

CS FOR SENATE BILL NO. 367(FIN)
IN THE LEGISLATURE OF THE STATE OF ALASKA
EIGHTEENTH LEGISLATURE - SECOND SESSION

BY THE SENATE FINANCE COMMITTEE

Offered: 4/29/94
Referred: Rules

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

A BILL

FOR AN ACT ENTITLED

1 "An Act prohibiting a civil action based on professional negligence against a
2 health care provider by a person who on the date of the negligent act or
3 omission is less than two years of age, unless the action is brought before the
4 person's eighth birthday; relating to health insurance fees, charges, premiums,
5 rates, and rating factors; relating to disclosure of health care provider prices, a
6 health care data system, and uniform data and procedures for health care billing
7 and payment of claims; relating to coordination of insurance benefits and to
8 determination and disclosure of fees paid to an insured or health care provider;
9 establishing an advisory committee on a health care plan and an advisory
10 committee on public health; and providing for an effective date."

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

12 * Section 1. AS 09.10 is amended by adding a new section to read:

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

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

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

11 (2) intentional concealment; or

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

15 (c) In this section,

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

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

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

23 * **Sec. 2.** AS 21.51 is amended by adding a new section to read:

24 **Sec. 21.51.350. PREMIUM RATES AND RATING FACTORS.** A disability
25 insurer

26 (1) shall file with the director rates or rating factors for disability
27 insurance before the intended effective date of the rate or rating factor;

28 (2) may not use a rate or rating factor that has not been filed with the
29 director; and

30 (3) may file a new rate or rating factor at any time.

31 * **Sec. 3.** AS 21 is amended by adding a new chapter to read:

1 confidential information or data in violation of this subsection is guilty of a class B
2 misdemeanor.

3 (d) Information or data regarding health care services

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

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

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

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

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

20 Sec. 21.58.400. DEFINITIONS. In this chapter,

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

23 (2) "health care provider" means an acupuncturist licensed under
24 AS 08.06; an audiologist licensed under AS 08.11; a chiropractor licensed under
25 AS 08.20; a dental hygienist licensed under AS 08.32; a dentist licensed under
26 AS 08.36; a marital or family therapist licensed under AS 08.63; a direct-entry
27 midwife certified under AS 08.65; a nurse licensed under AS 08.68; a dispensing
28 optician licensed under AS 08.71; a naturopath licensed under AS 08.45; an
29 optometrist licensed under AS 08.72; a pharmacist licensed under AS 08.80; a physical
30 therapist or occupational therapist licensed under AS 08.84; or a physician's assistant
31 certified under AS 08.64; a physician licensed under AS 08.64; a podiatrist; a

1 psychologist and a psychological associate licensed under AS 08.86; a clinical social
2 worker licensed under AS 08.95; an emergency medical technician certified under
3 AS 18.08.082; a mobile intensive care paramedic trained as required under
4 AS 18.08.082; a health maintenance organization as defined in AS 21.86.900; a
5 hospital or medical service corporation as defined in AS 21.87.330; a hospital as
6 defined in AS 18.20.130, including a governmentally owned or operated hospital; and
7 an employee of a health care provider acting within the course and scope of
8 employment;

9 (3) "health care services" means preventive, diagnostic, medical,
10 surgical, reproductive, psychiatric, psychologic, rehabilitative, health maintenance,
11 dental, podiatric, optometric, optical, audiologic, nutritive, and chiropractic care;
12 prescription drugs, laboratory and radiologic services, medical supplies, durable
13 medical equipment and devices; personal assistance services; inpatient and outpatient
14 care; home health care; hospice care; and long-term or institutional care;

15 (4) "health insurance" means an individual or group contract or other
16 plan providing coverage of health care services that is issued by the corporation or by
17 a health insurance company, a hospital service corporation, a medical service
18 corporation, or a health maintenance organization; "health insurance" includes disability
19 insurance under AS 21.12.050;

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

22 * Sec. 4. AS 21.86.070(g) is amended to read:

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

26 * Sec. 5. AS 21.86 is amended by adding a new section to read:

27 Sec. 21.86.075. **PREMIUM RATES AND CHARGES.** A health maintenance
28 organization

29 (1) shall file with the director rates, rating factors, premiums, fees for
30 services, and enrollee fees, including a change to a rate, rating factor, premium, or fee,
31 used in providing health care services to enrollees of the health maintenance

1 organization;
2 (2) may not use a rate, rating factor, premium, or fee that has not been
3 filed with the director; and
4 (3) may use a new rate, rating factor, premium, or fee at any time.

5 * Sec. 6. AS 21.86.260(a) is amended to read:

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

12 * Sec. 7. AS 21.87.190 is repealed and reenacted to read:

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

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

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

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

21 * Sec. 8. AS 21.87.340 is amended to read:

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

28 (1) AS 21.03;

29 (2) AS 21.06;

30 (3) AS 21.09, except AS 21.09.090;

31 (4) AS 21.18.010;

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

18 * Sec. 9. AS 21.89 is amended by adding new sections to read:

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

26 (b) A plan that provides for coordination of benefits must contain a provision
27 that

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

30 (2) states what benefits from the plan and other sources are recognized
31 under the coordinating provision and that indicates if one or more plan benefits are

1 exempt from the coordinating provision;

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

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

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

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

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

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

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

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

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

30 (7) allows the insurer to make a payment necessary to repay another
31 insurer for a payment that should have been made under the policy applicable to the

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insured; and

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

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

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

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

(A) its allowed benefit for the service;

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

1 care provider are secondary coverage;

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

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

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

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

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

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

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

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

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

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

17 Sec. 21.89.120. DEFINITIONS FOR AS 21.89.100 - 21.89.120. In
18 AS 21.89.100 - 21.89.120,

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

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

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

24 (4) "professional services contract" includes a contract for professional
25 services between a health care provider and insurer or health maintenance corporation,
26 and a service contract between a health care provider and a hospital or medical service
27 corporation;

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

29 * Sec. 10. Section 7, ch. 39, SLA 1993, is amended to read:

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

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

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

6 * Sec. 11. Section 9, ch. 39, SLA 1993, is amended to read:

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

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

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

1 (19) AS 21.89.060 and 21.89.100 - 21.89.120

2 (20) AS 21.90.

3 * Sec. 12. AS 21.86.070(e) and 21.86.070(f) are repealed.

4 * Sec. 13. APPLICABILITY. Sections 6, 8, and 9 of this Act apply to a policy of
5 insurance, evidence of coverage under AS 21.86, or a service agreement or subscriber's
6 contract under AS 21.87, issued or renewed on or after the effective date of this Act.

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

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

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

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

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

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

23 (5) three persons who represent the public.

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

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

30 (e) The committee may

31 (1) establish subcommittees;

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

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

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

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

13 (3) coverage shall be designed to impose a family deductible of \$3,000 for all
14 covered health care services other than prenatal care, preventive care, and immunizations, and
15 to allow reimbursement in a calendar year at not more than 80 percent for all covered health
16 care services, other than prenatal care, preventive care, and immunizations, after the first
17 \$3,000 in covered expenses; prenatal care, preventive care, and immunizations may be
18 reimbursed at more than 80 percent for a covered expense; coverage for health care services
19 that are offered on an outpatient basis shall provide reimbursement for outpatient health care
20 services at a rate equal to or higher than the rate for inpatient services;

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

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

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

30 (5) a one-year exclusion for preexisting conditions for new enrollees is
31 imposed; this paragraph does not apply to a person who has resided in the state for at least

1 one year, or who is less than one year old and was born in this state.

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

3 (1) the cost of providing health insurance coverage under the following
4 conditions:

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

7 (B) additional medical benefits are included as recommended by the
8 committee;

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

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

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

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

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

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

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

25 (4) recommended legislation regarding public health issues;

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

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

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

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

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

6 (h) By December 15, 1995, the committee shall recommend to the legislature
7 legislation necessary to improve data collection used to control health care expenditures or to
8 improve the efficiency of the health care system in the state.

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

10 * **Sec. 15. PUBLIC HEALTH ADVISORY COMMITTEE.** (a) The Public Health
11 Advisory Committee is established in the Office of the Governor. The committee consists of
12 nine members with significant public health expertise who are appointed by the governor. The
13 governor shall consider public and private health care professionals, labor organizations,
14 businesses, the education system, the Alaska Public Health Association, the Alaska Mental
15 Health Board, and the Alaska Native Health Board for service on the Public Health Advisory
16 Committee, as well as recognizing the need for geographic, ethnic, and cultural diversity.

17 (b) A committee member is entitled to travel and per diem expenses authorized by law
18 for boards and commissions under AS 39.20.180.

19 (c) The committee may

- 20 (1) establish subcommittees;
21 (2) conduct hearings;
22 (3) employ personnel necessary to complete assigned duties;
23 (4) enter into contracts;
24 (5) subject to appropriation, expend money.

25 (d) The committee shall

26 (1) advise the commissioner of health and social services, the commissioner
27 of administration, and the commissioner of commerce and economic development on public
28 health matters;

29 (2) develop a public health improvement plan as described under (e) of this
30 section.

31 (e) The plan developed by the committee may

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(1) recognize the need for

- (A) community involvement in health care planning and delivery;
- (B) attention to local needs that may vary from place to place;
- (C) accountability for the use of public funds;
- (D) equity and stability in the distribution of public funds;
- (E) shared responsibility of all levels of government for administering and financing public health care delivery; and
- (F) coordination of basic public health services; and

(2) include

- (A) an analysis of the health status of the residents of the state;
- (B) an assessment of the most appropriate role for various levels of government to play in addressing the health care needs of the residents of the state;
- (C) a delineation of the standards that should be used in assessment, policy development, and quality assurance in the delivery of public health services;
- (D) documentation of the extent to which the current public health system implements or achieves the standards identified under (C) of this paragraph;
- (E) identification of interjurisdictional issues involved in health care access and delivery;
- (F) recommendations, including recommendations for specific legislative action when necessary, pertaining to the following:
 - (i) strategies, time lines, financial needs, and specific sources of stable revenue for bringing the state public health care system up to standards identified by the committee;
 - (ii) appropriate sharing of the responsibility of local, regional, state, and federal government entities to deliver public health care services efficiently and effectively, including recommendations for organization within state government;
 - (iii) integration of the public health care system with state and national health care reform efforts;
 - (iv) the committee's estimate of the optimal share that public health should represent in the total health care delivery system of the state,

1 expressed in terms of a percentage of health care dollars spent or in terms of
2 public dollars per state resident;

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

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

7 * **Sec. 16.** Sections 14 and 15 of this Act are repealed June 30, 1996.

8 * **Sec. 17.** This Act takes effect July 1, 1994.