions of this Act relative to preferred provider
17 arrangements and relative to the relationship between nonparticipating
18 providers and hospital and medical service corporations; the study shall be
19 completed before the effective date of this Act. Before making recommenda-
20 tions to the governor, the commission shall consult with health care con-
21 sumer groups regarding its recommendations and shall give the groups an
22 opportunity to respond at public hearing and in writing. A written re-
23 sponse shall be incorporated in the commission's final report.
24 (b) The commission shall make its recommendations to the governor and
25 the legislature before October 1, 1989, and shall issue a final report
26 before November 15, 1989. The report of the commission shall include
27 recommendations concerning maintenance of the current status by nonprofit
28 hospital and medical service corporations, alternative methods to fulfill
29 to the insurer of last resort responsibilities of the nonprofit hospital

1 and medical service corporations, if needed, or reorganization of these
2 corporations as a mutual insurance company under AS 21.69.
3 * Sec. 8. (a) This section applies to the uncompensated care pool
4 until the Disability Insurance Authority assumes responsibility for manag-
5 ing the uncompensated care pool on October 1, 1989. The Rate-setting
6 Commission shall calculate each acute hospital's net estimated liability to
7 the uncompensated care pool using the same data and estimates that the
8 Rate-setting Commission uses to calculate the uniform allowance for uncom-
9 pensated care. The commission shall notify the hospital and the pool's
10 administrative agent of the estimated net liability to the pool, or adjust-
11 ment of the liability, no later than 30 days in advance of the first peri-
12 odic payment and 15 days in advance of any subsequent adjustment to the
13 periodic payment.
14 (b) The commission shall establish an interim payments system to
15 assure periodic payments of estimated liabilities to and from the pool.
16 Acute hospitals that have an estimated annual net liability to the pool
17 shall be required to pay monthly a percentage of their estimated net annual
18 liability to the pool that will ensure that the full annual net liability
19 is paid, and acute hospitals to which the pool owes an estimated net li-
20 ability shall receive monthly from the pool a percentage of the estimated
21 annual net liability that will ensure that the full annual net liability is
22 received. Each hospital's payments to or from the voluntary uncompensated
23 care pool in operation from October 1, 1988, until the effective date of
24 this section shall be credited against its net liability to or from the
25 pool.
26 (c) The commission shall contract with a nonprofit hospital service
27 corporation to act as its administrative agent for payments to and from the
28 pool. The agent shall maintain any cash balance in the pool in a separate
29 interest-bearing account and any interest on this account shall be applied

1 to the final settlement of the pool. The agent shall disburse payments
2 determined by the commission under (d) of this section. The agent shall
3 provide the commission with the detail of monthly receipts to and payments
4 from the pool at the end of each monthly period, including the name of any
5 acute hospital that did not make its scheduled periodic payment to the
6 pool. Upon proper notification by the agent and verification by the com-
7 mission, the commission shall instruct the agent to offset payments on
8 hospital claims from the agent in the amount of the payment owed to the
9 pool, plus a surcharge of five percent on that amount, and to transfer the
10 withheld funds into the pool.
11 (d) The agent may not make periodic pay-outs from the pool in excess
12 of the money that has been paid into the pool for the same period. Each
13 acute hospital having an estimated net liability to the pool shall make
14 payment to the agent on the first day of each month. On the 15th of each
15 month, the agent shall make payment to each hospital that is to receive a
16 periodic payment for an amount equal to the pool's periodic net liability
17 to the hospital multiplied by the lesser of (1) one, or (2) the ratio of
18 the pool's total receipts to the pool's total expected receipts for that
19 period; except that a late payment to the pool made in one period for a
20 prior period shall be added on a pro rata basis to the next periodic pay-
21 ment to hospitals.
22 (e) The nonprofit hospital service corporation shall, when acting
23 upon the instructions of the commission and as its administrative agency,
24 be immune from all liability, legal actions, damages, or other penalties
25 for administration of the pool, except for its own fraudulent or negligent
26 acts. If the agent offsets claims payments as ordered by the commission,
27 it is not in breach of contract, and hospitals to which payment is offset
28 under order of the commission must serve all members and subscribers of the
29 non-profit hospital service corporation under hospital agreements then in

1 effect. For the cost of administering the pool for the fiscal years ending
2 October 1, 1989, and October 1, 1990, the commission may pay the reasonable
3 costs of the administrative agent.
4 (f) An independent audit of the agent's administration of the pool
5 shall be conducted annually and reported to the commission.
6 * Sec. 9. The director of the division of insurance shall, subject to
7 legislative appropriation, contract for a comprehensive, six-year study of
8 the impact of mandatory disability care in the state as required by this
9 Act. The study shall include projected costs to the state for the follow-
10 ing programs: the establishment of voluntary incentives for small busi-
11 ness, including technical assistance grants, tax credits, the health insur-
12 ance hardship trust fund, and an experimental project of state brokering
13 health care for small business; the state's share of the uncompensated care
14 pool; the operation of the Disability Insurance Authority; all pilot pro-
15 grams established to provide health care coverage to the uninsured; all
16 costs to the state, beginning in 1993, for providing health care to those
17 individuals not otherwise provided for, including demographic information
18 relative to individuals; and the assumption of all hospital costs of gen-
19 eral relief recipients. The study shall also
20 (1) assess the costs to all colleges and universities, students,
21 and the state associated with the implementation of mandatory disability
22 insurance coverage for college students;
23 (2) assess the economic impact of mandatory health care coverage
24 on the cost of doing business in the state and the effect, if any, on the
25 competitiveness of Alaska firms;
26 (3) include the projected costs to the state for the Medicaid
27 program, including any changes to the existing program as provided in the
28 study; and
29 (4) provide not less than one periodic report each year to the

1 legislature.

2 * Sec. 10. The Disability Insurance Authority shall establish an ac-
3 count for the purposes of addressing the critical labor shortage facing
4 hospitals. The account shall be administered by the authority according to
5 regulations adopted by the authority and approved by the commissioner of
6 administration. Projects financed through the account shall include train-
7 ing of health care workers, the development of career ladders within the
8 health care professions, and the establishment of day care programs at
9 hospitals and other health care facilities. Funds for this account shall
10 be provided for by an assessment on each acute care hospital equal to
11 1/10 of one percent of the gross patient service revenue of the hospital.

12 * Sec. 11. (a) The commissioner of health and social services shall,
13 by July 1, 1989, develop criteria regarding the identification and desig-
14 nation of medically underserved and health manpower shortage areas in the
15 state.

16 (b) The commissioner of health and social services shall convene and
17 chair a task force that shall include the commissioner of education, the
18 chairman of the University of Alaska Board of Regents, and representatives
19 from state higher education, and any other groups the commissioner deter-
20 mines appropriate. The task force shall, by July 1, 1989, report back to
21 the legislature on recommendations for legislation with respect to the
22 development of a state Health Service Corps. The recommendations shall
23 include

24 (1) a provision whereby individuals enrolled in medical schools
25 whose education is supported by state funds shall be required to sign a
26 contract whereby the student agrees to a service or monetary payback; the
27 service payback shall be completed in placement sites or areas designated
28 and approved by the commissioner under this section;

29 (2) guidelines regarding the duration of the service payback and

1 the amount of alternative monetary payback;
2 (3) a provision whereby individuals enrolled in medical schools
3 whose education is supported by state funds shall be required to register
4 with the state as a provider in the state's Medicaid program for the same
5 number of years as the physician received state financial assistance.
6 * Sec. 12. (a) There is established a special commission to consist of
7 the commissioner of administration, the commissioner of health and social
8 services, the director of the division of insurance, a representative of
9 the Life Insurance Association of Alaska, a representative of the Hospital
10 Association of Alaska, a representative of the Alaska Medical Society, a
11 member of the business roundtable, a representative of the Alaska Federa-
12 tion of Nursing Homes, a representative of the Alaska League of Community
13 of Health Centers, a representative of the Alaska Association of Health
14 Maintenance Organizations, and a recipient of Medicaid; however, each
15 representative shall be designated by the respective organization repre-
16 sented and the Medicaid recipient shall be appointed by the governor.
17 (b) The commission is authorized and directed to investigate, study,
18 and prepare plans relative to the complete or partial consolidation of the
19 Medicaid program, the Disability Insurance Authority, and the Group Insur-
20 ance Commission. The commission may travel within the state and may con-
21 duct public hearings. The commission shall file its recommended plan,
22 including recommended legislation, regarding a consolidation with the
23 legislature not later than January 1, 1990. The plan shall contain a
24 proposal capable of being implemented on July 1, 1990, if the recommended
25 legislation is enacted. The commission shall develop recommendations to
26 allow the state to utilize resources more efficiently through the exercise
27 of consolidated purchasing power, without jeopardizing the quality of
28 medical care provided to participants in the Medicaid program, the Disabil-
29 ity Insurance Authority, and the Group Insurance Commission.

1 * Sec. 13. If federal legislation is enacted establishing a national
2 health insurance program, the Disability Insurance Authority shall, within
3 60 days of the enactment, submit a report to the legislature analyzing the
4 relationship of the national program to the programs of the authority and
5 recommending legislation to eliminate duplication between the state and
6 national programs or to provide that the programs are coordinated in a
7 manner as to promote maximum, cost-efficient access to health care for the
8 citizens of the state.
9 * Sec. 14. The Rate-setting Commission is authorized and directed to
10 study the desirability and feasibility of establishing reasonable maximum
11 rates of reimbursement that nursing pools may charge. The commission shall
12 file a report of the study, including recommended legislation, if any, with
13 the legislature by October 1, 1989.
14 * Sec. 15. The commissioner of health and social services is authorized
15 and directed to study the desirability and feasibility of establishing
16 minimum standards for the registration and operation of nursing pools. The
17 commissioner shall file a report of the study, including recommended legis-
18 lation, if any, with the legislature by October 1, 1990.
19 * Sec. 16. TEMPORARY REVENUE ADJUSTMENT. (a) For all acute care hos-
20 pitals, excluding a comprehensive cancer center as defined in AS 18.21.900
21 and an acute care hospital that predominantly limits its admissions to
22 patients under active diagnosis and treatment of eye, ears, nose and
23 throat, approved gross patient service revenue for fiscal years 1989, 1990,
24 and 1991, shall be determined under AS 18.21.040 - 18.21.130.
25 (b) A comprehensive cancer center may, at its option, elect to be
26 exempt from AS 18.21.040 - 18.21.130 and establish, prospectively and
27 retrospectively, its approved gross patient service revenue, its Blue Cross
28 rate of payment and compliance with approved gross patient service revenue
29 under AS 18.21.240.

1 (c) A hospital that predominantly limits its admissions to patients
2 under active diagnosis and treatment of eye, ears, nose and throat, may, at
3 its option, elect to be exempt from AS 18.21.040 - 18.21.130, and estab-
4 lish, prospectively and retrospectively, its approved gross patient service
5 revenue, its Blue Cross rate of payment and compliance with approved gross
6 patient service revenue under AS 18.21.250.
7 * Sec. 17. The division of insurance is directed to require all health
8 insurers and health maintenance organizations doing business in the state
9 to identify persons who are recipients of medical assistance, or who are
10 responsible for supporting a recipient, and who are also beneficiaries
11 under any policy for health insurance or parties to any health maintenance
12 contract in force and effect in the state. The Department of Health and
13 Social Services shall provide information to the extent sufficient to allow
14 insurers to identify these persons. This information shall be made avail-
15 able by insurers and health maintenance organizations and by the department
16 only for the purposes of and to the extent necessary for identifying these
17 persons. A health insurer or health maintenance organization that complies
18 with this section may not be held liable in a civil or criminal action or
19 proceedings brought by a beneficiary or member on account of compliance.
20 The division shall further direct all health insurers and health mainte-
21 nance organizations doing business in the state to participate with the
22 department in any procedure, including but not limited to automated file
23 matches, conducted under the direction of the department for the purpose of
24 identifying those persons who are recipients of medical assistance, or who
25 are responsible for supporting the recipients, and who are also benefi-
26 ciaries under a policy for health insurance or parties to a health mainte-
27 nance contract in force in the state. Participation in a procedure by a
28 health insurer or health maintenance organization doing business in the
29 state shall include but shall not be limited to reasonable financial

1 participation in the cost of the procedure.

2 * Sec. 18. This Act takes effect July 1, 1988.