

SENATE BILL NO. 313

IN THE LEGISLATURE OF THE STATE OF ALASKA

EIGHTEENTH LEGISLATURE - SECOND SESSION

BY SENATOR KERTTULA

Introduced: 2/14/94
Referred: HES, L&C, FIN

A BILL

FOR AN ACT ENTITLED

1 "An Act relating to the Comprehensive Health Insurance Association and to
2 health insurance provided to residents of the state who are high risks; and
3 providing for an effective date."

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

5 * Section 1. AS 21.55.010 is amended to read:

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

1 maintenance organization or managed care arrangement, in the state.

2 * Sec. 2. AS 21.55.100 is amended by adding a new subsection to read:

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

6 * Sec. 3. AS 21.55.120(c) is amended to read:

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

15 * Sec. 4. AS 21.55.120 is amended by adding a new subsection to read:

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

19 * Sec. 5. AS 21.55.150(b) is amended to read:

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

24 * Sec. 6. AS 21.55.300 is repealed and reenacted to read:

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

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

29 (1) while covered by another health insurance policy or subscriber
30 contract; or

31 (2) if the person is eligible to be covered by a plan subject to the

1 requirements of AS 21.56.110 - 21.56.250.

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

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

7 * Sec. 7. AS 21.55.310 is amended to read:

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

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

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

14 (3) information relevant to whether the person is a high risk; and

15 (4) payment of the first premium.

16 * Sec. 8. AS 21.55.320 is amended to read:

17 Sec. 21.55.320. WRITING CARRIER'S RESPONSE. Within 30 days after
18 receiving the certificate described in AS 21.55.310, the writing carrier shall either
19 reject the application for failing to comply with the requirements of AS 21.55.300 and
20 21.55.310 or forward the eligible person a notice of acceptance [AND BILLING
21 INFORMATION].

22 * Sec. 9. AS 21.55.400 is amended to read:

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

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

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

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

31 (4) formulate general policy, adopt regulations that are reasonably

1 necessary to administer this chapter.

2 * Sec. 10. AS 21.55 is amended by adding a new section to read:

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

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

7 * Sec. 11. AS 21.55.500(10) is amended to read:

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

9 (A) have been rejected for medical reasons after applying for
10 a subscriber contract, a policy of health insurance, or a Medicare supplement
11 policy by at least two association members within the six months immediately
12 preceding the date of application for a state plan; medical reasons may include
13 preexisting medical conditions, a family history that predicts future medical
14 conditions, or an occupation that generates a frequency or severity of injury or
15 disease that results in coverage not being generally available; [OR]

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

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

23 * Sec. 12. This Act takes effect July 1, 1994.