

**SENATE CS FOR CS FOR HOUSE BILL NO. 538(HES)****IN THE LEGISLATURE OF THE STATE OF ALASKA****EIGHTEENTH LEGISLATURE - SECOND SESSION****BY THE SENATE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE****Offered: 5/5/94**  
**Referred: Labor and Commerce****Sponsor(s): HOUSE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE****A BILL****FOR AN ACT ENTITLED**

1 "An Act relating to uniform claims forms, uniform standards, and uniform  
2 procedures for processing data relating to billing and payment of health care  
3 services; relating to the Comprehensive Health Insurance Association and to health  
4 insurance provided to residents of the state who are high risks; and providing  
5 for an effective date."

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

7 \* Section 1. AS 21.06 is amended by adding a new section to read:

8           **Sec. 21.06.085. UNIFORM DATA AND PROCEDURES FOR HEALTH**  
9           **CLAIMS. (a) The director shall adopt by regulation uniform claims forms, uniform**  
10           **standards, and uniform procedures for the processing of data relating to billing for and**  
11           **payment of health care services provided to state residents. A health insurer shall use**  
12           **the uniform claims forms and comply with the uniform standards and procedures**  
13           **established under this section.**

1 (b) In this section,

2 (1) "health care services" has the meaning given in AS 21.86.900;

3 (2) "health insurance" has the meaning given "disability insurance" in  
4 AS 21.12.050;

5 (3) "health insurer" means an insurer transacting the business of health  
6 insurance, a health maintenance organization under AS 21.86, a hospital service  
7 corporation under AS 21.87, a medical service corporation under AS 21.87, or a  
8 combined medical service and hospital service corporation under AS 21.87.

9 \* Sec. 2. AS 21.55.010 is amended to read:

10 Sec. 21.55.010. CREATION; MEMBERSHIP. There is established a nonprofit  
11 incorporated legal entity to be known as the Comprehensive Health Insurance  
12 Association. Membership consists of all licensed hospital or medical service  
13 corporations in the state that offer subscriber contracts for major medical coverage, all  
14 health maintenance organizations or other managed care arrangements approved  
15 by the director, and all insurers licensed to transact health insurance in the state that  
16 offer policies for major medical coverage on an expense incurred basis. All members  
17 shall maintain membership in the association as a condition of doing health insurance  
18 business, or being able to offer subscriber contracts or enrollment in a health  
19 maintenance organization or managed care arrangement, in the state.

20 \* Sec. 3. AS 21.55.100 is amended by adding a new subsection to read:

21 (d) The association may make available to residents who are high risks  
22 coverage through a health maintenance organization or other managed care  
23 arrangement as approved by the director.

24 \* Sec. 4. AS 21.55.120(c) is amended to read:

25 (c) Except as provided in (e) of this section, the [THE] sum of the  
26 deductible and copayments required in any calendar year under a plan may not exceed  
27 a maximum limit of \$2,000 per covered individual. Covered expenses incurred after  
28 the applicable maximum limit has been reached shall be paid at the rate of 100 percent  
29 of usual, customary, reasonable, or prevailing charges, except that expenses incurred  
30 for treatment of mental and nervous conditions shall be paid at the rate of 50 percent.  
31 The \$2,000 maximum shall be adjusted yearly to correspond with the change in the

1        medical care component of the Consumer Price Index as adjusted by the director.

2        \* **Sec. 5.** AS 21.55.120 is amended by adding a new subsection to read:

3                (e) In addition to the deductible, copayment, and applicable maximums  
4                described in this section, other deductible, copayment, or maximum limits may be  
5                offered if approved by the director.

6        \* **Sec. 6.** AS 21.55.150(b) is amended to read:

7                (b) The association shall use separate scales of premium rates based on age  
8                and geographic location of the insured. The association may use separate scales of  
9                premium rates based on other factors, including use or nonuse of tobacco, if  
10                approved by the director.

11        \* **Sec. 7.** AS 21.55.300 is repealed and reenacted to read:

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

15                (b) A person may not be covered by the state plan

16                        (1) while covered by another health insurance policy or subscriber  
17                        contract; or

18                        (2) if the person is eligible to be covered by a plan subject to the  
19                        requirements of AS 21.56.110 - 21.56.250.

20                (c) Upon ceasing to be a resident, a person is not eligible to purchase or renew  
21                coverage under a state plan, but previously purchased coverage remains in effect for  
22                the period covered by payments made while a resident.

23                (d) Additional eligibility requirements for enrollment in a state plan may be  
24                imposed if approved by the director.

25        \* **Sec. 8.** AS 21.55.310 is amended to read:

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

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

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

1 (3) information relevant to whether the person is a high risk; and  
2 (4) payment of the first premium.

3 \* Sec. 9. AS 21.55.320 is amended to read:

4 Sec. 21.55.320. WRITING CARRIER'S RESPONSE. Within 30 days after  
5 receiving the certificate described in AS 21.55.310, the writing carrier shall either  
6 reject the application for failing to comply with the requirements of AS 21.55.300 and  
7 21.55.310 or forward the eligible person a notice of acceptance [AND BILLING  
8 INFORMATION].

9 \* Sec. 10. AS 21.55.400 is amended to read:

10 Sec. 21.55.400. DUTIES OF DIRECTOR. The director may

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

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

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

18 (4) formulate general policy, adopt regulations that are reasonably  
19 necessary to administer this chapter.

20 \* Sec. 11. AS 21.55 is amended by adding a new section to read:

21 Sec. 21.55.420. BOARD MEMBER CIVIL AND CRIMINAL IMMUNITY.

22 A member of the board of directors of the association may not be held civilly or  
23 criminally liable for an act or omission if the act or omission was in good faith and  
24 within the scope of the director's duties under this chapter.

25 \* Sec. 12. AS 21.55.500(10) is amended to read:

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

27 (A) have been rejected for medical reasons after applying for  
28 a subscriber contract, a policy of health insurance, or a Medicare supplement  
29 policy by at least two association members within the six months immediately  
30 preceding the date of application for a state plan; medical reasons may include  
31 preexisting medical conditions, a family history that predicts future medical

1 conditions, or an occupation that generates a frequency or severity of injury or  
2 disease that results in coverage not being generally available; [OR]

3 (B) have had a restrictive rider placed on a subscriber contract,  
4 a health insurance policy, or a Medicare supplement policy that substantially  
5 reduces coverage; or

6 (C) meet other requirements adopted by regulation by the  
7 director that are consistent with this chapter and that indicate that a  
8 person is unable to obtain coverage substantially similar to that which may  
9 be obtained by a person who is considered a standard risk;

10 \* Sec. 13. By July 1, 1995, the director of the division of insurance shall adopt regulations  
11 necessary to implement the uniform claim form required under AS 21.06.085, added by sec. 1  
12 of this Act.

13 \* Sec. 14. This Act takes effect July 1, 1994.