

**SENATE BILL NO. 313 am(efd fld)**  
**IN THE LEGISLATURE OF THE STATE OF ALASKA**  
**EIGHTEENTH LEGISLATURE - SECOND SESSION**

**BY SENATOR KERTTULA**

**Amended: 4/29/94**  
**Introduced: 2/14/94**

**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; relating  
3 to health insurance fees, charges, premiums, rates, and rating factors; relating to  
4 disclosure of health care provider prices, a health care data system, and uniform  
5 data and procedures for health care billing and payment of claims; relating to  
6 coordination of insurance benefits and to determination and disclosure of fees paid  
7 to an insured or health care provider; establishing an advisory committee on a  
8 health care plan and an advisory committee on public health."

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

10 \* Section 1. AS 21.51 is amended by adding a new section to read:

11                   Sec. 21.51.350. PREMIUM RATES AND RATING FACTORS. A disability  
12                   insurer

- 1 (1) shall file with the director rates or rating factors for disability  
2 insurance before the intended effective date of the rate or rating factor;  
3 (2) may not use a rate or rating factor that has not been filed with the  
4 director; and  
5 (3) may file a new rate or rating factor at any time."

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

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

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

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

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

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

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

31 (e) In addition to the deductible, copayment, and applicable maximums

1 described in this section, other deductible, copayment, or maximum limits may be  
2 offered if approved by the director.

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

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

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

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

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

13 (1) while covered by another health insurance policy or subscriber  
14 contract; or

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

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

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

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

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

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

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

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

30 (4) payment of the first premium.

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

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

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

7           Sec. 21.55.400. DUTIES OF DIRECTOR. The director may  
8           (1) approve the selection of the writing carrier by the association and  
9 approve the association's contract with the writing carrier, including the coverages and  
10 premiums to be charged;  
11           (2) contract with the federal government or another unit of government  
12 to ensure coordination of the state plans with other governmental assistance programs;  
13           (3) undertake directly or through contracts with other persons studies  
14 or demonstration programs to develop awareness of the benefits of this chapter; and  
15           (4) formulate general policy, adopt regulations that are reasonably  
16 necessary to administer this chapter.

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

18           Sec. 21.55.420. BOARD MEMBER CIVIL AND CRIMINAL IMMUNITY.  
19 A member of the board of directors of the association may not be held civilly or  
20 criminally liable for an act or omission if the act or omission was in good faith and  
21 within the scope of the director's duties under this chapter.

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

23           (10) "residents who are high risks" means residents who  
24           (A) have been rejected for medical reasons after applying for  
25 a subscriber contract, a policy of health insurance, or a Medicare supplement  
26 policy by at least two association members within the six months immediately  
27 preceding the date of application for a state plan; medical reasons may include  
28 preexisting medical conditions, a family history that predicts future medical  
29 conditions, or an occupation that generates a frequency or severity of injury or  
30 disease that results in coverage not being generally available; [OR]  
31           (B) have had a restrictive rider placed on a subscriber contract,

1 a health insurance policy, or a Medicare supplement policy that substantially  
2 reduces coverage; or

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

7 \* Sec. 13. AS 21 is amended by adding a new chapter to read:

8 CHAPTER 58. HEALTH CARE.

9 Sec. 21.58.010. REQUIRED AVAILABILITY OF PRICE LIST. A health care  
10 provider shall prepare a list of the provider's prices that includes the dates during  
11 which the prices will be applicable. The price list shall be made available either by  
12 posting the price list in a conspicuous location in the health care provider's office or  
13 by similarly posting a notice that the price list is available for review upon request.  
14 The contents of the price list required under this section must include the provider's  
15 40 most commonly provided health care services or those health care services provided  
16 more than five times in a calendar year, whichever would result in a shorter price list  
17 of health care services.

18 Sec. 21.58.020. HEALTH CARE DATA SYSTEM. (a) The Department of  
19 Commerce and Economic Development shall develop and may, subject to  
20 appropriation, periodically update a health care data system. To the extent practicable,  
21 the data system base year shall be calendar year 1995 and the system may include

22 (1) health care expenditures, including capital expenditures associated  
23 with receiving health care;

24 (2) demographic data;

25 (3) clinical information in a format that does not identify individual  
26 patients, including diagnosis, type of provider, type of service, location and length of  
27 care, referral patterns, quality of care, and result of care;

28 (4) billing and payment data in a format that does not identify  
29 individual patients; and

30 (5) public health data, including vital statistics and health status.

31 (b) The commissioner may request health care data necessary to develop or

1 update the data system required under (a) of this section from a health care provider  
2 or insurer. A health care provider or insurer who receives a request from the  
3 commissioner under this subsection may, but is not required to, comply with the  
4 request.

5 (c) Information and data obtained or produced by the director under this  
6 section, except as provided under (d) of this section, shall be kept confidential as a  
7 matter of law. A person who wrongfully discloses or who uses or permits the use of  
8 confidential information or data in violation of this subsection is guilty of a class B  
9 misdemeanor.

10 (d) Information or data regarding health care services

11 (1) may be disclosed in an aggregate form that does not identify an  
12 individual recipient or health care provider; and

13 (2) that identify an individual recipient may be disclosed to a health  
14 care provider, if the individual recipient has agreed to release the information or data.

15 Sec. 21.58.030. UNIFORM DATA AND PROCEDURES FOR HEALTH  
16 CLAIMS. (a) The director shall adopt by regulation uniform claims forms, uniform  
17 standards, and uniform procedures for the processing of data relating to billing for and  
18 payment of health care services provided to residents of the state. A health insurance  
19 company shall comply with the uniform claims forms, standards, and procedures  
20 established under this section.

21 (b) The director shall ensure that other regulations adopted by the director  
22 under this title that apply to a health insurer are not in conflict or inconsistent with  
23 regulations adopted under (a) of this section.

24 Sec. 21.58.040. APPROPRIATIONS. The legislature may appropriate a  
25 portion of the proceeds of the tax on insurance premiums collected under  
26 AS 21.09.210 to pay the administrative costs of this chapter.

27 Sec. 21.58.400. DEFINITIONS. In this chapter,

28 (1) "commissioner" means the commissioner of commerce and  
29 economic development;

30 (2) "health care provider" means an acupuncturist licensed under  
31 AS 08.06; an audiologist licensed under AS 08.11; a chiropractor licensed under

1 AS 08.20; a dental hygienist licensed under AS 08.32; a dentist licensed under  
2 AS 08.36; a marital or family therapist licensed under AS 08.63; a direct-entry  
3 midwife certified under AS 08.65; a nurse licensed under AS 08.68; a dispensing  
4 optician licensed under AS 08.71; a naturopath licensed under AS 08.45; an  
5 optometrist licensed under AS 08.72; a pharmacist licensed under AS 08.80; a physical  
6 therapist or occupational therapist licensed under AS 08.84; or a physician's assistant  
7 certified under AS 08.64; a physician licensed under AS 08.64; a podiatrist; a  
8 psychologist and a psychological associate licensed under AS 08.86; a clinical social  
9 worker licensed under AS 08.95; an emergency medical technician certified under  
10 AS 18.08.082; a mobile intensive care paramedic trained as required under  
11 AS 18.08.082; a health maintenance organization as defined in AS 21.86.900; a  
12 hospital or medical service corporation as defined in AS 21.87.330; a hospital as  
13 defined in AS 18.20.130, including a governmentally owned or operated hospital; and  
14 an employee of a health care provider acting within the course and scope of  
15 employment;

16 (3) "health care services" means preventive, diagnostic, medical,  
17 surgical, reproductive, psychiatric, psychologic, rehabilitative, health maintenance,  
18 dental, podiatric, optometric, optical, audiologic, nutritive, and chiropractic care;  
19 prescription drugs, laboratory and radiologic services, medical supplies, durable  
20 medical equipment and devices; personal assistance services; inpatient and outpatient  
21 care; home health care; hospice care; and long-term or institutional care;

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

27 (5) "health insurance company" means an insurer that is authorized to  
28 transact health insurance.

29 \* Sec. 14. AS 21.86.070(g) is amended to read:

30 (g) The director may require that additional relevant material considered  
31 necessary by the director be submitted in order to determine the acceptability of a

1 filing made under [EITHER] (b) [OR (c)] of this section.

2 \* Sec. 15. AS 21.86 is amended by adding a new section to read:

3 Sec. 21.86.075. PREMIUM RATES AND CHARGES. A health maintenance  
4 organization

5 (1) shall file with the director rates, rating factors, premiums, fees for  
6 services, and enrollee fees, including a change to a rate, rating factor, premium, or fee,  
7 used in providing health care services to enrollees of the health maintenance  
8 organization;

9 (2) may not use a rate, rating factor, premium, or fee that has not been  
10 filed with the director; and

11 (3) may use a new rate, rating factor, premium, or fee at any time.

12 \* Sec. 16. AS 21.86.260(a) is amended to read:

13 (a) Except as provided in AS 21.56, AS 21.89.100 - 21.89.120, and in this  
14 chapter, this title does not apply to a health maintenance organization that obtains a  
15 certificate of authority under this chapter. This subsection does not apply to an insurer  
16 licensed under AS 21.09 or a hospital or medical service corporation licensed under  
17 AS 21.87 except with respect to its health maintenance organization activities  
18 authorized by and regulated under this chapter.

19 \* Sec. 17. AS 21.87.190 is repealed and reenacted to read:

20 Sec. 21.87.190. RATES AND CHARGES. A service corporation

21 (1) shall file with the director subscription rates, rating factors, fees,  
22 and payment charges, including a change to a rate, rating factor, fee, or payment  
23 charge, to be charged to or on account of the service corporation's subscribers;

24 (2) may not use a rate, rating factor, fee, or payment charge that has  
25 not been filed with the director; and

26 (3) may file a new rate, rating factor, fee, or payment charge at any  
27 time.

28 \* Sec. 18. AS 21.87.340 is amended to read:

29 Sec. 21.87.340. OTHER PROVISIONS APPLICABLE. In addition to the  
30 provisions contained or referred to previously in this chapter, the following chapters  
31 and provisions of this title also apply with respect to service corporations to the extent

1 applicable and not in conflict with the express provisions of this chapter and the  
2 reasonable implications of the express provisions, and for the purposes of the  
3 application the corporations shall be considered to be mutual "insurers":

- 4 (1) AS 21.03;
- 5 (2) AS 21.06;
- 6 (3) AS 21.09, except AS 21.09.090;
- 7 (4) AS 21.18.010;
- 8 (5) AS 21.18.030;
- 9 (6) AS 21.18.040;
- 10 (7) AS 21.18.120;
- 11 (8) AS 21.21.321;
- 12 (9) AS 21.36;
- 13 (10) AS 21.42.345 - 21.42.365, 21.42.375, 21.42.380, and 21.42.385;
- 14 (11) AS 21.51.120;
- 15 (12) AS 21.53;
- 16 (13) AS 21.54.020;
- 17 (14) AS 21.56;
- 18 (15) AS 21.69.400;
- 19 (16) AS 21.69.520;
- 20 (17) AS 21.69.600, 21.69.620, and 21.69.630;
- 21 (18) AS 21.78;
- 22 (19) AS 21.89.040;
- 23 (20) AS 21.89.060 and 21.89.100 - 21.89.120;
- 24 (21) AS 21.90.

25 \* Sec. 19. AS 21.89 is amended by adding new sections to read:

26 Sec. 21.89.100. REQUIRED PROVISIONS REGARDING COORDINATION  
27 OF BENEFITS. (a) When an insured has coverage under two or more plans that  
28 provide for coordination of benefits, the coverage from those plans must be  
29 coordinated so that the insured receives the maximum allowable benefit from each  
30 plan. The aggregate benefit should be more than that offered by any of the plans  
31 individually, but the insured may not receive more than the total of the charges for the

1 health care services received.

2 (b) A plan that provides for coordination of benefits must contain a provision  
3 that

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

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

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

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

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

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

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

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

26 (D) when one of the plans is a medical plan and the other is a  
27 dental plan, and a determination cannot be made under the provisions of (A) -  
28 (C) of this paragraph, the medical plan shall be considered as the primary  
29 coverage;

30 (E) if under the provisions of (A) - (D) of this paragraph the  
31 plan is secondary to another source of benefits, the benefits of the plan may not

1 be reduced unless the sum of benefits payable for allowable expenses and the  
2 benefits payable for allowable expenses under the other source exceed the  
3 allowable expenses in a claim determination period;

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

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

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

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

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

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

22 (A) its allowed benefit for the service;

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

25 (3) when a full fee plan is the primary coverage and a reduced fee plan  
26 is secondary coverage, the full fee plan shall provide its allowed amount for the  
27 service and the secondary plan shall pay the lesser of its allowed benefit for the service  
28 or the difference between the primary plan's benefits and the health care provider's full  
29 fee.

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

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

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

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

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

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

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

25 (1) maintain and use a statistically credible profile of fees of health care  
26 providers in this state on which to base payment of the claim; the profile must (A) be  
27 updated at least once every six months and may not contain fees for services  
28 performed more than one year before the date of the most recent profile; (B) contain  
29 fees for the geographic area in which a claimant might receive treatment; and (C) may  
30 not include fees clearly marked "DO NOT PROFILE"; if statistically credible data for  
31 a particular health care service in a certain geographic area does not exist, the insurer

1 may include in the profile a sufficient number of fees for that service from another  
2 geographic area in order to establish a reliable data base; however, the final basis for  
3 payment must be adjusted to reflect the general cost difference between the geographic  
4 area where the service was performed and the other geographic area used in  
5 establishing the statistically credible profile; the adjustment may be based upon the  
6 Consumer Price Index, the medical care component of the Consumer Price Index, or  
7 a reasonable basis stated in writing and determined acceptable by the director;

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

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

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

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

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

24 Sec. 21.89.120. DEFINITIONS FOR AS 21.89.100 - 21.89.120. In  
25 AS 21.89.100 - 21.89.120,

26 (1) "health care provider" has the meaning given in AS 21.58.400;

27 (2) "health care service" has the meaning given in AS 21.87.330;

28 (3) "plan" means a group or blanket disability policy issued under  
29 AS 21.54, small employer coverage issued under AS 21.56, evidence of coverage  
30 issued under AS 21.86, or a subscriber contract issued under AS 21.87;

31 (4) "professional services contract" includes a contract for professional

1 services between a health care provider and insurer or health maintenance corporation,  
2 and a service contract between a health care provider and a hospital or medical service  
3 corporation;

4 (5) "service corporation" has the meaning given in AS 21.87.330.

5 \* Sec. 20. Section 7, ch. 39, SLA 1993, is amended to read:

6 Sec. 7. AS 21.86.260(a) is repealed and reenacted to read:

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

13 \* Sec. 21. Section 9, ch. 39, SLA 1993, is amended to read:

14 Sec. 9. AS 21.87.340 is repealed and reenacted to read:

15 Sec. 21.87.340. OTHER PROVISIONS APPLICABLE. In addition to the  
16 provisions contained or referred to previously in this chapter, the following chapters  
17 and provisions of this title also apply with respect to service corporations to the extent  
18 applicable and not in conflict with the express provisions of this chapter and the  
19 reasonable implications of the express provisions, and for the purposes of the  
20 application the corporations shall be considered to be mutual "insurers":

21 (1) AS 21.03

22 (2) AS 21.06

23 (3) AS 21.09, except AS 21.09.090

24 (4) AS 21.18.010

25 (5) AS 21.18.030

26 (6) AS 21.18.040

27 (7) AS 21.18.120

28 (8) AS 21.21.321

29 (9) AS 21.36

30 (10) AS 21.42.345 - 21.42.365, 21.42.375, 21.42.380, and 21.42.385

31 (11) AS 21.51.120

- 1 (12) AS 21.53  
2 (13) AS 21.54.020  
3 (14) AS 21.69.400  
4 (15) AS 21.69.520  
5 (16) AS 21.69.600, 21.69.620, and 21.69.630  
6 (17) AS 21.78  
7 (18) AS 21.89.040  
8 (19) AS 21.89.060 and 21.89.100 - 21.89.120  
9 (20) AS 21.90.

10 \* Sec. 22. AS 21.86.070(c) and 21.86.070(f) are repealed.

11 \* Sec. 23. APPLICABILITY. Sections 16, 18, and 19 of this Act apply to a policy of  
12 insurance, evidence of coverage under AS 21.86, or a service agreement or subscriber's  
13 contract under AS 21.87, issued or renewed on or after the effective date of this Act.

14 \* Sec. 24. HEALTH CARE PLAN ADVISORY COMMITTEE. (a) The legislature finds  
15 that it is necessary to have reliable information on the specific content and cost of any  
16 proposed mandatory health care plan, before it can be taken to the public for review. The  
17 legislature further finds that questions of a single payer system versus a multi payer system  
18 for any mandatory coverage, and questions regarding inclusion or exclusion of certain groups  
19 of Alaskans who are covered by other federal health insurance, are not prejudiced by the  
20 direction given to the advisory committee created in this section.

21 (b) The Health Care Plan Advisory Committee is established in the Office of the  
22 Governor. The committee consists of seven members who are appointed by the governor as  
23 follows:

24 (1) one person with experience in providing health care services on an inpatient  
25 basis;

26 (2) one person with experience in providing health care services on an  
27 outpatient basis;

28 (3) one person with experience as a health care provider;

29 (4) one person who has experience in health care insurance; and

30 (5) three persons who represent the public.

31 (c) Notwithstanding any other provision of law, a committee member is subject to the

1 provisions of AS 39.50 as if the committee member were a member of a state commission or  
2 board described under AS 39.50.200(b).

3 (d) A committee member is entitled to receive compensation at the rate of \$250 a day  
4 for each day spent in performing duties as a committee member and to travel and per diem  
5 expenses authorized by law for boards and commissions under AS 39.20.180.

6 (e) The committee may

7 (1) establish subcommittees;

8 (2) conduct hearings;

9 (3) employ personnel necessary to complete assigned duties;

10 (4) enter into contracts;

11 (5) subject to appropriation, expend money.

12 (f) By December 15, 1994, the committee shall report to the legislature on the scope  
13 of the health care insurance coverage and the cost of providing health care insurance if health  
14 care insurance were to be offered under the following conditions:

15 (1) participation is mandatory by all state residents; coverage shall include a  
16 spouse and dependent children;

17 (2) health care services that are covered must include preventive care and  
18 immunizations, prenatal care, children's health care, and catastrophic medical expense  
19 coverage;

20 (3) coverage shall be designed to impose a family deductible of \$3,000 for all  
21 covered health care services other than prenatal care, preventive care, and immunizations, and  
22 to allow reimbursement in a calendar year at not more than 80 percent for all covered health  
23 care services, other than prenatal care, preventive care, and immunizations, after the first  
24 \$3,000 in covered expenses; prenatal care, preventive care, and immunizations may be  
25 reimbursed at more than 80 percent for a covered expense; coverage for health care services  
26 that are offered on an outpatient basis shall provide reimbursement for outpatient health care  
27 services at a rate equal to or higher than the rate for inpatient services;

28 (4) premiums shall be set at a single rate for all covered individuals, except

29 (A) a surcharge for coverage of each dependent child or spouse may  
30 be imposed; a surcharge may not exceed 50 percent of the individual premium; it is  
31 the intent of the legislature that the premium be set at a rate that does not exceed \$100

1 per month or 14 percent of the individual's monthly gross income, whichever is lower;

2 (B) premium rates are allowed to vary depending on whether the  
3 individual smokes or any other factors within the control of an individual, and  
4 depending on whether the individual is less than 30 years of age; a premium may not  
5 vary under a community rating system, other than as specified in this section;

6 (5) a one-year exclusion for preexisting conditions for new enrollees is  
7 imposed; this paragraph does not apply to a person who has resided in the state for at least  
8 one year, or who is less than one year old and was born in this state.

9 (g) By December 15, 1995, the committee shall report to the legislature on

10 (1) the cost of providing health insurance coverage under the following  
11 conditions:

12 (A) coverage shall meet the conditions set out under (f)(1) - (5) of this  
13 section;

14 (B) additional medical benefits are included as recommended by the  
15 committee;

16 (C) it is the intent of the legislature that the premium be set at a rate  
17 that does not exceed \$150 per month or 14 percent of the individual's monthly gross  
18 income, whichever is lower;

19 (2) the effect of the following conditions assuming that insurance coverage as  
20 specified under (f) of this section is provided:

21 (A) premium payment is by payroll deduction, employer contribution,  
22 or a combination of employer contribution and payroll deduction;

23 (B) premium payment by an unemployed or self-employed person is  
24 by direct payment;

25 (3) assuming that the state requires all residents to participate in a state health  
26 insurance plan, changes necessary in existing provisions of law to

27 (A) allow integration of optional health insurance plans with the  
28 mandatory insurance plan; the integration should allow an individual or group to  
29 purchase supplemental insurance coverage without duplication of coverage; and

30 (B) discourage health insurance that reimburses covered benefits at a  
31 rate greater than 80 percent of the cost of the benefits;

- 1 (4) recommended legislation regarding public health issues;
- 2 (5) recommended legislation to simplify health care administration;
- 3 (6) recommended legislation regarding antitrust changes necessary to allow the
- 4 use of pooled purchasing to reduce the cost of health care if required under federal law;
- 5 (7) recommended legislation to enact tort reform measures intended to reduce
- 6 the cost of health care, including changes to statutes of limitation, contingent fee agreements,
- 7 and to the Alaska Rules of Civil Procedure;
- 8 (8) recommended legislation regarding long-term health care, including
- 9 methods to encourage individual savings for the cost of long-term health care;
- 10 (9) recommended legislation regarding how the state should educate residents
- 11 on health care, including how to be a prudent consumer, increasing awareness of provider
- 12 charges, and a curriculum that should be used in public schools in the state.
- 13 (h) By December 15, 1995, the committee shall recommend to the legislature
- 14 legislation necessary to improve data collection used to control health care expenditures or to
- 15 improve the efficiency of the health care system in the state.
- 16 (i) In this section, "health care provider" has the meaning given in AS 21.58.400.
- 17 \* Sec. 25. PUBLIC HEALTH ADVISORY COMMITTEE. (a) The Public Health
- 18 Advisory Committee is established in the Office of the Governor. The committee consists of
- 19 nine members with significant public health expertise who are appointed by the governor. The
- 20 governor shall consider public and private health care professionals, labor organizations,
- 21 businesses, the education system, the Alaska Public Health Association, the Alaska Mental
- 22 Health Board, and the Alaska Native Health Board for service on the Public Health Advisory
- 23 Committee, as well as recognizing the need for geographic, ethnic, and cultural diversity.
- 24 (b) A committee member is entitled to travel and per diem expenses authorized by law
- 25 for boards and commissions under AS 39.20.180.
- 26 (c) The committee may
- 27 (1) establish subcommittees;
- 28 (2) conduct hearings;
- 29 (3) employ personnel necessary to complete assigned duties;
- 30 (4) enter into contracts;
- 31 (5) subject to appropriation, expend money.

- 1 (d) The committee shall
- 2 (1) advise the commissioner of health and social services, the commissioner
- 3 of administration, and the commissioner of commerce and economic development on public
- 4 health matters;
- 5 (2) develop a public health improvement plan as described under (e) of this
- 6 section.
- 7 (e) The plan developed by the committee may
- 8 (1) recognize the need for
- 9 (A) community involvement in health care planning and delivery;
- 10 (B) attention to local needs that may vary from place to place;
- 11 (C) accountability for the use of public funds;
- 12 (D) equity and stability in the distribution of public funds;
- 13 (E) shared responsibility of all levels of government for administering
- 14 and financing public health care delivery; and
- 15 (F) coordination of basic public health services; and
- 16 (2) include
- 17 (A) an analysis of the health status of the residents of the state;
- 18 (B) an assessment of the most appropriate role for various levels of
- 19 government to play in addressing the health care needs of the residents of the state;
- 20 (C) a delineation of the standards that should be used in assessment,
- 21 policy development, and quality assurance in the delivery of public health services;
- 22 (D) documentation of the extent to which the current public health
- 23 system implements or achieves the standards identified under (C) of this paragraph;
- 24 (E) identification of interjurisdictional issues involved in health care
- 25 access and delivery;
- 26 (F) recommendations, including recommendations for specific
- 27 legislative action when necessary, pertaining to the following:
- 28 (i) strategies, time lines, financial needs, and specific sources
- 29 of stable revenue for bringing the state public health care system up to
- 30 standards identified by the committee;
- 31 (ii) appropriate sharing of the responsibility of local, regional,

1 state, and federal government entities to deliver public health care services  
2 efficiently and effectively, including recommendations for organization within  
3 state government;

4 (iii) integration of the public health care system with state and  
5 national health care reform efforts;

6 (iv) the committee's estimate of the optimal share that public  
7 health should represent in the total health care delivery system of the state,  
8 expressed in terms of a percentage of health care dollars spent or in terms of  
9 public dollars per state resident;

10 (v) a program designed to give incentives to a primary health  
11 care provider to practice in the state, especially in rural and underserved areas  
12 of the state.

13 (f) In this section, "health care provider" has the meaning given in AS 21.58.400.

14 \* Sec. 26. Sections 24 and 25 of this Act are repealed June 30, 1996.