

CS FOR SENATE BILL NO. 367(HES)

IN THE LEGISLATURE OF THE STATE OF ALASKA

EIGHTEENTH LEGISLATURE - SECOND SESSION

BY THE SENATE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

Offered: 4/8/94
Referred: JUD, FIN

Sponsor(s): SENATE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

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; relating to the offense of operating a commercial motor vehicle while
6 intoxicated and the offense of operating a motor vehicle, aircraft, or watercraft
7 while intoxicated; relating to presumptions arising from the amount of alcohol in
8 a person's breath or blood; relating to the rate of interest on certain judgments
9 and decrees; to excise taxes on cigarettes; amending Alaska Rules of Civil
10 Procedure 26, 27, 68, 79, and 82 and Alaska Rules of Evidence 802, 803, and
11 804; repealing Alaska Rule of Civil Procedure 72.1; and providing for an effective
12 date."

SB0367b

-1-

CSSB 367(HES)

New Text Underlined (DELETED TEXT BRACKETED)

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

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

3 Sec. 08.64.326. **GROUND**S FOR IMPOSITION OF DISCIPLINARY
4 **SANCTIONS.** (a) The board may impose a sanction if the board finds after a hearing
5 that a licensee

6 (1) secured a license through deceit, fraud, or intentional
7 misrepresentation;

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

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

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

13 (A) a felony or other crime if the felony or other crime is
14 substantially related to the qualifications, functions, or duties of the licensee;
15 or

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

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

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

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

25 (8) has demonstrated

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

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

- 1 (C) unfitness because of physical or mental disability;
2 (9) engaged in unprofessional conduct or in lewd or immoral conduct
3 in connection with the delivery of professional services to patients;
4 (10) has violated AS 18.16.010;
5 (11) has violated any code of ethics adopted by regulation by the board;

6 or

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

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

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

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

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

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

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

26 (3) habitually abuses alcoholic beverages, or illegally uses controlled
27 substances;

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

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

31 (6) practices or attempts to practice nursing while afflicted with

1 physical or mental illness, deterioration, or disability that interferes with the
2 individual's performance of nursing functions;

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

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

7 (9) is professionally incompetent [;

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

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

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

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

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

23 (2) intentional concealment; or

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

27 (c) In this section,

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

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

31 (3) "professional services" means services provided by a health care

1 provider that are within the scope of services for which the health care provider is
2 licensed, and that are not prohibited under the health care provider's license or by a
3 hospital in which the health care provider practices.

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

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

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

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

15 (b) When a claim is submitted as required by (a) of this section, the court shall
16 determine if the parties can agree on an arbitrator to review the claim. If the parties
17 agree on an arbitrator, the court shall appoint that person to review the claim. If
18 within 30 days after the filing of an answer to the complaint the parties have not
19 agreed on an arbitrator, the court shall appoint an arbitrator to review the claim. The
20 arbitrator appointed to review the claim shall interview the parties and examine all
21 records or materials relating to the claim and may compel the attendance of witnesses,
22 interview the parties, or consult with medical specialists.

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

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

30 (e) If the decision of the arbitrator is rejected by a party, the action may
31 proceed in the appropriate court. The arbitrator's decision is admissible evidence in

1 that action and may be used by a party to support or oppose a claim of damages.

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

7 (1) does not apply to costs or attorney fees incurred in an appeal of
8 a court decision; and

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

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

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

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

26 (b) The expert advisor [ADVISORY PANEL] may compel the attendance of
27 witnesses, interview the parties, physically examine the injured person if alive, consult
28 with the specialists or learned works they consider appropriate, and compel the
29 production of and examine all relevant hospital, medical, or other records or materials
30 relating to the health care in issue. The advisor [PANEL] may meet in camera, but
31 shall maintain a record of any testimony or oral statements of witnesses, and shall keep

1 copies of all written statements received [IT RECEIVES].

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

5 (1) What was the disorder for which the plaintiff came to medical care?

6 (2) What would have been the probable outcome without medical care?

7 (3) Was the treatment selected appropriate for the case?

8 (4) Did an injury arise from the medical care?

9 (5) What is the nature and extent of the medical injury?

10 (6) What specifically caused the medical injury?

11 (7) Was the medical injury caused by unskillful care?

12 (8) If a medical injury had not occurred, how would the plaintiff's
13 condition differ from the plaintiff's present condition?

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

30 (e) The report of the advisor [PANEL WITH ANY DISSENTING OR
31 CONCURRING OPINION] is admissible in evidence to the same extent as though its

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

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

14 (g) The expert advisor is [MEMBERS OF A PANEL ARE] entitled to a fee
15 of \$500 and travel expenses and per diem in accordance with state law pertaining to
16 members of boards and commissions for all time spent in preparing its report. If an
17 advisor [A PANEL MEMBER] is called upon as a witness at trial or upon deposition,
18 the advisor [MEMBER] is entitled to payment of an expert witness fee, which may
19 not exceed \$300 [\$150] per day. All expenses incurred by the advisor [PANEL] shall
20 be paid by the court. However, in any case in which the court determines that a party
21 has made a patently frivolous claim or a patently frivolous denial of liability, it shall
22 order that all costs of the expert advisor [ADVISORY PANEL] be borne by the party
23 making that claim or denial.

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

28 * Sec. 7. AS 21.51 is amended by adding a new section to read:

29 Sec. 21.51.350. PREMIUM RATES AND RATING FACTORS. (a) A
30 disability insurer

31 (1) shall file with the director rates or rating factors for disability

1 insurance at least 90 days before the intended effective date of the rate or rating factor;
2 and

3 (2) may not use a rate or rating factor that has not been filed with the
4 director as required under this subsection.

5 (b) A rate or rating factor not disapproved by the director before the intended
6 effective date of the rate or rating factor is considered approved by the director.

7 * Sec. 8. 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 periodically update a health
20 care data system. To the extent practicable, the data system base year shall be
21 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, including patient diagnosis, type of provider,
26 type of service, location and length of care, referral patterns, quality of care, and result
27 of care;

28 (4) billing and payment data; and

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

30 (b) The commissioner may, by regulation, require health care providers to
31 submit claims data and additional information necessary to develop or update the data

1 system required under (a) of this section.

2 (c) The commissioner may pursue waivers from applicable federal law or from
3 federal agencies to the extent necessary to maximize the collection and analysis of
4 health care data.

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

14 (e) Information or data regarding health care services

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

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

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

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

28 Sec. 21.58.040. **APPROPRIATIONS.** The legislature may appropriate a
29 portion of the proceeds of the tax on insurance premiums collected under
30 AS 21.09.210 to pay the administrative costs of this chapter.

31 Sec. 21.58.400. **DEFINITIONS.** In this chapter,

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

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

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

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

31 (5) "health insurance company" means an insurer that is authorized to

1 transact health insurance.

2 * Sec. 9. AS 21.86.070(g) is amended to read:

3 (g) The director may require that additional relevant material considered
4 necessary by the director be submitted in order to determine the acceptability of a
5 filing made under [EITHER] (b) [OR (e)] of this section.

6 * Sec. 10. AS 21.86 is amended by adding a new section to read:

7 Sec. 21.86.075. PREMIUM RATES AND CHARGES. (a) A health
8 maintenance organization

9 (1) shall file with the director rates, rating factors, premiums, fees for
10 services, and enrollee fees, including a change to a rate, rating factor, premium, or fee,
11 used in providing health care services to enrollees of the health maintenance
12 organization; a filing required under this paragraph must be made at least 90 days
13 before the intended effective date of the filing; and

14 (2) may not use a rate, rating factor, premium, or fee that has not been
15 filed with the director as required under this subsection.

16 (b) A filing under this section not disapproved by the director before its
17 intended effective date is considered approved by the director.

18 * Sec. 11. AS 21.86.260(a) is amended to read:

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

25 * Sec. 12. AS 21.87.190 is repealed and reenacted to read:

26 Sec. 21.87.190. RATES AND CHARGES. (a) A service corporation

27 (1) shall file with the director subscription rates, rating factors, fees,
28 and payment charges, including a change to a rate, rating factor, fee, or payment
29 charge, to be charged to or on account of the service corporation's subscribers; a filing
30 required under this paragraph must be made at least 90 days before the intended
31 effective date of the filing; and

1 (2) may not use a rate, rating factor, fee, or payment charge that has
2 not been filed with the director as required under this subsection.

3 (b) A filing under this section not disapproved by the director before its
4 intended effective date is considered approved by the director.

5 * Sec. 13. AS 21.87.340 is amended to read:

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

12 (1) AS 21.03;

13 (2) AS 21.06;

14 (3) AS 21.09, except AS 21.09.090;

15 (4) AS 21.18.010;

16 (5) AS 21.18.030;

17 (6) AS 21.18.040;

18 (7) AS 21.18.120;

19 (8) AS 21.21.321;

20 (9) AS 21.36;

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

22 (11) AS 21.51.120;

23 (12) AS 21.53;

24 (13) AS 21.54.020;

25 (14) AS 21.56;

26 (15) AS 21.69.400;

27 (16) AS 21.69.520;

28 (17) AS 21.69.600, 21.69.620, and 21.69.630;

29 (18) AS 21.78;

30 (19) AS 21.89.040;

31 (20) AS 21.89.060 and 21.89.100 - 21.89.120;

1 (21) AS 21.90.

2 * **Sec. 14.** AS 21.89 is amended by adding new sections to read:

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

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

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

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

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

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

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

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

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

31 (C) benefits not determined under this paragraph that are

1 applicable under more than one plan are determined under that plan applicable
2 to the insured for the longer period of time;

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

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

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

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

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

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

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

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

30 (A) its allowed benefit for the service;

31 (B) the difference between the primary plan's benefits for the

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31

service and the health care provider's full fee;

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

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

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

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

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

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

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

Sec. 21.89.110. **DETERMINATION AND DISCLOSURE OF USUAL, CUSTOMARY, AND REASONABLE FEES.** An insurer who pays a claim under a disability policy or an indemnity under a group or blanket disability insurance policy, a health maintenance organization that adopts a schedule of charges, or a hospital or medical service corporation that pays a subscriber or compensates a health care

1 provider on the basis of a usual, customary, or reasonable fee or charge shall

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

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

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

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

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

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

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

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

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

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

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

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

13 * Sec. 15. AS 28.33.030(a) is amended to read:

14 (a) A person commits the crime of operating a commercial motor vehicle while
15 intoxicated if the person operates a commercial motor vehicle

16 (1) while under the influence of intoxicating liquor or any controlled
17 substance;

18 (2) when, as determined by a chemical test taken within four hours
19 after the alleged offense was committed, there is at the time the test is taken 0.04
20 percent or more by weight of alcohol in the person's blood or 40 milligrams or more
21 of alcohol per 100 milliliters of blood, or when there is 0.04 grams or more of alcohol
22 per 210 liters of the person's breath; or

23 (3) while under the combined influence of intoxicating liquor and a
24 controlled substance.

25 * Sec. 16. AS 28.35.030(a) is amended to read:

26 (a) A person commits the crime of driving while intoxicated if the person
27 operates or drives a motor vehicle or operates an aircraft or a watercraft

28 (1) while under the influence of intoxicating liquor, or any controlled
29 substance;

30 (2) when, as determined by a chemical test taken within four hours
31 after the alleged offense was committed, there is at the time the test is taken 0.08

1 [0.10] percent or more by weight of alcohol in the person's blood or 80 [100]
2 milligrams or more of alcohol per 100 milliliters of blood, or when there is 0.08 [0.10]
3 grams or more of alcohol per 210 liters of the person's breath; or

4 (3) while the person is under the combined influence of intoxicating
5 liquor and a controlled substance.

6 * Sec. 17. AS 28.35.033(a) is amended to read:

7 (a) Upon the trial of a civil or criminal action or proceeding arising out of acts
8 alleged to have been committed by a person while operating or driving a motor vehicle
9 or operating an aircraft or a watercraft while intoxicated, the amount of alcohol in the
10 person's blood or breath at the time alleged shall give rise to the following
11 presumptions:

12 (1) If there was 0.04 [0.05] percent or less by weight of alcohol in the
13 person's blood, or 40 [50] milligrams or less of alcohol per 100 milliliters of the
14 person's blood, or 0.04 [0.05] grams or less of alcohol per 210 liters of the person's
15 breath, it shall be presumed that the person was not under the influence of intoxicating
16 liquor.

17 (2) If there was in excess of 0.04 [0.05] percent but less than 0.08
18 [0.10] percent by weight of alcohol in the person's blood, or in excess of 40 [50] but
19 less than 80 [100] milligrams of alcohol per 100 milliliters of the person's blood, or
20 in excess of 0.04 [0.05] grams but less than 0.08 [0.10] grams of alcohol per 210 liters
21 of the person's breath, that fact does not give rise to any presumption that the person
22 was or was not under the influence of intoxicating liquor, but that fact may be
23 considered with other competent evidence in determining whether the person was
24 under the influence of intoxicating liquor.

25 (3) [REPEALED]

26 (4) If there was 0.08 [0.10] percent or more by weight of alcohol in
27 the person's blood, or 80 [100] milligrams or more of alcohol per 100 milliliters of the
28 person's blood, or 0.08 [0.10] grams or more of alcohol per 210 liters of the person's
29 breath, it shall be presumed that the person was under the influence of intoxicating
30 liquor.

31 * Sec. 18. AS 28.35.033(c) is amended to read:

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31

(c) The provisions of (a) of this section

(1) may not be construed to limit the introduction of any other competent evidence bearing upon the question of whether the person was or was not under the influence of intoxicating liquor; and

(2) do not apply to a civil action permitted under AS 04.21.020.

* Sec. 19. AS 43.50.190(a) is amended to read:

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

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

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

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

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

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

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

- (1) AS 21.03
- (2) AS 21.06
- (3) AS 21.09, except AS 21.09.090
- (4) AS 21.18.010
- (5) AS 21.18.030
- (6) AS 21.18.040
- (7) AS 21.18.120

- 1 (8) AS 21.21.321
- 2 (9) AS 21.36
- 3 (10) AS 21.42.345 - 21.42.365, 21.42.375, 21.42.380, and 21.42.385
- 4 (11) AS 21.51.120
- 5 (12) AS 21.53
- 6 (13) AS 21.54.020
- 7 (14) AS 21.69.400
- 8 (15) AS 21.69.520
- 9 (16) AS 21.69.600, 21.69.620, and 21.69.630
- 10 (17) AS 21.78
- 11 (18) AS 21.89.040
- 12 (19) AS 21.89.060 and 21.89.100 - 21.89.120
- 13 (20) AS 21.90.

14 * Sec. 22. APPLICABILITY. Sections 11, 13, and 14 of this Act apply to a policy of
15 insurance, evidence of coverage under AS 21.86, or a service agreement or subscriber's
16 contract under AS 21.87, issued or renewed on or after the effective date of this Act.

17 * Sec. 23. HEALTH CARE PLAN ADVISORY COMMITTEE. (a) The legislature finds
18 that it is necessary to have reliable information on the specific content and cost of any
19 proposed mandatory health care plan, before it can be taken to the public for review. The
20 legislature further finds that questions of a single payer system versus a multi payer system
21 for any mandatory coverage, and questions regarding inclusion or exclusion of certain groups
22 of Alaskans who are covered by other federal health insurance, are not prejudiced by the
23 direction given to the advisory committee created in this section.

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

- 27 (1) one person with experience in providing health care services on an inpatient
28 basis;
- 29 (2) one person with experience in providing health care services on an
30 outpatient basis;
- 31 (3) one person with experience as a health care provider;

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

3 (5) one person who has experience in health care insurance; and

4 (6) two persons who represent the public.

5 (c) Notwithstanding any other provision of law, a committee member is subject to the
6 provisions of AS 39.50 as if the committee member were a member of a state commission or
7 board described under AS 39.50.200(b).

8 (d) A committee member is entitled to receive compensation at the rate of \$400 a day
9 for each day spent in performing duties as a committee member and to travel and per diem
10 expenses authorized by law for boards and commissions under AS 39.20.180.

11 (e) The committee may

12 (1) establish subcommittees;

13 (2) conduct hearings;

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

15 (4) enter into contracts;

16 (5) subject to appropriation, expend money.

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

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

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

25 (3) coverage shall be designed to impose a family deductible of \$3,000 for all
26 covered health care services other than prenatal care, preventive care, and immunizations, and
27 to allow reimbursement in a calendar year at not more than 80 percent for all covered health
28 care services, other than prenatal care, preventive care, and immunizations, after the first
29 \$3,000 in covered expenses; prenatal care, preventive care, and immunizations may be
30 reimbursed at more than 80 percent for a covered expense; coverage for health care services
31 that are offered on an outpatient basis shall provide reimbursement for outpatient health care

1 services at a rate equal to or higher than the rate for inpatient services;

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

3 (A) a surcharge for coverage of each dependent child or spouse may
4 be imposed; a surcharge may not exceed 50 percent of the individual premium; it is
5 the intent of the legislature that the premium be set at a rate that does not exceed \$100
6 per month or 14 percent of the individual's monthly gross income, whichever is lower;

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

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

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

15 (1) the cost of providing health insurance coverage under the following
16 conditions:

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

19 (B) additional medical benefits are included as recommended by the
20 committee;

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

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

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

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

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

30 (A) allow integration of optional health insurance plans with the
31 mandatory insurance plan; the integration should allow an individual or group to

- 1 purchase supplemental insurance coverage without duplication of coverage; and
- 2 (B) discourage health insurance that reimburses covered benefits at a
- 3 rate greater than 80 percent of the cost of the benefits;
- 4 (4) recommended legislation regarding public health issues;
- 5 (5) recommended legislation to simplify health care administration;
- 6 (6) recommended legislation regarding antitrust changes necessary to allow the
- 7 use of pooled purchasing to reduce the cost of health care if required under federal law;
- 8 (7) recommended legislation to enact tort reform measures intended to reduce
- 9 the cost of health care, including changes to statutes of limitation, contingent fee agreements,
- 10 and to the Alaska Rules of Civil Procedure;
- 11 (8) recommended legislation regarding long-term health care, including
- 12 methods to encourage individual savings for the cost of long-term health care;
- 13 (9) recommended legislation regarding how the state should educate residents
- 14 on health care, including how to be a prudent consumer, increasing awareness of provider
- 15 charges, and a curriculum that should be used in public schools in the state.
- 16 (h) By December 15, 1995, the committee shall recommend to the legislature
- 17 legislation necessary to improve data collection used to control health care expenditures or to
- 18 improve the efficiency of the health care system in the state.
- 19 (i) In this section, "health care provider" has the meaning given in AS 21.58.400.
- 20 * Sec. 24. MEDICAL PRACTICE ADVISORY COMMITTEE. (a) The Medical Practice
- 21 Advisory Committee is established in the Office of the Governor. The committee consists of
- 22 four members who are appointed by the governor as follows:
- 23 (1) two persons licensed under AS 08.64;
- 24 (2) one person who is a health care provider licensed under AS 08 but who
- 25 is not licensed under AS 08.64; and
- 26 (3) one person who is a health care provider licensed under AS 08 and who
- 27 practices in a rural area of the state.
- 28 (b) Notwithstanding any other provision of law, a committee member is subject to the
- 29 provisions of AS 39.50 as if the committee member were a member of a state commission or
- 30 board described under AS 39.50.200(b).
- 31 (c) A committee member is entitled to receive compensation at the rate of \$400 a day

1 for each day spent in performing duties as a committee member and to travel and per diem
2 expenses authorized by law for boards and commissions under AS 39.20.180.

3 (d) The committee may

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

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

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

13 (2) medical practice parameters intended to reduce or eliminate medical
14 malpractice claims;

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

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

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

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

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

26 * Sec. 25. Alaska Rule of Civil Procedure 72.1 is repealed.

27 * Sec. 26. AS 21.86.070(e) and 21.86.070(f) are repealed.

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

1 incurred in the court proceeding, and by providing that the provisions of AS 09.55.535(f)
2 apply notwithstanding a different result required under an Alaska Rule of Civil Procedure
3 relating to an offer of judgment.

4 * Sec. 28. AS 09.55.536(f), amended by sec. 6 of this Act, amends Alaska Rules of Civil
5 Procedure 26 and 27 by providing that discovery may not be undertaken until the expert
6 advisor's report is received.

7 * Sec. 29. AS 09.55.536(e), amended by sec. 6 of this Act, amends Alaska Rules of
8 Evidence 802, 803, and 804 by providing that the expert advisor's report is admissible in
9 evidence to the same extent as though its contents were orally testified to by the advisor.

10 * Sec. 30. Section 25 of this Act takes effect July 1, 1994, only if that section receives the
11 two-thirds majority vote of each house required by art. IV, sec. 15, Constitution of the State
12 of Alaska.

13 * Sec. 31. Sections 23 and 24 of this Act are repealed June 30, 1996.

14 * Sec. 32. This Act takes effect July 1, 1994.