SENATE BILL NO. 74

IN THE LEGISLATURE OF THE STATE OF ALASKA

SEVENTEENTH LEGISLATURE - FIRST SESSION

BY SENATOR KERTTULA

Introduced: 1/22/91
Referred: L&C and Finance

A BILL

FOR AN ACT ENTITLED

"An Act relating to pooled health insurance for individuals who are uninsured or denied adequate coverage; and providing for an effective date."

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

*** Section 1.** PURPOSE. It is the purpose of this Act to provide access to health insurance to all residents of the state who are presently denied adequate health insurance or who are considered uninsurable.

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

CHAPTER 55. STATE HEALTH INSURANCE.

ARTICLE 1. COMPREHENSIVE HEALTH INSURANCE ASSOCIATION.

Sec. 21.55.010. CREATION; MEMBERSHIP. There is established a nonprofit incorporated legal entity to be known as the Comprehensive Health Insurance Association. Membership consists of all licensed hospital or medical service corporations in the state that offer subscriber contracts for major medical coverage and all insurers licensed to transact health insurance in the state that offer policies for major medical coverage on an expense incurred basis.

All members shall maintain membership in the association as a condition of doing health insurance business, or being able to offer subscriber contracts, in the state.

Sec. 21.55.020. BOARD OF DIRECTORS; ORGANIZATION. The board of directors of the association shall be made up of seven individuals selected by participating members, subject to approval by the director of the division of insurance. The director or the director's designee shall serve as a nonvoting ex officio member of the board. In determining voting rights at members' meetings, a member is entitled to vote in person or proxy. The vote shall be a weighted vote based upon the member's premiums for health insurance for major medical coverage on an expense incurred basis, or the member's subscriber fees, derived from or on behalf of state residents in the previous calendar year, as determined by the director. In approving members of the board, the director shall consider, among other things, whether all types of participating members are fairly represented. Members of the board other than the director or the director's designee may be reimbursed from the association for expenses incurred by them as members, but may not otherwise be compensated by the association for their services. The costs of conducting meetings of the association and its board of directors shall be borne by members of the association.

Sec. 21.55.030. GENERAL POWERS. The association may

(1) exercise the powers granted to insurers under the laws of the state;

(2) sue or be sued;

(3) enter into contracts with insurers, similar associations in other states, or with other persons for the performance of administrative functions;

(4) establish administrative and accounting procedures for the operation of the association.

Sec. 21.55.040. PLAN OF OPERATION. (a) The association shall submit to the director a plan of operation and amendments necessary or suitable to assure the fair, reasonable, and equitable administration of the association. The plan of operation and amendments become effective upon approval in writing by the director. If the association fails to submit a suitable plan of operation by a date that is 180 days after the effective date of this Act, or if at subsequent time the association fails to submit suitable amendments to the plan, the director may, after notice and hearing, adopt reasonable regulations necessary or advisable to effectuate the provisions of this chapter. These regulations shall continue in force until modified by the director or

superseded by a plan submitted by the association and approved by the director.

(b) All members of the association shall comply with the plan of operation.

(c) The plan of operation shall

(1) establish procedures whereby all the powers and duties of the association under this chapter will be performed;

(2) establish procedures for handling assets of the association;

(3) establish the amount and method of reimbursing members of the board of directors under AS 21.55.020;

(4) establish regular places and times for meetings of the board of directors;

(5) establish procedures for records to be kept of all financial transactions of the association, its agents, and the board of directors;

(6) provide that a member insurer aggrieved by a final action or decision of the association may appeal to the director within 30 days after the action or decision;

(7) establish procedures whereby selections for the board of directors will be submitted to the director;

(8) contain additional provisions necessary or proper for the execution of the powers and duties of the association.

Sec. 21.55.050. ADMINISTRATIVE PROCEDURE ACT. The association is exempt from the Administrative Procedure Act (AS 44.62).

Sec. 21.55.060. TAX EXEMPTION. The association is exempt from the payment of fees and taxes levied by the state or any of its political subdivisions except taxes levied on real or personal property.

ARTICLE 2. STATE HEALTH INSURANCE PLANS.

Sec. 21.55.100. TYPES OF INSURANCE PLANS. (a) The association shall make available to residents who are high risks an individual state plan of health insurance. The association shall offer three alternatives related to deductibles as described in AS 21.55.120.

(b) The association shall make available to residents who are high risks and 65 years of age or older a Medicare supplement plan that meets the minimum policy standards and minimum benefit standards established by regulations adopted by the director under AS 21.89.060.

(c) The association may not deny coverage under a state plan to a resident who satisfies the requirements of AS 21.55.300 - 21.55.310. The association shall determine whether a person

is a high risk in accordance with AS 21.55.500(9) and the director's regulations.

Sec. 21.55.110. MINIMUM BENEFITS OF STATE HEALTH INSURANCE PLAN. Except as provided in AS 21.55.120 - 21.55.140, the minimum standard benefits of a health insurance plan offered under AS 21.55.100(a) shall be benefits with a lifetime maximum of $1,000,000 per individual for usual, customary, reasonable, or prevailing charges or, when applicable, the allowance agreed upon between a provider and the writing carrier for charges, for the following medical services performed for an individual covered by the plan for the diagnosis or treatment of nonoccupational disease or nonoccupational injury:

(1) hospital services;

(2) subject to the limitations of AS 21.36.090(d), professional services that are rendered by a physician or by a registered nurse at the physician's direction, other than services for mental or dental conditions;

(3) the diagnosis or treatment of mental conditions, as defined in regulations of the director, rendered during the year on other than an inpatient basis, up to a yearly maximum benefit of $4,000;

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

(5) services of a skilled nursing facility for not more than 120 days in a policy year;

(6) home health agency services up to a maximum of 270 visits in a calendar year if the services commence within seven days following confinement in a hospital or skilled nursing facility of at least three consecutive days for the same condition, except that in the case of an individual diagnosed by a physician as terminally ill with a prognosis of six months or less to live, the home health agency services may commence irrespective of whether the covered person was previously confined or, if the covered person was confined, irrespective of the seven-day period, and the yearly benefit for medical social services may not exceed $200;

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

(8) use of radium or other radioactive materials;

(9) outpatient chemotherapy;

(10) oxygen;

(11) anesthetics;

(12) nondental prosthesis and maxillo-facial prosthesis used to replace any

anatomic structure lost during treatment for head and neck tumors or additional appliances essential for the support of the prosthesis;

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

(14) diagnostic x-rays and laboratory tests;

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

(16) services of a licensed physical therapist rendered under the direction of a physician;

(17) transportation by a local ambulance operated by licensed or certified personnel to the nearest health care institution for treatment of the illness or injury and round trip transportation by air to the nearest health care institution for treatment of the illness or injury if the treatment is not available locally; if the patient is a child under 12 years of age, the transportation charges of a parent or legal guardian accompanying the child may be paid if the attending physician certifies the need for the accompaniment;

(18) confinement in a licensed or certified facility established primarily for the treatment of alcohol or drug abuse or in a part of a hospital used primarily for this treatment, for a period of at least 45 days within any calendar year;

(19) alternatives to inpatient services as defined by the association in the state plan benefits;

(20) second surgical opinions;

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

Sec. 21.55.120. DEDUCTIBLES AND COPAYMENTS. (a) A state plan other than a Medicare supplement plan may require deductibles of $200 a person, $500 a person, or $1,000 a person. The amount of the deductible may not be greater when a service is rendered on an outpatient basis than when that service is offered on an inpatient basis. Expenses incurred during the last three months of a calendar year and actually applied to an individual's deductible for that year shall also be applied to that individual's deductible in the following calendar year. The $200 maximum, the $500 maximum, and the $1,000 maximum may be adjusted yearly to corre-

spond with the change in the medical care component of the Consumer Price Index, as adjusted by the director. The base year for the computation shall be the first full calendar year of operation of the association.

(b) A state plan other than a Medicare supplement plan shall require a maximum copayment of 20 percent for charges for all types of health care in excess of the deductible and 50 percent for services described in AS 21.55.110(3) in excess of the deductible.

(c) The sum of the deductible and copayments required in any calendar year under a plan may not exceed a maximum limit of $2,000 per covered individual. Covered expenses incurred after the applicable maximum limit has been reached shall be paid at the rate of 100 percent of usual, customary, reasonable, or prevailing charges, except that expenses incurred for treatment of mental and nervous conditions shall be paid at the rate of 50 percent. The $2,000 maximum shall be adjusted yearly to correspond with the change in the medical care component of the Consumer Price Index as adjusted by the director.

(d) In this section, "Consumer Price Index" means the Consumer Price Index for all urban consumers for the Anchorage Metropolitan Area compiled by the Bureau of Labor Statistics, United States Department of Labor.

Sec. 21.55.130. PREEXISTING CONDITIONS. (a) A preexisting condition exclusion in a state plan may not exclude coverage of a preexisting condition unless

(1) the condition first manifested itself within the period of three months immediately before the effective date of coverage in a manner that would cause a reasonably prudent person to seek diagnosis, care, or treatment; or

(2) medical advice or treatment was recommended or received within the period of three months immediately before the effective date of coverage.

(b) A policy may not exclude coverage for a loss due to preexisting conditions for a period greater than six months following the effective date of coverage.

(c) A state plan issued to a person whose previous subscriber contract, health policy, or Medicare supplement policy was involuntarily terminated shall credit the time covered under the previous contract or policy toward an exclusion for preexisting conditions under the state plan if the previous contract or policy had a similar preexisting condition exclusion and the person applies for a state plan within 31 days after termination of the previous contract or policy. If a person covered by this subsection is accepted by the writing carrier and pays a specified premium

for retroactive coverage, the state plan is effective retroactively to the date that the person's previous contract or policy terminated.

Sec. 21.55.140. CARE AND SERVICES NOT COVERED. A state plan may not provide benefits for charges for the following:

(1) care for an injury or disease either

(A) arising out of and in the course of an employment subject to a workers' compensation or similar law or where the benefit is required to be provided under a workers' compensation policy to a sole proprietor, business partner, or corporation officer; or

(B) to the extent benefits are payable without regard to fault under a coverage statutorily required to be contained in a motor vehicle or other liability insurance policy or equivalent self-insurance;

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

(3) travel, other than transportation covered under AS 21.55.110(17);

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

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

(6) services or articles that are determined not to be medically necessary, except for the fabrication or placement of the prosthesis as specified in AS 21.55.110(12) and (2) of this section;

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

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

(9) services or articles for custodial care or designed primarily to assist an individual in the activities of daily living;

(10) service charges that would not have been made if no insurance existed or that the covered individual is not legally obligated to pay;

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

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

(13) services of a registered nurse who ordinarily resides in the covered individual's home, or who is a member of the covered individual's family or the family of the covered individual's spouse;

(14) experimental procedures; and

(15) services and supplies for which the patient was not charged.

Sec. 21.55.150. STATE PLAN PREMIUMS. (a) The association may not charge a rate for coverage issued by or through the association that is excessive, inadequate, or unfairly discriminatory.

(b) The association shall use separate scales of premium rates based on age and geographic location of the insured.

(c) The five members of the association that insure, or have subscriber contracts with, the largest number of individuals in the state under plans with benefits substantially equivalent to the state plan benefits shall submit to the association an estimate of the rate that would be actuarially sound for a person who is a standard risk for coverage substantially equivalent to the state plan. The premium for a state plan may not exceed 125 percent of the average of those five estimates.

ARTICLE 3. ADMINISTRATION OF PLANS.

Sec. 21.55.200. SELECTION OF WRITING CARRIERS. The association shall develop bid specifications for members that wish to be selected as a writing carrier to administer a state plan. The selection of the writing carrier shall be based upon criteria including the member's proven ability to handle a large number of health insurance cases or subscriber contracts, efficient claim paying capacity, and the estimate of total charges for administering the plan.

Sec. 21.55.210. DUTIES OF WRITING CARRIERS. (a) The writing carrier shall perform the administrative and claims payment functions required by this section. The writing carrier shall provide these services for a period of three years, unless a request to terminate is approved by the director. The director shall approve or deny a request to terminate within 90 days of its receipt. A failure to make a final decision on a request to terminate within the specified period shall be considered an approval. Six months before the expiration of each three-year period, the association shall invite submissions of policy forms from members of the

association, including the writing carrier. The association shall follow the provisions of AS 21.55.210 in selecting a writing carrier for the subsequent three-year period.

(b) The writing carrier shall provide to all eligible persons enrolled in a state plan an individual policy or certificate, setting out a statement of the insurance protection to which the person is entitled, with whom claims are to be filed, and to whom benefits are payable. The policy or certificate must indicate that coverage was obtained through the association.

(c) The writing carrier shall submit to the association and the director on a quarterly basis a report on the operation of the state plans. Specific information to be contained in the report shall be determined by the association.

(d) Claims shall be paid by the writing carrier and shall indicate that the claim was paid under a state plan. A claim payment shall include a telephone number that can be used for inquiries regarding the claim.

(e) The writing carrier shall be reimbursed from the state plan premiums received for its direct and indirect expenses for administering the plan. Direct and indirect expenses shall include a pro rata reimbursement for that portion of the writing carrier's administrative, printing, claims administration, management and building overhead expenses that are assignable to the maintenance and administration of the state plans. The association shall approve cost accounting methods to substantiate the writing carrier's cost reports consistent with generally accepted accounting principles. Direct and indirect expenses may not include costs directly related to the original submission of policy forms before selection as the writing carrier.

(f) The writing carrier shall at all times when carrying out its duties under this chapter be considered an agent of the association.

Sec. 21.55.220. OPERATION OF THE PLAN. (a) Upon notification of eligibility under AS 21.55.320, a person may enroll in a state plan by payment of the appropriate state plan premium to the writing carrier.

(b) An employer that has in its employ one or more eligible persons enrolled in a state plan may make all or a portion of a state plan premium payment directly to the writing carrier.

(c) Each member of the association shall share the losses due to claims expenses of the state plans issued or approved for issuance by the association, and shall share in the operating and administrative expenses incurred or estimated to be incurred by the association incident to the conduct of its affairs. Claims expenses of the state plan that exceed the premium payments

allocated to the payment of benefits shall be the liability of the members. Each member shall share in the claims expense of the state plans and operating and administrative expenses of the association in an amount equal to the ratio of the member's total fees for subscriber contracts or total health insurance premiums, received from or on behalf of state residents, as divided by the total subscriber fees and health insurance premiums received by all members from or on behalf of state residents, as determined by the director.

(d) The association shall make an annual determination of each member's liability, if any, and may make an annual fiscal year end assessment if necessary. The association may also, subject to the approval of the director, provide for interim assessments against the members as may be necessary to assure the financial capability of the association in meeting the incurred or estimated claims expenses of the state plans and operating and administrative expenses of the association until the association's next annual fiscal year end assessment. Payment of an assessment is due within 30 days of receipt by a member of written notice of a fiscal year end or interim assessment. Failure by a member to tender to the association the assessment within 30 days shall be grounds for revocation of a member's certificate of authority. A member that ceases to do health insurance business in the state, or ceases to offer subscriber contracts in the state, due to revocation, suspension, or voluntary surrender of its certificate of authority remains liable for assessments through the calendar year that the health insurance business ceased. The association may decline to levy an assessment against a member if the assessment would not exceed $10. Assessments paid by a member are a general expense of the member.

(e) Net gains, if any, from the operation of the state plans shall be held at interest and used by the association to offset future losses due to claims expenses of a state plan or allocated to reduce state plan premiums.

ARTICLE 4. ENROLLMENT IN THE STATE HEALTH INSURANCE PLAN.

Sec. 21.55.300. ELIGIBILITY FOR STATE HEALTH INSURANCE. (a) Except as provided in (b) of this section, a state resident who is a high risk is eligible to enroll in a state plan described in AS 21.55.100.

(b) A person may not be covered by the state plan while covered by another health insurance policy or subscriber contract. Upon ceasing to be a resident a person is not eligible to purchase or renew coverage under a state plan, but previously purchased coverage remains in effect for the period covered by payments made while a resident.

(c) Additional eligibility requirements may not be imposed by the director, the association, or a writing carrier.

Sec. 21.55.310. ENROLLMENT BY AN ELIGIBLE PERSON. A person may enroll in a state plan by applying to the writing carrier. The application must include the following:

(1) name, address, age, and length of residency of the applicant;

(2) a designation of the plan desired, including deductible option chosen;

(3) information relevant to whether the person is a high risk.

Sec. 21.55.320. WRITING CARRIER'S RESPONSE. Within 30 days after receiving the certificate described in AS 21.55.310, the writing carrier shall either reject the application for failing to comply with the requirements of AS 21.55.300 and 21.55.310 or forward the eligible person a notice of acceptance and billing information.

Sec. 21.55.330. EFFECTIVE DATE OF POLICIES. (a) Except as provided in (b) of this section and AS 21.55.130(c), insurance under a state plan is effective immediately upon receipt of the first quarterly premium, and is retroactive to the date of the application, if the applicant otherwise complies with the requirements of this chapter.

(b) Insurance under a state plan is effective retroactively to the date that the person's previous contract or policy terminated if the person

(1) applies for a state plan within 60 days after the previous contract or policy terminated;

(2) is accepted by the writing carrier; and

(3) pays a specified premium for the period of retroactive coverage.

Sec. 21.55.340. SOLICITATION OF ELIGIBLE PERSONS. (a) The association, under a plan approved by the director, shall disseminate appropriate information to the residents of the state regarding the existence of the state plans and the means of enrollment. Means of communication may include use of the press, radio, and television, as well as publication in appropriate state offices and publications.

(b) The association shall devise and implement means of maintaining public awareness of the provisions of this chapter regarding the state plans and shall administer this chapter in a manner that facilitates public participation in the state plans.

(c) Selling or marketing of qualified state plans is limited to licensed health insurance agents.

(d) An insurer or hospital or medical service corporation that rejects or applies underwriting restrictions to an applicant for a subscriber contract, a health insurance policy, or a Medicare supplement plan in the state shall notify the applicant of the existence of the state plans, the requirements for being accepted, and the procedure for applying.

ARTICLE 5. GENERAL PROVISIONS.

Sec. 21.55.400. DUTIES OF DIRECTOR. The director may

(1) approve the selection of the writing carrier by the association and approve the association's contract with the writing carrier including the coverages and premiums to be charged;

(2) contract with the federal government or another unit of government to ensure coordination of the state plans with other governmental assistance programs;

(3) undertake directly or through contracts with other persons studies or demonstration programs to develop awareness of the benefits of this chapter; and

(4) adopt regulations necessary to administer this chapter.

Sec. 21.55.410. STATE NOT LIABLE. The state is not liable for acts or omissions of the association or a writing carrier under this chapter, nor is the state liable for payment of a claim under a state plan issued by a writing carrier.

Sec. 21.55.500. DEFINITIONS. In this chapter

(1) "association" means the Comprehensive Health Insurance Association created in AS 21.55.010;

(2) "copayment" means the portion of the eligible expenses, in excess of the deductible, for which the insured is responsible;

(3) "deductible" means the portion of eligible expenses for which the insured is responsible in each calendar year under AS 21.55.120(a);

(4) "health insurance" means an individual or group contract or other plan providing coverage of health care services that is issued by a health insurance company, a hospital service corporation, a medical service corporation, or a health maintenance organization; "health insurance" includes disability insurance under AS 21.12.050;

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

(A) intermittent or part-time nursing services of a registered professional

nurse or a licensed practical nurse, that are provided to a person under the continued direction of the person's physician and within the limitation of the nurse's license;

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

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

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

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

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

(7) "major medical coverage" means a health insurance contract, or a subscriber contract, that provides benefits for hospital and medical care with potential lifetime maximum benefits per insured of at least $10,000;

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

(9) "resident" means a person who is physically present in the state, has lived in the state for at least the six consecutive months immediately preceding application for a state plan, and intends to remain permanently in the state; "resident" also includes a person who is not physically present in the state if the person lived in the state for at least six of the nine months

immediately preceding application for a state plan and the person's absence from the state is for medical treatment or education; a person ceases to be a resident if the person is absent from the state for more than 90 consecutive days for reasons other than for medical treatment or education;

(10) "residents who are high risks" means residents who

(A) have been rejected for medical reasons after applying for a subscriber contract, a policy of health insurance, or a Medicare supplement policy by at least two association members within the six months immediately preceding the date of application for a state plan; or

(B) have had a restrictive rider placed on a subscriber contract, a health insurance policy, or a Medicare supplement policy;

(11) "state plan" means a policy of insurance offered by the association through a writing carrier;

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

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

(B) the charge usually made by that provider for performing that procedure or service or for providing the supply item; or

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

(13) "writing carrier" means the insurer or insurers selected by the association and approved by the director to administer a state plan.

*** Sec. 3.** The association established by sec. 2 of this Act shall make available to residents the plans required by AS 21.55.100, enacted in sec. 2 of this Act, by January 1, 1992.

*** Sec. 4.** This Act takes effect immediately under AS 01.10.070(c).