

SENATE BILL NO. 201

IN THE LEGISLATURE OF THE STATE OF ALASKA

EIGHTEENTH LEGISLATURE - FIRST SESSION

BY SENATOR KELLY

Introduced: 4/19/93
Referred: HES, L&C, FIN

A BILL

FOR AN ACT ENTITLED

1 "An Act relating to coordination of insurance benefits and to determination and
2 disclosure of fees paid to an insured or a health care provider; and providing
3 for an effective date."

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

5 * Section 1. FINDINGS. The legislature finds that the legitimate interests of the citizens
6 of the state are best served by the use of precise, accurate, standardized, and publicly
7 announced methodologies for determining payment of the usual, customary, and reasonable
8 fees for health care services and for coordinating benefits among multiple insurers.

9 * Sec. 2. AS 21.86.260(a) is amended to read:

10 (a) Except as provided in this chapter and AS 21.89.100 - 21.89.120, this title
11 does not apply to a health maintenance organization that obtains a certificate of
12 authority under this chapter. This subsection does not apply to an insurer licensed
13 under AS 21.09 or a hospital or medical service corporation licensed under AS 21.87
14 except with respect to its health maintenance organization activities authorized by and

1 regulated under this chapter.

2 * Sec. 3. AS 21.87.340 is amended to read:

3 Sec. 21.87.340. OTHER PROVISIONS APPLICABLE. In addition to the provisions
4 contained or referred to previously in this chapter, the following chapters and provisions of
5 this title also apply with respect to service corporations to the extent applicable and not in
6 conflict with the express provisions of this chapter and the reasonable implications of the
7 express provisions, and for the purposes of the application the corporations shall be considered
8 to be mutual "insurers":

- 9 (1) AS 21.03
- 10 (2) AS 21.06
- 11 (3) AS 21.09, except AS 21.09.090
- 12 (4) AS 21.18.010
- 13 (5) AS 21.18.030
- 14 (6) AS 21.18.040
- 15 (7) AS 21.18.120
- 16 (8) AS 21.21.321
- 17 (9) AS 21.36
- 18 (10) AS 21.42.345 - 21.42.365, 21.42.375, 21.42.380, and 21.42.385
- 19 (11) AS 21.51.120
- 20 (12) AS 21.53
- 21 (13) AS 21.54.020
- 22 (14) AS 21.69.400
- 23 (15) AS 21.69.520
- 24 (16) AS 21.69.600, 21.69.620, and 21.69.630
- 25 (17) AS 21.78
- 26 (18) AS 21.89.040
- 27 (19) AS 21.89.060 and 21.89.100 - 21.89.120
- 28 (20) AS 21.90.

29 * Sec. 4. AS 21.89 is amended by adding new sections to read:

30 Sec. 21.89.100. REQUIRED PROVISIONS REGARDING COORDINATION
31 OF BENEFITS. (a) When an insured has coverage under two or more plans that

1 provide for coordination of benefits, the coverage from those plans must be
2 coordinated so that the insured receives the maximum allowable benefit from each
3 plan. The aggregate benefit should be more than that offered by any of the plans
4 individually, but the insured may not receive more than the total of the charges for the
5 health care services received.

6 (b) A plan that provides for coordination of benefits must contain a provision
7 that

8 (1) discloses that coordination of benefits applies when the insured has
9 health care coverage under more than one plan;

10 (2) states what benefits from the plan and other sources are recognized
11 under the coordinating provision and that indicates if one or more plan benefits are
12 exempt from the coordinating provision;

13 (3) states what health care expenses are allowable and what health care
14 expenses are excluded under the coordinating provision;

15 (4) states the claim period to be used in applying the coordinating
16 benefits provision; a claim period may not be less than 12 months, but may exclude
17 a period before coverage starts or after coverage ends;

18 (5) indicates the manner in which benefits are reduced by coordination;
19 a reduction in benefits is subject to the following order of benefit provisions:

20 (A) plan benefits applicable to an insured as an employee,
21 member, or subscriber, and also as a dependent, are first determined as benefits
22 applicable to the insured as employee, member, or subscriber;

23 (B) if a minor is eligible for benefits as a dependent of more
24 than one insured, the plan of the insured whose date of birth falls earlier in the
25 year is applied first, unless a different order of application is required by a
26 court;

27 (C) benefits not determined under this paragraph that are
28 applicable under more than one plan are determined under that plan applicable
29 to the insured for the longer period of time;

30 (D) when one of the plans is a medical plan and the other is a
31 dental plan, and a determination cannot be made under the provisions of (A) -

1 (C) of this paragraph, the medical plan shall be considered as the primary
2 coverage;

3 (E) if under the provisions of (A) - (D) of this paragraph the
4 plan is secondary to another source of benefits, the benefits of the plan may not
5 be reduced unless the sum of benefits payable for allowable expenses and the
6 benefits payable for allowable expenses under the other source exceed the
7 allowable expenses in a claim determination period;

8 (6) provides that the insurer has the right to receive and to release
9 information necessary to expedite a claim payment when coordinating benefits;

10 (7) allows the insurer to make a payment necessary to repay another
11 insurer for a payment that should have been made under the policy applicable to the
12 insured; and

13 (8) gives the insurer the right to recover excess payments from the
14 insured paid to another insurer providing benefits to the insured.

15 (c) In coordinating benefits from a plan that contractually reduces the fees for
16 services that participating health care providers accept as payment in full, the following
17 rules apply:

18 (1) when the reduced fee plan is the primary coverage and treatment
19 is provided by a participating health care provider, the reduced fee is that health care
20 provider's full fee; a secondary plan shall pay the lesser of its allowed benefit or the
21 difference between the primary plan's benefit and the reduced fee;

22 (2) when the reduced fee plan is the primary coverage and treatment
23 is provided by a nonparticipating health care provider, the reduced fee plan shall
24 provide its allowed amount for nonparticipating health care providers and the
25 secondary plan shall pay the lesser of

26 (A) its allowed benefit for the service;

27 (B) the difference between the primary plan's benefits for the
28 service and the health care provider's full fee;

29 (3) when a full fee plan is the primary coverage and a reduced fee plan
30 is secondary coverage, the full fee plan shall provide its allowed amount for the
31 service and the secondary plan shall pay the lesser of its allowed benefit for the service

1 or the difference between the primary plan's benefits and the health care provider's full
2 fee.

3 (d) In coordinating benefits between an indemnity and a capitation plan, the
4 following rules apply:

5 (1) when the capitation plan is the primary coverage, the capitation
6 payments to the treating health care provider remain the capitation plan's usual
7 benefits; the indemnity plan shall pay benefits for the patient's surcharges or
8 copayments up to the indemnity plan's allowable benefit;

9 (2) when the indemnity plan is the primary coverage and treatment is
10 received from a health care provider who is participating in a capitation plan, the
11 indemnity plan shall pay its allowable benefits; the capitation payments to the health
12 care provider are secondary coverage;

13 (3) when the indemnity plan or policy is the primary coverage, and
14 treatment is received from a health care provider who is not participating in a
15 capitation plan, the indemnity plan shall pay its allowable benefits; the capitation plan
16 shall pay benefits, in keeping with the capitation plan's allowed amount for treatment
17 by nonparticipating health care providers;

18 (4) a plan may not contractually direct a health care provider to charge
19 a secondary insurer for more than the amount that would be charged to the insured
20 absent secondary coverage.

21 (e) A certificate indicating insurance coverage must contain a summary of the
22 provisions in this section regarding coordination of benefits.

23 Sec. 21.89.110. DETERMINATION AND DISCLOSURE OF USUAL,
24 CUSTOMARY, AND REASONABLE FEES. An insurer who pays a claim under a
25 disability policy or an indemnity under a group or blanket disability insurance policy,
26 a health maintenance organization that adopts a schedule of charges, or a hospital or
27 medical service corporation that pays a subscriber or compensates a health care
28 provider on the basis of a usual, customary, or reasonable fee or charge shall

29 (1) maintain and use a statistically credible profile of fees of health care
30 providers in this state on which to base payment of the claim; the profile must (A) be
31 updated at least once every six months and may not contain fees for services

1 performed more than one year before the date of the most recent profile; (B) contain
2 fees for the geographic area in which a claimant might receive treatment; and (C) may
3 not include fees clearly marked "DO NOT PROFILE"; if statistically credible data for
4 a particular health care service in a certain geographic area does not exist, the insurer
5 may include in the profile a sufficient number of fees for that service from another
6 geographic area in order to establish a reliable data base; however, the final basis for
7 payment must be adjusted to reflect the general cost difference between the geographic
8 area where the service was performed and the other geographic area used in
9 establishing the statistically credible profile; the adjustment may be based upon the
10 Consumer Price Index, the medical care component of the Consumer Price Index, or
11 a reasonable basis stated in writing and determined acceptable by the director;

12 (2) respond within 15 working days after receiving a written request
13 from an insured, a health care provider with a valid assignment of payments, or a
14 health care provider engaged to provide services under a professional services contract,
15 with a full written disclosure of the methods employed under (1) of this section that
16 resulted in the difference between the amount paid on a claim for benefits and the
17 actual charges submitted; and

18 (3) disclose in a proposal for insurance, a policy of insurance, a
19 certificate of insurance, an employee benefit description or supplemental document, or
20 a professional service contract between an insurer and a health care provider

21 (A) the frequency with which the insurer determines the usual,
22 customary, and reasonable fee;

23 (B) a general description of the methodology used to determine
24 the usual, customary, and reasonable fee;

25 (C) the percentile of usual, customary, and reasonable fees at
26 which the insurer will reimburse the insured, or the contract health care
27 provider.

28 Sec. 21.89.120. DEFINITIONS FOR AS 21.89.100 - 21.89.120. In
29 AS 21.89.100 - 21.89.120,

30 (1) "health care provider" means

31 (A) an acupuncturist licensed under AS 08.06;

- 1 (B) an audiologist licensed under AS 08.11;
2 (C) a chiropractor licensed under AS 08.20;
3 (D) a dental hygienist licensed under AS 08.32;
4 (E) a dentist licensed under AS 08.36;
5 (F) a nurse licensed under AS 08.68;
6 (G) a dispensing optician licensed under AS 08.71;
7 (H) an optometrist licensed under AS 08.72;
8 (I) a pharmacist licensed under AS 08.80;
9 (J) a physical therapist or occupational therapist licensed under
10 AS 08.84;
11 (K) a physician, podiatrist, or osteopath licensed under
12 AS 08.64;
13 (L) a psychologist and a psychological associate licensed under
14 AS 08.86;
15 (M) a hospital as defined in AS 18.20.130, including a
16 governmentally owned or operated hospital;
17 (N) an employee of a health care provider acting within the
18 course and scope of employment;
19 (2) "health care service" has the meaning given in AS 21.87.330;
20 (3) "plan" means a group or blanket disability policy issued under
21 AS 21.54, evidence of coverage issued under AS 21.86, or a subscriber contract issued
22 under AS 21.87;
23 (4) "professional services contract" includes a contract for professional
24 services between a health care provider and insurer or health maintenance corporation,
25 and a service contract between a health care provider and a hospital or medical service
26 corporation;
27 (5) "service corporation" has the meaning given in AS 21.87.330.

28 * Sec. 5. **APPLICABILITY.** This Act applies to a policy of insurance, evidence of
29 coverage under AS 21.86, or a service agreement or subscriber's contract under AS 21.87,
30 issued or renewed on or after the effective date of this Act.

31 * Sec. 6. This Act takes effect July 1, 1993.