

Introduced: 1/9/89
Referred: Health, Education and Social
Services, Labor and Commerce
and Finance

6-0030A

1 IN THE SENATE

BY KERTTULA AND COGHILL

2

SENATE BILL NO. 6

3

IN THE LEGISLATURE OF THE STATE OF ALASKA

4

SIXTEENTH LEGISLATURE - FIRST 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) access by residents to basic health care services is a
12 natural, essential, and unalienable right that is protected by art. VII,
13 sec. 4, of the Constitution of the State of Alaska;

14 (2) many residents lack access to basic health care services
15 because they are not able to purchase health care insurance at a reasonable
16 price or because they are restricted from purchasing health insurance by
17 the practices of the insurance industry;

18 (3) lack of access to health care negatively affects the health
19 status of the uninsured by the delay or lack of medical treatment, thereby
20 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, but many other businesses are precluded
25 from providing assistance because of economic and cost concerns;

26 (6) the inability of certain businesses to offer health insur-
27 ance benefits to their employees is a hindrance to their ability to compete
28 for capable employees in the labor market and therefore has a negative
29 economic effect on the state.

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

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

5 CHAPTER 55. STATE HEALTH INSURANCE.

6 ARTICLE 1. HEALTH INSURANCE AUTHORITY.

7 Sec. 21.55.010. CREATION AND PURPOSE. (a) The Health Insurance
8 Authority is established. The authority is a public corporation and
9 an instrumentality of the state in the Department of Commerce and
10 Economic Development but has a legal existence independent of and
11 separate from the state.

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

19 Sec. 21.55.020. BOARD OF DIRECTORS. (a) The authority is
20 governed by a board of five directors. The directors are the com-
21 missioner of commerce and economic development, the commissioner
22 of health and social services, the director of the division of in-
23 surance, and a representative of the insurance industry, and a
24 representative of health care providers, appointed by the gover-
25 nor.

26 (b) The term of the directors who represent the insurance indus-
27 try and health care providers is three years. A vacancy in a di-
28 rectorship shall be filled for the unexpired term in the same manner
29 as the original appointment.

1 (c) The directors must be residents and shall comply with the
2 requirements of AS 39.50 (Conflict of Interest). The directors of the
3 authority serve without compensation, but are entitled to travel and
4 per diem expenses authorized by law for state boards and commissions
5 under AS 39.20.180.

6 Sec. 21.55.030. APPOINTMENT AND POWERS OF EXECUTIVE DIRECTOR.
7 The board shall appoint an executive director of the authority who
8 serves at the pleasure of the board and may be removed by the board at
9 any time. The executive director must have educational qualifications
10 and administrative and other experience that the board determines to
11 be necessary for the performance of the duties of executive director.
12 The executive director shall appoint and may remove agents and subor-
13 dinate officers that the executive director considers necessary and
14 may establish divisions and subdivisions within the authority. The
15 position of executive director is in the exempt service.

16 Sec. 21.55.040. DEPUTY EXECUTIVE DIRECTOR. The executive direc-
17 tor shall appoint a person to serve as deputy executive director of
18 the authority. The deputy executive director shall perform the duties
19 that the executive director determines and shall, in the case of a
20 vacancy in the office of executive director and during the executive
21 director's absence or disability, exercise the powers and perform the
22 duties of that office. The deputy executive director must have educa-
23 tional qualifications and administrative and other experience that the
24 executive director determines to be necessary for the performance of
25 the duties of deputy executive director. The position of deputy
26 executive director is in the exempt service.

27 Sec. 21.55.050. GENERAL POWERS. The authority may
28 (1) adopt regulations to implement this chapter;
29 (2) make contracts and execute all instruments necessary or

- 1 convenient for carrying out its business;
- 2 (3) acquire, own, hold, dispose of, and encumber personal
3 property and lease real property in the exercise of its powers;
- 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 21.55.200 in conjunction with the Health Care Cost Review
10 Board;
- 11 (6) establish advisory boards to expand the participation
12 in its decisions and to draw on the experience of representatives from
13 all aspects of the health care financing field, including providers,
14 consumers, third-party payors, businesses, 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; the financial assumptions underlying these purchas-
20 ing arrangements shall be made on an actuarially sound basis;
- 21 (9) design and revise a basic schedule of health care
22 services that enrollees in the health insurance program are entitled
23 to receive, including those services that are typically included in
24 employer sponsored health benefit plans in the state; the authority
25 may adopt schedules of covered health care services that differ from
26 the basic schedule and that apply to specific classes of enrollees;
- 27 (10) maintain a prudent level of reserve funds to protect
28 the solvency of the trust funds of the authority; and
- 29 (11) conduct studies concerning the status of health care in

1 the state, including the effect on consumers and businesses of pro-
2 grams established under this chapter.

3 Sec. 21.55.060. REQUIRED ADVISORY BOARDS. (a) The authority
4 shall establish an advisory board on small business access to afford-
5 able health care. The board must consist of nine members appointed by
6 the executive director, of whom five must represent small businesses,
7 one must be an agent or broker of health insurance, one must represent
8 a hospital service corporation, one must represent a health insurance
9 company, and one must represent a health maintenance organization.
10 The board shall meet from time to time, advise the executive director
11 on all matters concerning small businesses for which the authority is
12 authorized to establish programs, and evaluate incentives for volun-
13 tary participation in health insurance programs.

14 (b) The authority shall establish an advisory board on the unin-
15 sured. The board must consist of nine members appointed by the execu-
16 tive director, of whom three must be consumer representatives, one
17 must be an organized labor representative, one must be a hospital
18 representative, one must be a community health center representative,
19 one must be a physician representative, one must be a health insurance
20 representative, and one must be a business representative. The board
21 shall advise the executive director on all matters relative to the
22 programs of the authority to provide health insurance to the unin-
23 sured.

24 ARTICLE 2. STATE HEALTH INSURANCE PLANS.

25 Sec. 21.55.100. TYPES OF INSURANCE PLANS. The authority shall
26 establish health insurance programs consistent with this chapter and
27 provide health care insurance to all residents who are not covered by
28 a health insurance plan, a self-insurance plan, or the medical assis-
29 tance program under AS 47.07. The authority may not operate as an

1 insurance company but shall make health insurance plans available to
2 residents of the state through the purchase of health insurance plans,
3 including managed health care plans, from private health insurance
4 companies. The authority shall endeavor to purchase health insurance
5 plans in an economical manner and shall enroll individuals in managed
6 health care plans when practical.

7 Sec. 21.55.110. PURCHASE OF INSURANCE. (a) The authority
8 shall, subject to appropriation, negotiate with and purchase, on the
9 terms that it considers to be in the best interest of the authority
10 and its enrollees, from one or more health insurance companies, a
11 policy or policies of group general or blanket insurance providing
12 hospital, surgical, medical, and other health insurance benefits
13 covering all residents and their dependents not enrolled in a health
14 insurance plan, self-insurance health plan, or the medical assistance
15 program.

16 (b) The authority shall execute all agreements or contracts
17 pertaining to the policies or amendments to them for and on behalf and
18 in the name of the authority. The authority may negotiate a contract
19 for a term not exceeding three years that it considers to be the most
20 advantageous to the authority and its enrollees. The authority shall
21 endeavor to contract with health insurance companies only for managed
22 health care plans or for health insurance plans that employ other
23 methods to reduce costs of health care services. The authority shall
24 offer an enrollee a choice of at least two plans providing health care
25 insurance benefits. The authority shall ensure that not more than 30
26 percent of the enrollees are enrolled in a health insurance plan of a
27 single health insurance company.

28 (c) The authority shall

29 (1) adopt regulations regarding eligibility criteria,

1 enrollment, and termination policies;

2 (2) establish procedures by which individuals who partici-
3 pate or are seeking to participate in the health insurance program of
4 the authority may appeal determinations of noneligibility, enrollment,
5 and termination; and

6 (3) allow, on an annual basis, an opportunity for enrollees
7 to transfer their enrollments among participating health insurance
8 plans.

9 (d) The authority shall establish a schedule of premium contri-
10 butions, copayments, deductibles, or coinsurance amounts to be paid by
11 individual enrollees for a policy purchased by the authority. The
12 schedule shall establish a sliding scale of payments for enrollees
13 based on family income and size and other factors determined to be
14 appropriate by the authority. The schedule must provide for enrollees
15 to pay 100 percent of the premium contributions if their income sub-
16 stantially exceeds the nonfarm poverty guidelines of the United States
17 Office of Management and Budget. The authority shall establish proce-
18 dures by which an enrollee may appeal the determination of the en-
19 rollee's contribution.

20 (e) The authority shall require a health insurance company that
21 provides health care benefits under this chapter to establish griev-
22 ance procedures that are approved by the authority.

23 (f) A health insurance plan provided by the authority to its
24 enrollees through a contract with a health insurance company shall
25 provide a reasonable range of health care services to enrollees,
26 access to an adequate range of health care providers, and mandated
27 benefits otherwise required by law. A health insurance plan that
28 constitutes a managed health care plan shall provide, at a minimum,
29 the following benefits:

- 1 (1) inpatient and outpatient acute hospital services;
- 2 (2) inpatient and outpatient physician services;
- 3 (3) diagnostic and screening tests;
- 4 (4) preventive care;
- 5 (5) prenatal and well-baby care;
- 6 (6) medically necessary emergency health services; and
- 7 (7) all other benefits that health maintenance organiza-
- 8 tions are required by law to provide.

9 Sec. 21.55.120. DEVELOPMENT OF SMALL BUSINESS INSURANCE. The
10 authority shall assist small businesses in purchasing health insurance
11 for their employees at rates that are as equivalent as possible to the
12 rates at which large employers can purchase health insurance. Assis-
13 tance under this section must include the following:

14 (1) study of the insurance market and the practices of
15 health insurance companies, to determine the causes of the relative
16 unavailability of health insurance plans for small businesses, in-
17 cluding recommendations for improving the availability and reducing
18 the relative cost of health insurance for small businesses;

19 (2) awarding of technical assistance grants to private
20 organizations acting as brokers on behalf of small businesses seeking
21 to procure a health insurance plan;

22 (3) evaluation of tax incentives in reducing the cost of
23 health insurance to small businesses; and

24 (4) management of the health insurance hardship trust fund
25 to protect certain businesses from being overburdened by the required
26 contributions.

27 Sec. 21.55.130. 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 health insurance
3 companies, a policy of group general or blanket insurance providing
4 hospital, surgical, medical, and other health insurance benefits
5 covering persons who are the employees of small businesses in which
6 the number of full-time equivalent employees does not exceed six, and
7 the dependents of those persons.

8 (b) The authority shall execute all agreements or contracts
9 pertaining to pool policies or amendments to them in the name of the
10 authority. The authority may negotiate a contract for a term not
11 exceeding three years. The authority shall

12 (1) endeavor to purchase health insurance plans in an
13 economical manner and shall enroll individuals in managed health care
14 plans whenever practical;

15 (2) offer an enrollee a choice of at least two policies
16 providing health care insurance benefits;

17 (3) allow, on an annual basis, an opportunity for enrollees
18 to transfer their enrollments among participating health insurance
19 plans; and

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

26 Sec. 21.55.140. STUDENT HEALTH INSURANCE. (a) A full-time or
27 part-time student enrolled in a public or independent institution of
28 higher education located in the state shall participate in a quali-
29 fying student health insurance program. An institution may elect to

1 allow students to waive participation in its student health insurance
2 program or any part of it. An institution permitting a waiver shall
3 require students waiving participation to certify in writing before an
4 academic year in which they will not participate in the institution's
5 plan that they are participating in a health insurance program having
6 comparable coverage.

7 (b) The authority, with the advice and consent of the Board of
8 Regents, shall adopt regulations to

- 9 (1) define qualifying student health insurance programs;
10 (2) establish procedures to monitor compliance; and
11 (3) implement the provisions of this section.

12 (c) Each public and independent institution of higher education
13 shall submit an annual report to the authority detailing its comp-
14 liance with the provisions of this section.

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 of \$10 per student for every day during which the failure
18 continues. An institution that relies in good faith on statements by
19 students relative to their health insurance status may not be held
20 liable for a penalty or for failure to comply with the provisions of
21 this section caused by misstatements of that student.

22 Sec. 21.55.150. HARDSHIP INSURANCE PROGRAM. (a) The authority
23 shall, subject to appropriation, establish a health insurance hardship
24 program to assist employers severely affected by the employer contri-
25 bution required under AS 21.55.300. The program must provide assis-
26 tance to employers

- 27 (1) who are small businesses; and
28 (2) for whom the contribution exceeds five percent of the
29 employer's gross revenue; the assistance shall reduce the employer's

1 contribution to an amount equal to five percent of the employer's
2 gross revenue.

3 (b) The authority may transfer amounts from the medical security
4 trust fund to the health insurance hardship trust fund only upon a
5 finding by the cost review board established under AS 21.55.350 that
6 there is a surplus in the medical security trust fund and that the
7 transfer would be in the best interest of the employers of the state.

8 Sec. 21.55.160. UNINSURED AND UNDERINSURED PROGRAM. The author-
9 ity shall establish a continuing program of investigation and study of
10 the uninsured and underinsured in the state. The authority shall
11 examine

12 (1) the effect of the lack of adequate health insurance on
13 residents, including the effects of Medicare changes and premium
14 increases on poor and near-poor elders and the problems of persons,
15 particularly disabled children, who have difficulty obtaining adequate
16 health insurance coverage; the program shall document the effects and
17 shall develop recommendations and proposals to remedy the situation;
18 and

19 (2) the overall effect of programs developed by the author-
20 ity and the Department of Health and Social Services on the uninsured
21 the underinsured, and the role of employers in assisting their employ-
22 ees in affording health insurance.

23 Sec. 21.55.170. MEDICAL ASSISTANCE FOR PREGNANT WOMEN AND IN-
24 FANTS. (a) The authority shall establish a program of medical care
25 and assistance for pregnant women and infants who are not otherwise
26 eligible for medical assistance and who lack private health insurance
27 coverage or have health insurance coverage that does not cover all
28 medically necessary care covered by the program established by this
29 section. The authority shall furnish medical assistance to each

1 pregnant woman and infant residing in the state under standards of
2 eligibility established by the authority. The income eligibility
3 standards may not exclude a woman or infant with income of less than
4 200 percent of the nonfarm income poverty guidelines defined by the
5 United States Office of Management and Budget.

6 (b) Assistance furnished under this section shall be limited to
7 the following care and services:

8 (1) all medically necessary care to maintain health during
9 the course of the pregnancy and delivery, including newborn hospital
10 care;

11 (2) all medically necessary postpartum obstetric and
12 gynecological care;

13 (3) newborn care, including one postpartum pediatric ambu-
14 latory visit; and

15 (4) outreach services designed to identify and encourage
16 the participation of pregnant women and infants in this program.

17 (c) The authority shall ensure that all women who appear to be
18 eligible for medical assistance are assisted in enrolling for the
19 coverage. If a woman receiving services under the program established
20 under this section is found by the Department of Health and Social
21 Services to be eligible for public health services, the department
22 shall pay for the services and shall reimburse the authority for the
23 services if the reimbursements are allowed under 42 U.S.C. 1396
24 (Social Security Act).

25 Sec. 21.55.180. DISABLED PERSONS MEDICAL PROGRAM. The authority
26 shall establish a program of primary and supplemental medical care and
27 assistance for certain disabled residents who are not eligible for
28 medical assistance under 42 U.S.C. 1396 (Social Security Act). The
29 benefits of the program shall be available to all persons (1) who are

1 not covered for medical costs relative to their disability by an
2 employer's group health insurance plan, (2) who are not eligible for
3 medical assistance under a work incentive program with federal
4 participation, and (3) who, if not engaged in substantial gainful
5 activity, would meet all eligibility requirements for supplemental
6 security income under 42 U.S.C. 1381 - 1383 (Social Security Act) at
7 the time of application for the program of medical care and assis-
8 tance. After enrollment in the program, a disabled resident may
9 continue in the program notwithstanding the fact that the person no
10 longer meets the financial requirements under 42 U.S.C. 1381 - 1383.
11 The cost of the program shall be funded, in part, by premium contribu-
12 tions, copayments, and deductibles contributed by enrollees according
13 to a sliding scale schedule adopted by the authority.

14 Sec. 21.55.190. DISABLED CHILDREN'S CARE PROGRAM. The authority
15 shall establish a program of medical care and assistance for certain
16 disabled children in the state. The benefits of the program shall be
17 available to children who are not eligible for medical assistance
18 programs with federal financial participation and who would meet the
19 disability requirements for supplemental security income under 42
20 U.S.C. 1381 - 1383 (Social Security Act). The cost of the program
21 shall be funded, in part, by premium contributions, copayments, and
22 deductibles according to a sliding scale schedule adopted by the
23 authority.

24 Sec. 21.55.200. UNCOMPENSATED CARE POOL. (a) The authority
25 shall administer an uncompensated care pool consisting of the revenue
26 produced by the uniform statewide allowance for uncompensated care
27 included in gross patient service revenue of acute hospitals appropri-
28 ated for the pool under this section. Each hospital's liability to
29 the pool shall equal the product of the uniform statewide allowance

1 for uncompensated care times the sum of the hospital's private sector
2 share of projected patient care costs for the fiscal year, and a
3 working capital allowance specified by the authority for the fiscal
4 year. The liability of the pool to each hospital equals the lesser of

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

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

9 (b) In administering the pool the authority shall provide for
10 prompt payments to and from hospitals, and encourage maximum effi-
11 ciency in the use of acute hospital services by purchasing and enroll-
12 ing individuals in managed health care plans. For each fiscal year,
13 the authority shall calculate the net liability of each acute hospital
14 to the pool. The result, if positive, shall be the net hospital
15 liability to the pool, and, if negative, shall be the net liability of
16 the pool to the hospital. The authority shall establish a system of
17 payments by hospitals and by the pool whereby each fiscal year each
18 hospital pays an amount of revenue equal to its net liability to the
19 pool or receives from the pool an amount of revenue equal to the net
20 liability of the pool to the hospital. The system may provide for
21 periodic payments of net liabilities to and from the pool, for the
22 collection and expenditure by the pool of revenue equal to the amount
23 of each hospital's liability to and from the pool, or for another
24 payment mechanism that the authority finds appropriate to the manage-
25 ment of the pool and the financial needs of each hospital.

26 (c) The authority shall establish an appropriate mechanism for
27 enforcing a hospital's obligation to the pool in the event that a
28 hospital does not make a scheduled payment to the pool. The enforce-
29 ment mechanism may include the assessment of a five percent surcharge

1 on a withheld amount. The authority may not at any time make payments
2 from the pool for a period in excess of amounts that have been paid
3 into or are available in the pool for the period. The authority may
4 temporarily prorate payments from the pool for cash flow purposes.
5 The authority shall establish a final settlement of the pool for each
6 fiscal year to adjust for the differences between an interim payment
7 to or from the pool and the actual liability of each acute hospital to
8 the pool or of the pool to the hospital.

9 (d) Subject to the limits contained in this subsection, the
10 revenue in the pool shall be supplemented by annual appropriations in
11 the event that the total liability of the pool to all hospitals for
12 the fiscal year exceeds the total private sector liability of the pool
13 for the fiscal year. The total amount of the supplement for a fiscal
14 year may not exceed the sum of (1) 115 percent of the amount of the
15 total liability of the pool to all hospitals for the prior fiscal
16 year, minus the total private sector liability for the current year,
17 and (2) 50 percent of an amount by which the total of the liability of
18 the pool to all hospitals for the current fiscal year exceeds 115
19 percent of the amount of the liability of the pool to all hospitals
20 for the prior fiscal year. The authority may not pay an amount of the
21 liability of the pool to all hospitals that exceeds the sum of the
22 total private sector liability to the pool for the fiscal year and the
23 amount of the state's supplement for the fiscal year under this sub-
24 section. The authority shall prorate any resulting shortfall among
25 all hospitals. The authority and the cost review board shall periodi-
26 cally evaluate and determine jointly whether a supplement under this
27 subsection is necessary for the fiscal year.

28 (e) Payments by acute hospitals to the pool and state revenue
29 appropriated for the supplement provided in (d) of this section shall

1 be placed in an uncompensated care trust account established under
2 AS 21.55.250. Amounts placed in the fund may be expended by the
3 authority for the purposes of the pool, including lawful expenditures
4 for the purpose of reducing hospitals' write-offs for bad debt and
5 free care.

6 (f) The authority shall review hospital credit and collection
7 policies to ensure that hospitals make reasonable efforts to collect
8 payment for hospital services before attributing those services to bad
9 debt or free care. In developing the criteria, the authority shall
10 identify the populations that do not require collection action.

11 (g) The authority shall also adopt regulations necessary to
12 manage the uncompensated care pool under this section, including
13 regulations

14 (1) providing audit standards for the pool;

15 (2) establishing an enforcement mechanism under (c) of this
16 section; and

17 (3) containing reasonable controls on use that include the
18 purchase and enrollment of individuals in managed health care plans
19 and that are consistent with the controls contained in regulations
20 under 42 U.S.C. 1395 (Social Security Act).

21 ARTICLE 3. TRUST FUNDS.

22 Sec. 21.55.250. MEDICAL SECURITY TRUST FUND. (a) There is
23 established the medical security trust fund. The trust fund shall be
24 administered and expended by the authority. The trust fund consists
25 of money appropriated to the fund, all property and securities ac-
26 quired by and through the use of money belonging to the trust fund,
27 and all interest earned on the fund less (1) amounts transferred to
28 the health insurance hardship trust fund under AS 21.55.150 and (2)
29 payments to health insurance companies for refunds or abatements for

1 enrollees or former enrollees. All money appropriated to the authori-
2 ty for the purpose of providing health insurance for the uninsured and
3 all money earned on the amounts in the trust fund shall be deposited
4 or retained in the trust fund.

5 (b) The authority shall establish within the medical security
6 trust fund at least three separate accounts, as follows:

7 (1) an unemployment health insurance contribution account
8 that consists of employer contributions required under this chapter
9 and premiums paid by enrollees that shall be used exclusively for the
10 payment of premiums for health insurance plans provided to persons
11 receiving unemployment compensation;

12 (2) a medical security contribution account that consists
13 of employer contributions required under this chapter, premiums paid
14 by enrollees, other voluntary contributions by other persons or en-
15 tities, and appropriations from the state that shall be used exclu-
16 sively for the payment of premiums for health insurance plans provided
17 to eligible employees and their dependents;

18 (3) a public sector responsibility account that consists of
19 all premiums paid by enrollees, voluntary contributions by other
20 persons and entities, and appropriations that shall be used for pay-
21 ment of premiums for health insurance plans provided to all other
22 residents who lack health insurance; and

23 (4) an uncompensated care account that consists of appro-
24 priations for the purpose of uncompensated hospital care and all
25 property and securities acquired through the use of money belonging to
26 the trust fund and all interest on the account less payments from the
27 account for the purposes of the pool under AS 21.55.200.

28 (c) Amounts within accounts in the trust fund may not be com-
29 mingled except upon approval of the Health Care Cost Review Board and

1 a finding by the board that temporary commingling of the accounts is a
2 short-term measure necessary to ensure the solvency of the trust fund.
3 Amounts commingled shall be restored to the appropriate account within
4 90 days.

5 Sec. 21.55.260. HEALTH INSURANCE HARDSHIP TRUST FUND. (a)
6 There is established a health insurance hardship trust fund that shall
7 be administered and expended by the authority. The trust fund con-
8 sists of appropriations for purposes specified under AS 21.55.150,
9 property and securities acquired through the use of money belonging to
10 the trust fund, all interest on fund assets, and amounts transferred
11 from the medical security fund in accordance with AS 21.55.150 less
12 payments from the fund for the purposes of the health insurance hard-
13 ship program. All interest earned on the amounts in the trust fund
14 shall be deposited or retained in the trust fund.

15 (b) The authority may expend money from the trust fund as neces-
16 sary to meet the current or estimated obligations of the authority for
17 the purposes of the trust fund.

18 ARTICLE 4. MANDATORY CONTRIBUTIONS.

19 Sec. 21.55.300. EMPLOYER CONTRIBUTION. (a) Except as provided
20 in (g) of this section, an employer, except an employer who employs
21 five or fewer employees, shall pay, in the same manner and at the same
22 times that the authority prescribes, an unemployment health insurance
23 contribution computed by multiplying the wages paid its employees by
24 12/100ths of one percent.

25 (b) An employer, except an employer who employs five or fewer
26 employees, shall pay, in the same manner and at the same times that
27 the authority prescribes, a medical security contribution for each
28 employee computed by multiplying the wages paid each employee by 12
29 percent. Each employee shall be presumed to be an employee under this

1 section unless the employer certifies to the executive director, in
2 the form and manner that the executive director may require, that the
3 employee should not be included under the provisions of this section.
4 Each employer may require an employee to verify the employee's health
5 insurance status. An employer may not require an applicant for em-
6 ployment to disclose the applicant's health insurance status or the
7 health insurance status of the applicant's spouse, dependents, or
8 other family members.

9 (c) An employer may not discriminate against an applicant on the
10 basis of the applicant's health insurance status.

11 (d) A person aggrieved by a violation of this section may insti-
12 tute within three years of the violation a civil action for injunctive
13 relief and any damages thereby incurred. An employer who violates
14 this section shall pay reasonable attorney fees and court costs in-
15 curred in the action as determined by the court.

16 (e) An employer may deduct from the amount owed for each employ-
17 ee under (b) of this section the employer's average expenses per
18 employee for providing health insurance coverage or other health care
19 benefits for each employee, allowable for the current quarter by the
20 Internal Revenue Service as a deductible business expense; however, a
21 deduction for an employer may not reduce the contribution for an
22 employee below zero.

23 (f) An unemployment health insurance contribution and a medical
24 security contribution shall be paid to the authority under the proce-
25 dures prescribed by the authority. The receipts from the contribu-
26 tions shall be deposited in the general fund. The commissioner of
27 administration shall separately account for funds received under this
28 section that are deposited in the general fund. The legislature may
29 appropriate the annual estimated balance in the account to the medical

1 security trust fund established under AS 21.55.250.

2 (g) This section does not apply to an employer during the first
3 12 consecutive months of employment. During the first calendar year
4 in which this section applies to an employer the employer's unemploy-
5 ment health insurance contribution shall be computed at the rate of
6 14/100 of one percent multiplied by the wages paid and the employer's
7 medical security contribution shall be computed at the rate of four
8 percent multiplied by the wages paid. During the second calendar year
9 in which this section applies to an employer, the employer's unemploy-
10 ment health insurance contribution shall be computed at the rate of
11 8/100 of one percent multiplied by the wages paid, and the employer's
12 medical security contribution shall be computed at the rate of eight
13 percent multiplied by the wages paid.

14 (h) In this section,

15 (1) "employee" does not include the following employees of
16 an employer:

17 (A) an employee who has been employed by the employer
18 for fewer than 90 days from date of hire;

19 (B) an employee who normally works less than 30 hours
20 a week; however, a head of household who has dependent children
21 living at home and is working at least 20 hours a week or an
22 employee who has worked at least 520 hours in the previous six
23 months is considered to be an employee for the purposes of this
24 section;

25 (C) an employee who is hired to perform a service for
26 a period of less than five months;

27 (D) a seasonal or temporary agricultural employee; or

28 (E) an employee who is covered by a group or nongroup
29 health benefit plan that is financed without participation by the

1 employer, who is enrolled in the Medicare program, or who is
2 covered by a government operated medical assistance program
3 except that an employee covered by a health insurance plan is
4 considered to be an employee for the purposes of this section;

5 (2) "wages" does not include that part of remuneration
6 that, after remuneration equal to the medical security wage base with
7 respect to employment with the employer has been paid to an individual
8 during the calendar year, is paid to the individual during the year,
9 including remuneration paid to an individual during the calendar year
10 with respect to employment with a transferring employer; in this
11 paragraph "medical security wage base" means \$14,000 for the calendar
12 years 1991, 1992, and 1993; in each subsequent calendar year the
13 medical security wage base shall equal the product of

14 (A) the medical security wage base for the previous
15 calendar year; and

16 (B) the sum of one plus the health insurance inflation
17 rate for the previous calendar year, as reported by the Health
18 Care Cost Review Board established under AS 21.55.210.

19 ARTICLE 5. HEALTH CARE CHARGES.

20 Sec. 21.55.350. HEALTH CARE COST REVIEW BOARD ESTABLISHED;
21 COMPOSITION. (a) The Health Care Cost Review Board is established in
22 the authority.

23 (b) The board consists of the director of the division of insur-
24 ance and four members appointed by the governor, as follows:

- 25 (1) a certified public accountant;
26 (2) a representative of consumers of health services;
27 (3) a physician licensed to practice medicine in the state;

28 and

- 29 (4) a representative of the Alaska Hospital Association.

1 Sec. 21.55.360. TERM OF MEMBERSHIP AND COMPENSATION. (a) The
2 term of a member of the board appointed under AS 21.55.350(b)(1) - (4)
3 is three years. A member may not be appointed to a successive term,
4 except that a member appointed to fill a vacancy serves for the un-
5 expired term and may be appointed to a successive term.

6 (b) A member of the board serves without compensation but is
7 entitled to per diem and travel expenses authorized by law for boards
8 under AS 39.20.250.

9 Sec. 21.55.370. OFFICERS, MEETINGS, AND QUORUM. The board shall
10 elect a chairman at the first meeting of each year. A majority of the
11 members constitute a quorum for conducting business. The board shall
12 meet as often as necessary to conduct its business.

13 Sec. 21.55.380. POWERS AND DUTIES. (a) The board shall

14 (1) review proposed fees and charges for health care ser-
15 vices provided under this chapter;

16 (2) determine if actual fees and charges for health care
17 services are based on a fair rate of return for reasonable costs
18 incurred by the health care provider;

19 (3) establish a uniform statewide allowance for uncom-
20 pensated care;

21 (4) establish a uniform schedule of fees and charges for
22 all patients receiving comparable services; and

23 (5) develop an annual estimate of health care expenditures
24 required by this chapter.

25 (b) The board may

26 (1) impose a uniform system of accounting, budgeting, and
27 financial reporting for health care providers under this chapter;

28 (2) require inspection or audit of financial records of a
29 health care provider; and

1 (3) adopt regulations to implement AS 21.55.350 - 21.55.-
2 380.

3 ARTICLE 6. PREFERRED PROVIDER ARRANGEMENTS.

4 Sec. 21.55.400. AUTHORITY TO ENTER INTO ARRANGEMENTS. (a) A
5 health insurance company may enter into a preferred provider arrange-
6 ment with one or more health care providers upon a determination by
7 the authority that the health insurance company and the arrangement
8 comply with the requirements of this chapter and the regulations
9 adopted under this chapter. A health insurance company may not condi-
10 tion its willingness to allow a health care provider to participate in
11 a preferred provider arrangement on the health care provider's agree-
12 ing to enter into other contracts or arrangements with the health
13 insurance company that are not part of or related to the preferred
14 provider arrangements.

15 (b) A health insurance company shall submit information concern-
16 ing a proposed preferred provider arrangement to the authority for
17 approval under regulations adopted by the authority. The information
18 submitted must include at least the following:

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

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

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

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

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

26 (c) A preferred provider arrangement must contain standards for:

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

29 (2) controlling health care costs;

1 (3) ensuring reasonable levels of access of health care
2 services and an adequate number and geographical distribution of
3 preferred providers to render those services;

4 (4) ensuring appropriate utilization of health care ser-
5 vice; and

6 (5) other areas required by the executive director.

7 Sec. 21.55.410. PREFERRED PROVIDER INCENTIVES. A health insur-
8 ance company may offer a health benefit plan that provides incentives
9 for covered persons to use the health care services of preferred
10 providers. A health benefit policy or plan must meet at least the
11 following minimum requirements:

12 (1) benefit levels for health care services rendered by
13 nonpreferred providers shall be at least 80 percent of the benefit
14 levels for services rendered by preferred providers;

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

19 (3) a procedure shall be specified for resolving consumer
20 complaints and grievances; and

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

24 Sec. 21.55.420. DISCRIMINATION PROHIBITED. A health insurance
25 company may not refuse to enter into a preferred provider arrangement
26 with a health care provider on the basis of religion, race, color,
27 national origin, age, sex, marital status, sexual orientation, or the
28 provider's relationships with any other organization. The selection
29 of preferred providers shall be based primarily on cost, availability,

1 and quality of covered services. The terms and conditions offered by
2 a health insurance company that must be met or agreed to by physicians
3 and other professional providers of health care services desiring to
4 enter into a preferred provider arrangement shall be subject to the
5 disapproval of the executive director if the terms and conditions are
6 not consistent with the purposes, policies, and provisions of this
7 chapter.

8 Sec. 21.55.430. RECORDS REQUIREMENTS. A health insurance
9 company shall maintain financial and utilization records for its
10 preferred provider arrangements and activities in a form separate or
11 separable from the financial and utilization records of other opera-
12 tions and activities carried on by the company.

13 Sec. 21.55.440. BOND REQUIRED. A health insurance company that
14 enters into a preferred provider arrangement shall furnish to the
15 authority evidence of a surety bond, reinsurance, or other financial
16 resources in an amount satisfactory to the authority as a guarantee
17 that obligations to covered persons will be performed.

18 Sec. 21.55.450. ANNUAL REPORT. A health insurance company that
19 enters into a preferred provider arrangement shall file annually with
20 the authority, within 120 days of the close of the fiscal year, a
21 report covering the prior fiscal year. The report must include:

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

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

26 (3) a list of preferred providers; and

27 (4) other information that the executive director may
28 require.

29 Sec. 21.55.460. LICENSING REQUIREMENTS. A health insurance

1 company that offers or administers a health benefit plan under a
2 preferred provider arrangement is subject to all of the provisions of
3 the organization's licensing statute and any other applicable stat-
4 utes, including benefits required to be provided.

5 Sec. 21.55.470. PREMIUM TAX. (a) A health insurance company
6 operating a preferred provider arrangement shall annually pay a tax
7 equal to 2 and 28/100th's percent of the gross premiums received
8 during the preceding calendar year for coverage of covered persons
9 residing in the state; however, a tax may not be imposed on premiums
10 for Medicare supplemental coverage. In calculating the gross premi-
11 ums, there shall be deducted any canceled or returned premiums.

12 (b) The tax imposed by this section, including interest and
13 penalties, shall be collected by the authority and deposited in the
14 general fund. A health insurance company operating a preferred pro-
15 vider arrangement shall, on or before March 15 of each year, make a
16 return to the authority giving the information that the executive
17 director may require, for the determination of the tax for the preced-
18 ing calendar year.

19 ARTICLE 7. GENERAL PROVISIONS.

20 Sec. 21.55.900. DEFINITIONS. In this chapter

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

24 (2) "authority" means the Health Insurance Authority
25 created in AS 21.55.010;

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

28 (A) regarded as uncollectible, following reasonable
29 collection efforts consistent with the regulations of the

1 authority;

2 (B) charged as a credit loss;

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

5 (D) not free care;

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

7 (5) "community health center" means an organization that
8 provides primary health care and other health care services in confor-
9 mance with the requirements of 42 U.S.C. 300 (Social Security Act);

10 (6) "consumer" means a natural person responsible for
11 payment for health care services rendered by a provider;

12 (7) "dependent" means the spouse and children of an em-
13 ployee if these persons would qualify for dependent status or for whom
14 a support order could be granted under 26 U.S.C. 208 - 209 (Internal
15 Revenue Code);

16 (8) "employee" means a person who performs services primar-
17 ily in the state for remuneration for an employer; a person who is
18 self-employed is not considered to be an employee;

19 (9) "enrollee" means a person who becomes a member of an
20 insurance program of the authority either individually or as a member
21 of a family;

22 (10) "free care" means a revenue deduction associated with
23 the provision of services to patients who have reasonably been con-
24 sidered financially unable to pay, in whole or in part, for their
25 care, consistent with the regulations of the authority;

26 (11) "health care services" means supplies, care, and ser-
27 vices of medical, surgical, optometric, dental, podiatric, chiro-
28 practic, psychiatric, therapeutic, diagnostic, preventive, rehabilita-
29 tive, supportive, or geriatric nature, including inpatient and

1 outpatient acute hospital care and services, and services provided by
2 a community health center, by a sanatorium as included in the defini-
3 tion of "hospital" under 42 U.S.C. 1395 (Social Security Act) and
4 treatment and care compatible with such services, or by a health
5 maintenance organization;

6 (12) "health insurance company" means a company that engages
7 in the business of health insurance;

8 (13) "health insurance" means the Medicare program or an
9 individual or group contract or other plan providing coverage of
10 health care services that is issued by a health insurance company, a
11 hospital service corporation, a medical service corporation, or a
12 health maintenance organization; "health insurance" includes disabili-
13 ty insurance under AS 21.12.050;

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

18 (15) "hospital" means a hospital licensed under AS 18.20.-
19 040;

20 (16) "hospital service corporation" has the meaning given in
21 AS 21.87.330;

22 (17) "managed health care plan" means a health insurance
23 plan that provides or arranges for, supervises and coordinates health
24 care services to enrolled participants, including plans administered
25 by health maintenance organizations and preferred provider organiza-
26 tions;

27 (18) "maximum reimbursable uncompensated care costs" means
28 the sum of

29 (A) 114 percent multiplied by the projected patient

1 care costs for a hospital service corporation and for purchasers
2 and third-party payors who pay on the basis of charges; and
3 (B) the payments under 42 U.S.C. 1395 (Social Security
4 Act) made for free care to the acute hospital;
5 (19) "Medicaid program" means the medical assistance program
6 administered by the Department of Health and Social Services under
7 AS 47.07;
8 (20) "medical assistance program" means the Medicaid pro-
9 gram, the Veterans' Administration health and hospital programs, and
10 any other medical assistance program operated by a governmental unit
11 for persons categorically eligible for such a program;
12 (21) "medical service corporation" has the meaning given in
13 AS 21.87.330;
14 (22) "Medicare program" means the federal medical insurance
15 program established under 42 U.S.C. 1395 (Social Security Act);
16 (23) "patient care costs" means reimbursable costs under
17 this chapter;
18 (24) "private sector share of projected patient care costs"
19 means the sum of the projected patient care costs of a hospital ser-
20 vice corporation and the projected patient care costs for purchasers
21 and third-party payors who pay on the basis of charges;
22 (25) "provider" means a person, corporation, partnership,
23 governmental unit, state institution, and other entity qualified under
24 the laws of the state to perform or provide health care services;
25 (26) "purchasers and third-party payors who pay on the basis
26 of charges" means purchasers and third-party payors excluding those
27 who are paid under 42 U.S.C. 1395 - 1396 (Social Security Act), other
28 government payors, and nonprofit hospital service corporations;
29 (27) "reimbursable bad debt costs" means the amount of

1 projected patient care costs that are written off as bad debt, net of
2 amounts recovered as a result of collection efforts by the hospital or
3 its agents;

4 (28) "reimbursable free care costs" means the projected
5 patient care costs that are written off as free care, net of any
6 payments for free care;

7 (29) "reimbursable uncompensated care costs" means the sum
8 of reimbursable bad debt costs and reimbursable free care costs;

9 (30) "resident" means a person living in the state as de-
10 fined by the authority by regulation; it does not include a person who
11 moved to the state for the sole purpose of securing health insurance
12 under this chapter; confinement of a person in a nursing home, hospi-
13 tal, or other medical institution in the state is not by itself suffi-
14 cient to qualify the person as a resident;

15 (31) "self-employed" means a person who is not considered to
16 be an employee and whose primary source of income is derived from the
17 pursuit of a bona fide business;

18 (32) "self-insurance health plan" means a plan that provides
19 health benefits to the employees of a business, that is not a health
20 insurance plan, and in which the business is liable for the actual
21 costs of the health care services provided by the plan plus adminis-
22 trative costs;

23 (33) "small business" means a business, including a business
24 consisting only of the self-employed, in which the total of full-time
25 equivalent employees when averaged on an annual basis does not exceed
26 50;

27 (34) "third-party payor" means an entity including, but not
28 limited to, the Medicaid program, the Medicare program, a health
29 insurance company, a health maintenance organization, a hospital

1 service corporation, a medical service corporation, but not including
2 a consumer responsible for payment to a provider for health care
3 services rendered by a provider.

4 * Sec. 3. PHASE-IN COVERAGE. (a) The Health Insurance Authority
5 shall, subject to appropriation, establish phase-in coverage for state
6 health insurance required by this Act on a regional, statewide, or popula-
7 tion basis that is designed to test the relative advantages and disadvan-
8 tages of alternative methods of providing health insurance plans, particu-
9 larly managed health care plans, to persons lacking health insurance.
10 Phase-in coverage shall be established through contracts with health insur-
11 ance companies, hospital service corporations, medical service corpora-
12 tions, or health maintenance organizations. The authority shall use phase-
13 in coverage as part of a plan to provide health insurance to the uninsured
14 on an orderly and gradual basis. Phase-in coverage shall be purchased for
15 a period not to exceed two years; coverage found by the authority to be an
16 efficient and effective method of providing health care services to the
17 uninsured may be purchased by the authority on a permanent basis, under the
18 provisions of AS 21.55.110.

19 (b) The authority may include in a phase-in-coverage any of the
20 persons eligible for coverage in a health insurance program authorized by
21 AS 21.55 as well as persons eligible for Medicare and Medicaid programs.
22 The authority shall

23 (1) test several alternative methods of providing health care to
24 the uninsured, including the use of preferred provider arrangements estab-
25 lished by health insurance companies;

26 (2) establish phase-in coverage in different regions of the
27 state and in urban and rural settings; and

28 (3) perform a study of the effectiveness of the various phase-in
29 coverages.

1 (c) The authority shall require that a health insurance plan, includ-
2 ing a managed health care plan, with which it contracts under this section
3 submit annually to the authority a report of the demographics and utiliza-
4 tion patterns of the enrollees.

5 * Sec. 4. TRANSITION. The Health Insurance Authority shall provide all
6 residents of the state with access to basic health insurance or managed
7 care at a reasonable cost by March 1, 1993, subject to legislative appro-
8 priation. To achieve the goal of universal access to health care, the
9 following programs shall be established according to the following sched-
10 ule:

11 (1) by April 1, 1990, or as soon as possible thereafter, the
12 authority shall begin the following:

13 (A) initiation of a study of the adequacy of health insur-
14 ance for certain residents of the state under AS 21.55.160;

15 (B) initiation of a study of the relationship of small
16 businesses to the insurance market under AS 21.55.120;

17 (C) the purchase and enrollment of individuals in managed
18 health care plans under AS 21.55.200; and

19 (D) with the assistance of the Board of Regents, initiation
20 of a study analyzing the number of students lacking health insurance
21 and the cost of implementing AS 21.55.140;

22 (2) by July 1, 1990, the following programs shall be imple-
23 mented:

24 (A) the program of supplemental health care coverage to
25 disabled adults;

26 (B) the program of supplemental health coverage to disabled
27 children; and

28 (C) at least two phase-in policies to provide health insur-
29 ance for the uninsured under sec. 3 of this Act;

1 (3) by October 1, 1990, the authority shall begin operating the
2 uncompensated care pool under AS 21.55.200;

3 (4) by July 1, 1991, the following programs shall be imple-
4 mented:

5 (A) completion of the study authorized in (1)(B) of this
6 section;

7 (B) the small business health insurance pool established
8 under AS 21.55.130 and other phased coverage authorized under sec. 3
9 of this Act; and

10 (C) additional phase-in coverage to provide health insur-
11 ance for the uninsured under sec. 3 of this Act;

12 (5) on September 1, 1991, the requirement that all college and
13 university students have health insurance shall be implemented;

14 (6) on January 1, 1992, the program to provide health insurance
15 to persons receiving unemployment insurance shall be implemented; health
16 insurance benefits shall become available to eligible persons as of
17 April 1, 1992; in addition, the authority shall complete the study au-
18 thorized under (1)(A) of this section;

19 (7) by January 1, 1993, the state shall assume the cost of
20 hospital care for general relief recipients;

21 (8) by July 1, 1993, the authority shall complete the study of
22 the phase-in policies as authorized under sec. 3 of this Act;

23 (9) on January 1, 1994, the program to provide health insurance
24 to employed persons shall be implemented; health insurance benefits shall
25 become available to eligible persons as of April 1, 1994;

26 (10) by January 1, 1995, the authority shall complete a study of
27 the effect of the programs authorized or referred to in AS 21.55 on the
28 availability of health care for the uninsured in the state as authorized
29 under AS 21.55.160.

1 * Sec. 5. STUDY AND REPORT BY DIRECTOR OF INSURANCE. (a) The director
2 of the division of insurance shall conduct a study and examination of
3 nongroup and Medicare supplementary health care programs offered by non-
4 profit hospital and medical service corporations organized under AS 21.87,
5 by health insurance companies operating under AS 21.09, by preferred pro-
6 vider organizations, by self-insured employee welfare benefit plans, by
7 third-party administrators, and by health claims administration programs.

8 (b) The director shall study the need for, the availability of, the
9 financing for, and supportive governmental incentives available for non-
10 group and Medicare supplementary health care programs in the state. The
11 director shall conduct an audit of nongroup and Medicare supplementary
12 health care programs offered by nonprofit hospital and medical service
13 corporations. The audits shall determine and examine the losses from 1978
14 through 1988 attributable to the programs and the financial effect of the
15 statutory responsibilities and benefits conferred on the nonprofit hospital
16 and medical corporations.

17 (c) The director may request assistance from other state agencies in
18 the performance of duties imposed under this section. All nonprofit hospi-
19 tal and medical service corporations, health maintenance organizations,
20 health insurance companies, preferred provider organizations, self-insured
21 employee welfare benefit plans, third-party administrators, and health
22 claims administration programs referred to in (a) of this section shall
23 cooperate with and make all information available to the director in the
24 performance of the study and examination. An organization voluntarily
25 providing trade secret or commercial or financial information to the direc-
26 tor may request that the information be maintained as confidential informa-
27 tion by the director. Information provided that is accepted by the direc-
28 tor as confidential is not a public record under AS 09.25.110 or 09.25.120.

29 (d) The director shall make an interim report on the results of the

1 study and examination to the legislature by July 1, 1990, and shall submit
2 a final report not later than October 1, 1990. All nonprofit hospital and
3 medical service corporations, health maintenance organizations, health
4 insurance companies, preferred provider organizations, self-insured employ-
5 ee welfare benefit plans, third-party administrators, and health claims
6 administration programs shall have an opportunity to review and comment on
7 the interim and final reports 30 days before submission to the legislature.
8 These comments shall be incorporated in the report.

9 * Sec. 6. COMMISSION CREATED. (a) The Commission on Health Insurance
10 Reform is established to

11 (1) examine and determine what alternatives, if any, exist to
12 provide citizens of the state with an improved health care delivery and
13 health care insurance system;

14 (2) recommend improvements to the competitive environment in the
15 health insurance system;

16 (3) review the affordability and availability of actuarially
17 sound nongroup and Medicare supplementary health insurance coverage; and

18 (4) study the implications of the provisions of this Act rela-
19 tive to preferred provider arrangements and relative to the relationship
20 between nonparticipating providers and hospital and medical service corpo-
21 rations.

22 (b) The commission consists of a representative of a nonprofit hospi-
23 tal or medical service corporation, a representative of the Department of
24 Law, a representative of health care consumer groups, a representative of
25 health maintenance organizations, and a chairman, to be appointed by the
26 governor.

27 (c) The commission shall make its recommendations to the governor and
28 the legislature before October 1, 1990, and shall issue a final report
29 before November 15, 1990. The report of the commission must include

1 recommendations concerning maintenance of the current status by nonprofit
2 hospital and medical service corporations, alternative methods to fulfill
3 the responsibilities of the insurer of last resort of the nonprofit hospi-
4 tal and medical service corporations, if needed, or reorganization of these
5 corporations as a mutual insurance company under AS 21.69.

6 * Sec. 7. SIX-YEAR STUDY. The director of the division of insurance
7 shall, subject to legislative appropriation, contract for a comprehensive,
8 six-year study of the effect of mandatory health care in the state as
9 required by this Act. The study must include projected costs to the state
10 for the following programs: the establishment of voluntary incentives for
11 small business, including technical assistance grants, tax credits, the
12 health insurance hardship trust fund, and an experimental project of state
13 brokered health care for small business; the state's share of the uncom-
14 pensated care pool; the operation of the Health Insurance Authority; all
15 pilot programs established to provide health care coverage to the unin-
16 sured; all costs to the state, beginning in 1993, for providing health care
17 to those individuals not otherwise provided for, including demographic
18 information relative to individuals; and the assumption of all hospital
19 costs of general relief recipients. The study must 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 effect 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. 8. Section 6 of this Act is repealed January 1, 1991.

3 * Sec. 9. This Act takes effect July 1, 1989.