

HOUSE BILL NO. 530

**IN THE LEGISLATURE OF THE STATE OF ALASKA
SEVENTEENTH LEGISLATURE - SECOND SESSION**

BY REPRESENTATIVE KOPONEN

Introduced: 2/18/92

Referred: Health, Education & Social Services, Labor & Commerce, Finance

A BILL

FOR AN ACT ENTITLED

1 "An Act relating to health insurance; and providing for an effective date."

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

3 * Section 1. LEGISLATIVE FINDINGS AND PURPOSE. (a) The legislature finds that a
4 substantial percentage of the population of the state lacks health insurance and that this lack of insurance
5 is detrimental to individual health, to the fiscal stability of families, businesses, and workers in the state,
6 and to the general public welfare. The legislature believes that the state must make adequate health care
7 available to all residents to meet the state's constitutional duty to promote and protect the public health.
8 The legislature also finds that illness often results in substantial expenditures for health care, and the use
9 of universal insurance for illness and injury has significant potential to reduce the growth of health care
10 costs incurred by the people and businesses of the state.

11 (b) The purpose of this Act is to provide affordable health insurance to the residents of the state.

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

13 CHAPTER 56. ALASKA HEALTH INSURANCE.

14 Sec. 21.56.010. PROCUREMENT OF HEALTH INSURANCE. (a) Under AS 36.30

1 (State Procurement Code), the director shall obtain a policy or policies of health insurance that
2 would cover state residents, subject to transfer of sufficient funds under AS 37.13.145 or
3 legislative appropriations.

4 (b) The insurance required by (a) of this section shall be obtained from an insurer
5 authorized to transact business in the state under AS 21.09 and AS 21.90 unless the director
6 determines that the state should act as a self-insurer as provided under (c) of this section. The
7 director shall provide specifications for the insurance coverage required by AS 21.56.030 to all
8 insurers licensed in this state and qualified to provide the insurance coverage.

9 (c) If the director determines that self-insurance is actuarially preferable to obtaining
10 insurance from a licensed insurer as provided under (b) of this section, the director may provide
11 the benefits required by this chapter as a self-insurer. If the director acts as a self-insurer, the
12 director may also obtain reinsurance.

13 (d) At least once every three years the director shall solicit new bids for the insurance
14 required by this section.

15 Sec. 21.56.020. HEALTH INSURANCE ACCOUNT. There is established as a separate
16 account within the general fund the health insurance account. The account consists of money
17 transferred to the account under AS 37.13.145 or appropriated to the account by the legislature.
18 The account shall be used to provide health insurance under AS 21.56.010.

19 Sec. 21.56.030. REQUIRED INSURANCE BENEFITS. Except as provided in
20 AS 21.56.040 - 21.56.060, the minimum standard benefits of a health insurance policy selected
21 under AS 21.56.010 are benefits with a lifetime maximum of \$1,000,000 per person for usual,
22 customary, reasonable, or prevailing charges or, when applicable, the allowance agreed upon
23 between the insurer and the director for charges for the following medical services performed for
24 a person covered by the policy for the diagnosis or treatment of disease or injury:

25 (1) hospital services;

26 (2) subject to the limitations of AS 21.36.090(d), professional services that are
27 rendered by a physician or by a health care professional at the physician's direction;

28 (3) the diagnosis or treatment of mental conditions;

29 (4) drugs requiring a physician's prescription;

30 (5) services of a skilled nursing facility;

31 (6) home health agency services up to a maximum of 270 visits in a calendar year

1 if the services begin within seven days after confinement in a hospital or skilled nursing facility
2 of at least three consecutive days for the same condition, except that in the case of a person
3 diagnosed by a physician as terminally ill with a prognosis of six months or less to live, the
4 home health agency services may begin irrespective of whether the covered person was previ-
5 ously confined or, if the covered person was confined, irrespective of the seven-day period;

6 (7) medical social services; however, the yearly benefit for medical social services
7 may not exceed \$2000;

8 (8) hospice services for up to six months in a calendar year;

9 (9) postnatal care for a newborn child of a covered person for a period of two
10 years;

11 (10) use of radium or other radioactive therapy or diagnostic device;

12 (11) outpatient chemotherapy;

13 (12) oxygen;

14 (13) anesthetics;

15 (14) nondental prosthesis and maxillo-facial prosthesis used to replace any
16 anatomic structure lost during treatment for head and neck tumors or additional appliances
17 essential for the support of the prosthesis;

18 (15) rental, or purchase if purchase is more cost effective than rental, of durable
19 medical equipment that has no personal use in the absence of the condition for which it was
20 prescribed;

21 (16) diagnostic x-rays and laboratory tests;

22 (17) oral surgery for excision of partially or completely unerupted impacted teeth
23 or excision of a tooth root without the extraction of the entire tooth;

24 (18) services of a licensed chiropractor, physical therapist, or massage therapist
25 rendered under the direction of a physician;

26 (19) transportation by a local nonprofit ambulance service operated by licensed
27 or certified personnel to the nearest health care institution for treatment of the illness or injury
28 and round trip transportation by air to the nearest health care institution for treatment of the
29 illness or injury if the treatment is not available locally; if the patient is a child under 12 years
30 of age, the transportation charges of a parent or legal guardian accompanying the child may be
31 paid;

1 (20) confinement in a licensed or certified facility established primarily for the
2 treatment of alcohol or drug abuse or in a part of a hospital used primarily for this treatment for
3 a period of at least 30 days within any calendar year;

4 (21) alternatives to inpatient services as defined by the director;

5 (22) second surgical opinions;

6 (23) other services that are medically necessary in the treatment or diagnosis of
7 an illness or injury as may be designated or approved by the director;

8 (24) an annual physical examination.

9 Sec. 21.56.040. CARE AND SERVICES NOT COVERED. Insurance obtained under
10 AS 21.56.010 may not provide benefits for charges for the following:

11 (1) care for an injury or disease to the extent benefits are payable without regard
12 to fault under a coverage statutorily required to be contained in a motor vehicle or other liability
13 insurance policy or equivalent self-insurance;

14 (2) treatment for cosmetic purposes other than surgery for the prompt repair of
15 an accidental injury sustained while covered or for replacement of an anatomic structure removed
16 during treatment of tumors;

17 (3) travel, other than transportation covered under AS 21.56.030(19);

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

20 (5) services or articles to the extent that the charge exceeds the reasonable charge
21 in the locality for the service;

22 (6) services or articles that are determined not to be medically necessary, except
23 for the fabrication or placement of the prosthesis as specified in AS 21.56.030(14) and (2) of this
24 section;

25 (7) services or articles that are not within the scope of the license or certificate
26 of the institution or individual rendering the services or articles;

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

29 (9) services or articles for custodial care or designed primarily to assist a person
30 in the activities of daily living;

31 (10) service charges that would not have been made if no insurance existed or that

- 1 the covered person is not legally obligated to pay;
- 2 (11) eyeglasses, contact lenses, or hearing aids or the fitting of them;
- 3 (12) dental care not specifically covered by this chapter;
- 4 (13) experimental procedures; and
- 5 (14) services and supplies for which the patient was not charged.

6 Sec. 21.56.050. MULTIPLE INSURANCE COVERAGE. If a person insured under this
7 chapter is entitled to coverage under more than one policy of insurance, payment from the policy
8 provided in this chapter shall be made after payment from the other applicable policy or
9 coverage.

10 Sec. 21.56.060. PREEXISTING CONDITIONS. Insurance obtained under AS 21.56.010
11 may not exclude coverage of a preexisting condition.

12 Sec. 21.56.070. DEDUCTIBLES. (a) The insurance obtained under AS 21.56.010 shall
13 require a deductible not exceeding \$1,000 for a single charge and a total deductible not exceeding
14 \$5,000 a person. The amount of the deductible may not be greater when a service is rendered
15 on an outpatient basis than when that service is rendered on an inpatient basis. Expenses
16 incurred during the last three months of a calendar year and actually applied to a person's
17 deductible for that year shall also be applied to that person's deductible in the following calendar
18 year.

19 (b) Covered expenses incurred after the deductible has been reached shall be paid at the
20 rate of 100 percent of usual, customary, reasonable, or prevailing charges.

21 Sec. 21.56.080. ELIGIBILITY FOR STATE HEALTH INSURANCE. (a) Except as
22 provided in (b) of this section, a person who is eligible for a permanent fund dividend under
23 AS 43.23.005 may enroll as an insured in a state health insurance policy by applying to

- 24 (1) the insurance carrier if the insurance is obtained under AS 21.56.010(a); or
- 25 (2) the director of the division of insurance if the insurance is obtained under
26 AS 21.56.010(c).

27 (b) Upon ceasing to be a resident, a person is not eligible for coverage under this chapter.
28 Additional eligibility requirements may not be imposed by the director or the insurance carrier.

29 (c) The insurer shall promptly forward to each enrolled person

- 30 (1) a notice of enrollment;
- 31 (2) policy coverage information; and

1 (3) an enrollment card.

2 Sec. 21.56.090. PAYMENT FOR INSURANCE. Unless the director acts as a self-
3 insurer, by March 1 of each year, the insurance carrier who provides coverage under this chapter
4 shall notify the director of the insurance premium amount due to provide coverage for each
5 insured for the next state fiscal year. By May 15 of each year, the director shall notify the
6 commissioner of revenue of the amount required to be transferred under AS 37.13.145 to provide
7 for payment of the premium or the amount required for self-insurance. Unless the director acts
8 as a self-insurer, by July 15 of each year, the director shall, subject to transfer of sufficient funds
9 under AS 37.13.145, pay the cost of the insurance premium from the health insurance account
10 under AS 21.56.020.

11 Sec. 21.56.100. SOLICITATION OF ELIGIBLE PERSONS. The director shall
12 disseminate appropriate information to the residents of the state regarding the existence of state
13 health insurance and the means of enrollment. Means of communication may include use of the
14 press, radio, and television, as well as publication in appropriate state offices and publications,
15 including the application for a permanent fund dividend.

16 Sec. 21.56.110. PREVENTIVE HEALTH AND EDUCATION PROGRAM. The director
17 shall, after consulting with the Department of Health and Social Services, develop a program of
18 preventive health care and health education for enrollees.

19 Sec. 21.56.120. STATE NOT LIABLE. Except when the state acts as a self-insurer, the
20 state is not liable for acts or omissions of the insurer under this chapter, nor is the state liable
21 for payment of a claim made to an insurance carrier under this chapter.

22 Sec. 21.56.900. DEFINITIONS. In this chapter,

23 (1) "deductible" means the portion of eligible expenses for which the insured is
24 responsible in each calendar year under AS 21.56.060;

25 (2) "health insurance" means a major medical insurance contract, or a subscriber
26 contract, that provides benefits for hospital and medical care with potential lifetime maximum
27 benefits per insured of at least \$1,000,000;

28 (3) "home health agency services" means any of the following services provided
29 upon recommendation of a licensed physician as part of a treatment plan:

30 (A) intermittent or part-time nursing services of a registered professional
31 nurse, a licensed practical nurse, or a home health aide that are provided to a person

1 under the continued direction of the person's physician and within the limitation of the
2 nurse's license;

3 (B) nursing services that are provided to a person at the person's
4 residence, including a residential care facility or adult boarding home; a hospital, skilled
5 nursing facility, or intermediate care facility is not considered a residence;

6 (C) home health aide services that are prescribed by and under the
7 continued direction of a physician and supervised by a professional nurse;

8 (D) home health aide services that are provided to a person at the person's
9 residence, as described in (B) of this paragraph;

10 (E) physical and occupational therapy services, speech pathology, and
11 audiology services that are prescribed by a physician and provided to a person by or
12 under the supervision of a qualified practitioner; these services may be provided to a
13 person who is a patient in an intermediate care facility or skilled nursing facility;

14 (4) "hospice services" means services provided under a coordinated comprehensive
15 program of palliative and supportive care on a 24-hour, seven days per week basis for persons
16 who have been diagnosed as terminally ill and their families by an interdisciplinary team of
17 professionals or volunteers under an incorporated central administration that has a physician as
18 medical director;

19 (5) "medical social services" means services rendered the patient under the
20 direction of a physician by a qualified social worker holding a master's degree from an accredited
21 school of social work, including assessment of the social, psychological, and family problems
22 related to or arising out of the covered person's illness and treatment, appropriate action and
23 utilization of community resources to assist in resolving the problems, and participation in the
24 development of treatment for the covered person;

25 (6) "self-insurance" means a contract between the state and a resident whereby
26 the state undertakes to provide health insurance directly to the resident and not through an insurer
27 licensed under AS 21.09 and AS 21.90;

28 (7) "usual, customary, reasonable, or prevailing charge" means the charge for a
29 medical care procedure, service, or supply item that is the lowest of the following amounts:

30 (A) the billed amount for the medical service provider's actual charge;

31 (B) the charge usually made by that provider for performing that procedure

1 or service or for providing the supply item; or

2 (C) the customary charge, based on a profile of charges made for the same
3 medical procedure, service, or supply item in the same geographical area by other
4 providers that have performed the same procedure or service or can provide the same
5 supply item.

6 * Sec. 3. AS 36.30.850(b)(11) is amended to read:

7 (11) agreements with providers of services under AS 44.47.250; AS 47.07;
8 [AS 47.08;] AS 47.10; AS 47.17; AS 47.24; AS 47.25.195, and 47.25.310;

9 * Sec. 4. AS 37.13.145 is amended to read:

10 Sec. 37.13.145. DISPOSITION OF INCOME. At the end of each fiscal year, income
11 of the corporation shall be distributed as follows: (1) an amount sufficient to offset the effect
12 of inflation on principal of the Alaska permanent fund during that year, as measured by the
13 change in the calendar year average United States consumer price index for all urban consumers
14 shall be transferred from net income as defined in AS 37.13.140, excluding income on the
15 earnings reserve account in the Alaska permanent fund, to the principal of the Alaska permanent
16 fund for reinvestment; (2) an amount sufficient to provide health insurance under AS 21.56
17 shall be transferred to the health insurance account under AS 21.56.020. The balance of the
18 income available for distribution under AS 37.13.140 shall be transferred to the earnings reserve
19 account in the Alaska permanent fund. Money in the earnings reserve account shall be invested
20 in investments authorized under AS 37.13.120. Income from the investment of the earnings
21 reserve account shall be treated as an addition to that account.

22 * Sec. 5. AS 43.23.055 is amended by adding a new paragraph to read:

23 (8) annually provide to the director of the division of insurance the identity of
24 individuals who are eligible for a permanent fund dividend under AS 43.23.005.

25 * Sec. 6. The insurance required to be obtained under AS 21.56.010, as enacted by sec. 2 of this Act,
26 shall be made available to residents of the state by January 1, 1993.

27 * Sec. 7. AS 47.08 is repealed.

28 * Sec. 8. This Act takes effect immediately under AS 01.10.070(c).