

SENATE BILL NO. 367

IN THE LEGISLATURE OF THE STATE OF ALASKA

EIGHTEENTH LEGISLATURE - SECOND SESSION

BY THE SENATE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

Introduced: 3/24/94
Referred: HES, JUD, FIN

A BILL

FOR AN ACT ENTITLED

1 "An Act relating to health care and insurance for health care; to review and
2 approval of health insurance rates and rating factors; relating to certain civil
3 actions against health care providers; to coordination of insurance benefits and
4 to determination and disclosure of fees paid to an insured or health care
5 provider; to the rate of interest on certain judgments and decrees; to excise taxes
6 on cigarettes; amending Alaska Rules of Civil Procedure 26, 27, 68, 79, and 82
7 and Alaska Rules of Evidence 802, 803, and 804; repealing Alaska Rule of Civil
8 Procedure 72.1; and providing for an effective date."

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

10 * Section 1. AS 08.64.326 is amended to read:

11 Sec. 08.64.326. GROUNDS FOR IMPOSITION OF DISCIPLINARY
12 SANCTIONS. (a) The board may impose a sanction if the board finds after a hearing

1 that a licensee

2 (1) secured a license through deceit, fraud, or intentional
3 misrepresentation;

4 (2) engaged in deceit, fraud, or intentional misrepresentation while
5 providing professional services or engaging in professional activities;

6 (3) advertised professional services in a false or misleading manner;

7 (4) has been convicted, including conviction based on a guilty plea or
8 plea of nolo contendere, of

9 (A) a felony or other crime if the felony or other crime is
10 substantially related to the qualifications, functions, or duties of the licensee;
11 or

12 (B) a crime involving the unlawful procurement, sale,
13 prescription, or dispensing of drugs;

14 (5) has procured, sold, prescribed, or dispensed drugs in violation of
15 a law, regardless of whether there has been a criminal action;

16 (6) intentionally or negligently permitted the performance of patient
17 care by persons under the licensee's supervision that does not conform to minimum
18 professional standards even if the patient was not injured;

19 (7) failed to comply with this chapter, a regulation adopted under this
20 chapter, or an order of the board;

21 (8) has demonstrated

22 (A) professional incompetence, gross negligence, or repeated
23 negligent conduct; the board may not base a finding of professional
24 incompetence solely on the basis that a licensee's practice is unconventional or
25 experimental in the absence of demonstrable physical harm to a patient;

26 (B) addiction to, severe dependency on, or habitual overuse of
27 alcohol or other drugs that impairs the licensee's ability to practice safely;

28 (C) unfitness because of physical or mental disability;

29 (9) engaged in unprofessional conduct or in lewd or immoral conduct
30 in connection with the delivery of professional services to patients;

31 (10) has violated AS 18.16.010;

1 (11) has violated any code of ethics adopted by regulation by the board;
2 or

3 (12) [HAS DENIED CARE OR TREATMENT TO A PATIENT OR
4 PERSON SEEKING ASSISTANCE FROM THE PHYSICIAN IF THE ONLY
5 REASON FOR THE DENIAL IS THE FAILURE OR REFUSAL OF THE PATIENT
6 TO AGREE TO ARBITRATE AS PROVIDED IN AS 09.55.535(a); OR

7 (13)] has had a license or certificate to practice medicine in another
8 state or territory of the United States, or a province or territory of Canada suspended
9 or revoked unless the suspension or revocation was caused by the failure of the
10 licensee to pay fees to that state, territory, or province.

11 (b) In a case involving (a)(12) [(a)(13)] of this section, the final findings of
12 fact, conclusions of law, and order of the authority that suspended or revoked a license
13 or certificate constitutes a prima facie case that the license or certificate was suspended
14 or revoked and the grounds under which the suspension or revocation was granted.

15 * Sec. 2. AS 08.68.270 is amended to read:

16 Sec. 08.68.270. GROUNDS FOR DENIAL, SUSPENSION, OR
17 REVOCATION. The board may deny, suspend, or revoke the license of a person who

18 (1) has obtained or attempted to obtain a license to practice nursing by
19 fraud or deceit;

20 (2) has been convicted of a felony or other crime if the felony or other
21 crime is substantially related to the qualifications, functions or duties of the licensee;

22 (3) habitually abuses alcoholic beverages, or illegally uses controlled
23 substances;

24 (4) has impersonated a registered or practical nurse;

25 (5) has intentionally or negligently engaged in conduct that has resulted
26 in a significant risk to the health or safety of a client or in injury to a client;

27 (6) practices or attempts to practice nursing while afflicted with
28 physical or mental illness, deterioration, or disability that interferes with the
29 individual's performance of nursing functions;

30 (7) is guilty of unprofessional conduct as defined by regulations
31 adopted by the board;

1 (8) has wilfully or repeatedly violated a provision of this chapter or
2 regulations adopted under it;

3 (9) is professionally incompetent [;

4 (10) DENIES CARE OR TREATMENT TO A PATIENT OR PERSON
5 SEEKING ASSISTANCE IF THE SOLE REASON FOR THE DENIAL IS THE
6 FAILURE OR REFUSAL OF THE PATIENT OR PERSON SEEKING ASSISTANCE
7 TO AGREE TO ARBITRATE AS PROVIDED IN AS 09.55.535(a)].

8 * Sec. 3. AS 09.10 is amended by adding a new section to read:

9 Sec. 09.10.065. LIMITATION ON ACTIONS BY CERTAIN MINORS
10 AGAINST HEALTH CARE PROVIDERS. (a) Notwithstanding AS 09.10.140, an
11 action based on professional negligence may not be brought against a health care
12 provider by a person who is, on the date of the alleged negligent act or omission less
13 than two years of age, unless the action is brought before the person's eighth birthday.

14 (b) The limitation imposed under (a) of this section is tolled during any period
15 in which there exists

16 (1) fraud, including fraud or collusion by a parent, guardian, insurer,
17 or health care provider, resulting in the failure to bring an action on behalf of an
18 injured minor;

19 (2) intentional concealment; or

20 (3) the undiscovered presence of a foreign body, that has no therapeutic
21 or diagnostic purpose or effect, in the body of the injured person and the action is
22 based on the presence of the foreign body.

23 (c) In this section,

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

25 (2) "professional negligence" means a negligent act or omission by a
26 physician in rendering professional services;

27 (3) "professional services" means services provided by a health care
28 provider that are within the scope of services for which the health care provider is
29 licensed, and that are not prohibited under the health care provider's license or by a
30 hospital in which the health care provider practices.

31 * Sec. 4. AS 09.30.070(a) is amended to read:

1 (a) The rate of interest on judgments and decrees for the payment of money
2 is equal to the 12th Federal Reserve district discount rate as determined under
3 AS 45.45.010(b) [10.5 PERCENT A YEAR], except that a judgment or decree founded
4 on a contract in writing, providing for the payment of interest until paid at a specified
5 rate not exceeding the legal rate of interest for that type of contract, bears interest at
6 the rate specified in the contract if the interest rate is set out in the judgment or decree.

7 * Sec. 5. AS 09.55.535 is repealed and reenacted to read:

8 Sec. 09.55.535. MANDATORY ARBITRATION. (a) A person who files an
9 action for damages against a health care provider resulting from medical malpractice,
10 shall also submit the claim to the court for arbitration.

11 (b) When a claim is submitted as required by (a) of this section, the court shall
12 appoint an arbitrator to review the claim. The arbitrator appointed to review the claim
13 shall interview the parties and examine all records or materials relating to the claim
14 and may compel the attendance of witnesses, interview the parties, or consult with
15 medical specialists.

16 (c) An arbitrator appointed under this section shall conduct a prehearing
17 settlement conference within 30 days after the appointment. The arbitrator shall
18 establish a period for discovery and a date for a hearing. The hearing date may not
19 be more than 120 days after the settlement conference.

20 (d) An arbitrator shall render a decision within 30 days after hearing a claim
21 under (c) of this section. The decision must contain findings of fact and conclusions
22 of law. The decision of the arbitrator may be rejected by a party.

23 (e) If the decision of the arbitrator is rejected by a party, the action may
24 proceed in the appropriate court. The arbitrator's decision is admissible evidence in
25 that action and may be used by a party to support or oppose a claim of damages.

26 (f) A party that rejects the arbitrator's decision, proceeds in court as provided
27 under (e) of this section, and obtains a final judgment that is not more favorable to that
28 party than the arbitrator's decision, shall pay the opposing party's actual costs and
29 attorney fees incurred during the court proceeding and may not be awarded its own
30 costs or attorney fees. This subsection

31 (1) does not apply to costs or attorney fees incurred in an appeal of

1 a court decision; and

2 (2) applies notwithstanding a different result required by an Alaska
3 Rule of Civil Procedure relating to an offer of judgment.

4 (g) The provisions of AS 09.43.010 - 09.43.180 (Uniform Arbitration Act)
5 apply to an arbitration under this section, if the provisions do not conflict with the
6 provisions of this section.

7 * Sec. 6. AS 09.55.536 is amended to read:

8 Sec. 09.55.536. EXPERT ADVISOR [ADVISORY PANEL]. (a) In an action
9 for damages due to personal injury or death based upon the provision of professional
10 services by a health care provider [WHEN THE PARTIES HAVE NOT AGREED TO
11 ARBITRATION OF THE CLAIM UNDER AS 09.55.535,] the court shall appoint
12 within 20 days after filing of answer to a summons and complaint an expert medical
13 advisor [A THREE-PERSON EXPERT ADVISORY PANEL] unless the court decides
14 that an expert advisory opinion is not necessary for a decision in the case. When the
15 action is filed the court shall, by order, determine the professions or specialties to be
16 represented by the medical expert [ON THE EXPERT ADVISORY PANEL], giving
17 the parties the opportunity to object or make suggestions.

18 (b) The expert advisor [ADVISORY PANEL] may compel the attendance of
19 witnesses, interview the parties, physically examine the injured person if alive, consult
20 with the specialists or learned works they consider appropriate, and compel the
21 production of and examine all relevant hospital, medical, or other records or materials
22 relating to the health care in issue. The advisor [PANEL] may meet in camera, but
23 shall maintain a record of any testimony or oral statements of witnesses, and shall keep
24 copies of all written statements received [IT RECEIVES].

25 (c) Not more than 30 days after selection of the advisor, the advisor [PANEL,
26 IT] shall make a written report to the parties and to the court, answering the following
27 questions and other questions submitted to the advisor [PANEL] by the court:

- 28 (1) What was the disorder for which the plaintiff came to medical care?
29 (2) What would have been the probable outcome without medical care?
30 (3) Was the treatment selected appropriate for the case?
31 (4) Did an injury arise from the medical care?

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- (5) What is the nature and extent of the medical injury?
- (6) What specifically caused the medical injury?
- (7) Was the medical injury caused by unskillful care?
- (8) If a medical injury had not occurred, how would the plaintiff's condition differ from the plaintiff's present condition?

(d) In any case in which the answer to one or more of the questions submitted to the advisor [PANEL] depends upon the resolution of factual questions which are not the proper subject of expert opinion, the report shall so state and may answer questions based upon hypothetical facts that are fully set out in the opinion. The report must [SHALL] include copies of all written statements, opinions, or records relied upon by the advisor [PANEL] and either a transcription or other record of any oral statements or opinions; must [SHALL] specify any medical or scientific authority relied upon by the advisor [PANEL]; and must [SHALL] include the results of any physical or mental examination performed on the plaintiff. The advisor [EACH MEMBER] shall sign the report and the signature constitutes the advisor's [MEMBER'S] adoption of all statements and opinions contained in it [; HOWEVER, A MEMBER MAY, INSTEAD OF SIGNING THE REPORT, SUBMIT A CONCURRING OR DISSENTING REPORT WHICH COMPLIES WITH THE REQUIREMENTS OF THIS SUBSECTION]. An advisor [A MEMBER] may not attest to any portion of the report as to which the advisor [MEMBER] is not qualified to give expert testimony.

(e) The report of the advisor [PANEL WITH ANY DISSENTING OR CONCURRING OPINION] is admissible in evidence to the same extent as though its contents were orally testified to by the person or persons preparing it. The court shall delete any portion that would not be admissible because of lack of foundation for opinion testimony, or otherwise. Either party may submit testimony to support or refute the report. The jury shall be instructed in general terms that the report shall be considered and evaluated in the same manner as any other expert testimony. The expert advisor [ANY MEMBER OF THE PANEL] may be called by any party and may be cross-examined as to the contents of the report [OR OF THAT MEMBER'S DISSENTING OR CONCURRING OPINION].

1 (f) Discovery [NO DISCOVERY] may not be undertaken in a case until the
2 report of the expert advisor [ADVISORY PANEL] is received. However, the court
3 may relax this prohibition upon a showing of good cause by a [ANY] party. If the
4 advisor [PANEL] has not completed its report within the 30-day period prescribed in
5 (c) of this section, the court may, upon application, grant [IT] an additional 30 days.

6 (g) The expert advisor is [MEMBERS OF A PANEL ARE] entitled to travel
7 expenses and per diem in accordance with state law pertaining to members of boards
8 and commissions for all time spent in preparing its report. If an advisor [A PANEL
9 MEMBER] is called upon as a witness at trial or upon deposition, the advisor
10 [MEMBER] is entitled to payment of an expert witness fee, which may not exceed
11 \$300 [\$150] per day. All expenses incurred by the advisor [PANEL] shall be paid by
12 the court. However, in any case in which the court determines that a party has made
13 a patently frivolous claim or a patently frivolous denial of liability, it shall order that
14 all costs of the expert advisor [ADVISORY PANEL] be borne by the party making
15 that claim or denial.

16 (h) Parties to the case and their counsel may not initiate communication out
17 of court with an expert advisor [MEMBERS OF THE PANEL] on the subject matter
18 of its inquiry and report or cause or solicit others to do so, except through ordinary
19 discovery proceedings.

20 * Sec. 7. AS 21.51 is amended by adding new sections to read:

21 Sec. 21.51.350. REVIEW AND APPROVAL OF RATES AND RATING
22 FACTORS. (a) A disability insurer shall file with the director rates or rating factors
23 for disability insurance, including a change to a disability rate or factor. The filing
24 must include detailed information that allows the director to evaluate the
25 appropriateness of the proposed rate or rating factor. A disability insurer may furnish
26 the following information in support of a filing:

- 27 (1) actuarial judgment;
- 28 (2) interpretation of the statistical data relied upon by the disability
29 insurer;
- 30 (3) the loss and expense experience of the policy or plan or a similar
31 policy or plan;

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(4) other information or data requested by the director.

(b) A filing must be made at least 75 days before the intended effective date of the rate or rating factor and is subject to the approval of the director.

* Sec. 8. AS 21 is amended by adding a new chapter to read:

CHAPTER 58. HEALTH CARE.

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

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

- (1) health care expenditures, including capital expenditures associated with receiving health care;
- (2) demographic data;
- (3) clinical information, including patient diagnosis, type of provider, type of service, location and length of care, referral patterns, quality of care, and result of care;
- (4) billing and payment data; and
- (5) public health data, including vital statistics and health status.

(b) The commissioner may, by regulation, require health care providers to submit claims data and additional information necessary to develop or update the data system required under (a) of this section.

(c) The commissioner may pursue waivers from applicable federal law or from federal agencies to the extent necessary to maximize the collection and analysis of

1 health care data.

2 (d) Information and data obtained or produced by the director under this
3 section are subject to the disclosure requirements and exceptions of AS 09.25.110 and
4 09.25.120 and the regulations adopted under those statutes. Information or data
5 identifying a recipient of health care services is considered to be a medical and related
6 public health record subject to the exception to public inspection under AS 09.25.120
7 and, except as provided under (e) of this section, shall be kept confidential as a matter
8 of law. A person who wrongfully discloses or who uses or permits the use of
9 confidential information or data in violation of this subsection is guilty of a class B
10 misdemeanor.

11 (e) Information or data regarding health care services

12 (1) may be disclosed in an aggregate form that does not identify an
13 individual recipient; and

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

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

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

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

28 Sec. 21.58.400. DEFINITIONS. In this chapter,

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

31 (2) "health care provider" means an acupuncturist licensed under

1 AS 08.06; an audiologist licensed under AS 08.11; a chiropractor licensed under
2 AS 08.20; a dental hygienist licensed under AS 08.32; a dentist licensed under
3 AS 08.36; a marital or family therapist licensed under AS 08.63; a direct-entry
4 midwife certified under AS 08.65; a nurse licensed under AS 08.68; a dispensing
5 optician licensed under AS 08.71; a naturopath licensed under AS 08.45; an
6 optometrist licensed under AS 08.72; a pharmacist licensed under AS 08.80; a physical
7 therapist or occupational therapist licensed under AS 08.84; or a physician's assistant
8 certified under AS 08.64; a physician licensed under AS 08.64; a podiatrist; a
9 psychologist and a psychological associate licensed under AS 08.86; a clinical social
10 worker licensed under AS 08.95; an emergency medical technician certified under
11 AS 18.08.082; a mobile intensive care paramedic trained as required under
12 AS 18.08.082; a health maintenance organization as defined in AS 21.86.900; a
13 hospital or medical service corporation as defined in AS 21.87.330; a hospital as
14 defined in AS 18.20.130, including a governmentally owned or operated hospital; and
15 an employee of a health care provider acting within the course and scope of
16 employment;

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

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

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

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

31 (a) Except as provided in AS 21.56, AS 21.89.100 - 21.89.120, and in this

1 chapter, this title does not apply to a health maintenance organization that obtains a
2 certificate of authority under this chapter. This subsection does not apply to an insurer
3 licensed under AS 21.09 or a hospital or medical service corporation licensed under
4 AS 21.87 except with respect to its health maintenance organization activities
5 authorized by and regulated under this chapter.

6 * Sec. 10. AS 21.87.340 is amended to read:

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

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

1 (20) AS 21.89.060 and 21.89.100 - 21.89.120;

2 (21) AS 21.90.

3 * **Sec. 11.** AS 21.89 is amended by adding new sections to read:

4 **Sec. 21.89.100. REQUIRED PROVISIONS REGARDING COORDINATION**
5 **OF BENEFITS.** (a) When an insured has coverage under two or more plans that
6 provide for coordination of benefits, the coverage from those plans must be
7 coordinated so that the insured receives the maximum allowable benefit from each
8 plan. The aggregate benefit should be more than that offered by any of the plans
9 individually, but the insured may not receive more than the total of the charges for the
10 health care services received.

11 (b) A plan that provides for coordination of benefits must contain a provision
12 that

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

31 (A) its allowed benefit for the service;

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

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

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

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

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

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

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

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

28 Sec. 21.89.110. DETERMINATION AND DISCLOSURE OF USUAL,
29 CUSTOMARY, AND REASONABLE FEES. An insurer who pays a claim under a
30 disability policy or an indemnity under a group or blanket disability insurance policy,
31 a health maintenance organization that adopts a schedule of charges, or a hospital or

1 medical service corporation that pays a subscriber or compensates a health care
2 provider on the basis of a usual, customary, or reasonable fee or charge shall

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

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

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

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

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

30 (C) the percentile of usual, customary, and reasonable fees at
31 which the insurer will reimburse the insured, or the contract health care

1 provider.

2 Sec. 21.89.120. DEFINITIONS FOR AS 21.89.100 - 21.89.120. In
3 AS 21.89.100 - 21.89.120,

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

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

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

9 (4) "professional services contract" includes a contract for professional
10 services between a health care provider and insurer or health maintenance corporation,
11 and a service contract between a health care provider and a hospital or medical service
12 corporation;

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

14 * Sec. 12. AS 43.50.190(a) is amended to read:

15 (a) There is levied an excise tax of 17 [12] mills on each cigarette imported
16 or acquired in this state.

17 * Sec. 13. Section 7, ch. 39, SLA 1993, is amended to read:

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

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

25 * Sec. 14. Section 9, ch. 39, SLA 1993, is amended to read:

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

27 Sec. 21.87.340. OTHER PROVISIONS APPLICABLE. In addition to the
28 provisions contained or referred to previously in this chapter, the following chapters
29 and provisions of this title also apply with respect to service corporations to the extent
30 applicable and not in conflict with the express provisions of this chapter and the
31 reasonable implications of the express provisions, and for the purposes of the

1 application the corporations shall be considered to be mutual "insurers":

2 (1) AS 21.03

3 (2) AS 21.06

4 (3) AS 21.09, except AS 21.09.090

5 (4) AS 21.18.010

6 (5) AS 21.18.030

7 (6) AS 21.18.040

8 (7) AS 21.18.120

9 (8) AS 21.21.321

10 (9) AS 21.36

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

12 (11) AS 21.51.120

13 (12) AS 21.53

14 (13) AS 21.54.020

15 (14) AS 21.69.400

16 (15) AS 21.69.520

17 (16) AS 21.69.600, 21.69.620, and 21.69.630

18 (17) AS 21.78

19 (18) AS 21.89.040

20 (19) AS 21.89.060 and 21.89.100 - 21.89.120

21 (20) AS 21.90.

22 * Sec. 15. APPLICABILITY. Sections 9, 10, and 11 of this Act apply to a policy of
23 insurance, evidence of coverage under AS 21.86, or a service agreement or subscriber's
24 contract under AS 21.87, issued or renewed on or after the effective date of this Act.

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

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

4 (1) one person who is employed in providing health care services on an
5 inpatient basis;

6 (2) one person who is employed in providing health care services on an
7 outpatient basis;

8 (3) one person who is a health care provider;

9 (4) one person who is an accountant who has experience in health care
10 insurance;

11 (5) one person who is an actuary who has experience in health care insurance;

12 and

13 (6) two persons who represent the public.

14 (c) The committee may

15 (1) establish subcommittees;

16 (2) conduct hearings;

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

18 (4) enter into contracts;

19 (5) subject to appropriation, expend money.

20 (d) By December 15, 1994, the committee shall report to the legislature on the scope
21 of the health care insurance coverage and the cost of providing health care insurance if health
22 care insurance were to be offered under the following conditions:

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

25 (2) health care services that are covered must include preventive care and
26 immunizations, prematernal care, children's health care, and catastrophic medical expense
27 coverage;

28 (3) coverage shall be designed to allow reimbursement in a calendar year at
29 not more than 80 percent for all covered health care services, other than prematernal care,
30 preventive care, and immunizations, after the first \$3,000 in covered expenses; prematernal
31 care, preventive care, and immunizations may be reimbursed at more than 80 percent for a

1 covered expense; coverage for health care services that are offered on an outpatient basis shall
2 provide reimbursement for outpatient health care services at a rate equal to or higher than the
3 rate for inpatient services;

4 (4) premiums shall be set at a single rate for all covered individuals, except
5 (A) a surcharge for coverage of each dependent child or spouse may
6 be imposed; a surcharge may not exceed 50 percent of the individual premium; it is
7 the intent of the legislature that the premium be set at a rate that does not exceed \$100
8 per month or 14 percent of the individual's monthly gross income, whichever is
9 higher;

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

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

17 (e) By December 15, 1995, the committee shall report to the legislature on

18 (1) the cost of providing health insurance coverage under the following
19 conditions:

20 (A) coverage shall meet the conditions set out under (d)(1) - (5) of this
21 section;

22 (B) additional medical benefits are included as recommended by the
23 committee;

24 (C) the premium for a single person may not exceed \$150 per month;

25 (2) the effect of the following conditions assuming that insurance coverage as
26 specified under (d) of this section is provided:

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

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

31 (3) assuming that the state requires all residents to participate in a state health

1 insurance plan, changes necessary in existing provisions of law to

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

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

7 (4) recommended legislation regarding public health issues;

8 (5) recommended legislation to simplify health care administration;

9 (6) recommended legislation regarding antitrust changes necessary to allow the
10 use of pooled purchasing to reduce the cost of health care if required under federal law;

11 (7) recommended legislation to enact tort reform measures intended to reduce
12 the cost of health care, including changes to statutes of limitation, contingent fee agreements,
13 and to the Alaska Rules of Civil Procedure;

14 (8) recommended legislation regarding long-term health care, including
15 methods to encourage individual savings for the cost of long-term health care;

16 (9) recommended legislation regarding how the state should educate residents
17 on health care, including how to be a prudent consumer, increasing awareness of provider
18 charges, and a curriculum that should be used in public schools in the state.

19 (f) By December 15, 1995, the committee shall recommend to the legislature
20 legislation necessary to improve data collection used to control health care expenditures or to
21 improve the efficiency of the health care system in the state.

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

23 * Sec. 17. MEDICAL PRACTICE ADVISORY COMMITTEE. (a) The Medical Practice
24 Advisory Committee is established in the Office of the Governor. The committee consists of
25 four members who are appointed by the governor as follows:

26 (1) one person who is a doctor of medicine licensed under AS 08.64;

27 (2) one person who is a doctor of osteopathy licensed under AS 08.64;

28 (3) one person who is a health care provider licensed under AS 08 but who
29 is not licensed under AS 08.64; and

30 (4) one person who is a health care provider licensed under AS 08 and who
31 practices in a rural area of the state.

- 1 (b) The committee may
- 2 (1) establish subcommittees;
- 3 (2) conduct hearings;
- 4 (3) employ personnel necessary to complete assigned duties;
- 5 (4) enter into contracts;
- 6 (5) subject to appropriation, expend money.

7 (c) By December 15 of each year, the committee shall provide recommendations for
8 necessary health care reform legislation to the legislature on the following:

9 (1) training necessary for primary health care providers regarding proper
10 referral of cases;

11 (2) medical practice parameters intended to reduce or eliminate medical
12 malpractice claims;

13 (3) required additions or changes in the authority given to health care providers
14 in order to prudently maximize a health care provider's scope of practice;

15 (4) obstacles that may arise from federal antitrust laws in allowing health care
16 providers to join in a peer review process, share price information, or share equipment or
17 facilities;

18 (5) recommendations to facilitate the use of video teleconferencing or other
19 long-distance communications that allow health care providers with special skills to extend
20 their practice to remote areas of the state;

21 (6) the creation of peer review boards to sanction health care providers, to
22 require approval of certain medical procedures, and to recommend practice incentives.

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

24 * Sec. 18. Alaska Rule of Civil Procedure 72.1 is repealed.

25 * Sec. 19. AS 09.55.535(f), as enacted in sec. 5 of this Act, has the effect of amending
26 Alaska Rules of Civil Procedure 68, 79, and 82 by providing that a party that rejects an
27 arbitration decision and receives a judgment that is not more favorable than the decision
28 obtained in arbitration is required to pay the opposing party's actual costs and attorney fees
29 incurred in the court proceeding, and by providing that the provisions of AS 09.55.535(f)
30 apply notwithstanding a different result required under an Alaska Rule of Civil Procedure
31 relating to an offer of judgment.

1 * **Sec. 20.** AS 09.55.536(g), amended by sec. 6 of this Act, amends Alaska Rules of Civil
2 Procedure 26 and 27 by providing that discovery may not be undertaken until the expert
3 advisor's report is received.

4 * **Sec. 21.** AS 09.55.536(e), amended by sec. 6 of this Act, amends Alaska Rules of
5 Evidence 802, 803, and 804 by providing that the expert advisor's report is admissible in
6 evidence to the same extent as though its contents were orally testified to by the advisor.

7 * **Sec. 22.** Section 18 of this Act takes effect July 1, 1994, only if that section receives the
8 two-thirds majority vote of each house required by art. IV, sec. 15, Constitution of the State
9 of Alaska.

10 * **Sec. 23.** Sections 16 and 17 of this Act are repealed June 30, 1996.

11 * **Sec. 24.** This Act takes effect July 1, 1994.