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FISCAL NOTE

STATE OF ALASKA
1994 LEGISLATIVE SESSION

No. 1
Bill Version: HB 414
(H) Publish Date: 1/28/94

Revision Date: _____
Title: "An Act creating the Alaska Health Commission..."
Sponsor: Senate Rules Committee
Requestor: Governor

Department Affected: Office of the Governor
BRU: Commissions and Special Offices
Component: Alaska Health Commission

COMPONENT SERIAL NO. _____

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 95	FY 96	FY 97	FY 98	FY 99	FY 00
PERSONAL SERVICES	580.2	616.3	626.0	636.5	646.7	657.9
TRAVEL	17.0	17.0	17.0	17.0	17.0	17.0
CONTRACTUAL	226.3	226.3	226.3	226.3	226.3	226.3
SUPPLIES	8.0	8.0	8.0	8.0	8.0	8.0
EQUIPMENT	54.3	.5	.5	.5	.5	.5
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	885.8	868.1	877.8	888.3	898.5	909.7

CAPITAL EXPENDITURES						
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CHANGE IN REVENUES ()						
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FUND SOURCE	FY 95	FY 96	FY 97	FY 98	FY 99	FY 00
1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts	885.8	868.1	877.8	888.3	898.5	909.7
1006 EXHIBITA						
OTHER						
TOTAL	885.8	868.1	877.8	888.3	898.5	909.7

POSITIONS	FY 95	FY 96	FY 97	FY 98	FY 99	FY 00
FULL-TIME	9	9	9	9	9	9
PART-TIME						
TEMPORARY						

Estimate of any current year (FY94) cost: 0

ANALYSIS: (Attach a separate page if necessary.)
See attached analysis

Prepared by: Michael A. Nizich, Director *MN*
Division: Division of Administrative Services

Phone: 465-3876
Date: 1/27/94

Approved by Commissioner: Patrick P. Ryan, Chief of Staff *Patrick P. Ryan*
Agency: Office of the Governor

Date: 1/27/94

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PERSONAL SERVICES

580.2

Fiscal note assumes Commissioners appointments on 7/1/94 and provides for 11 months of staff within first year. Subsequent years include merit increases for staff.

3	Commissioners	Rg. 26C	290.7
1	Special Assistant	Rg. 23A	70.9
3	Research Analysts	Rg. 18A	155.9
1	Secretary I	Rg. 10A/B	32.9
1	Clerk Typist III	Rg. 08A/B	29.8

TRAVEL

17.0

Travel costs and per diem associated with Commission activities -- research, investigation, public hearings

CONTRACTUAL

226.3

Professional Services:

technical/legal assistance contracts	150.0
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Communication:

Telephone (toll costs, base/local fixed costs, fax postage) 900/mo x 12	10.8
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Advertising, Printing:

Public hearing advertising, report printing	5.0
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Transportation:

Freight and express charges 75/mo x 12	.9
--	----

Minor Repair, Maintenance:	.8
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Equipment rental:

Photocopier 600/mo x 12	7.2
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Rental for space:

1433 sq. ft. x \$3.00/ft x 12 mos.	<u>51.6</u>
	226.3

SUPPLIES

8.0

Data processing and office supplies

EQUIPMENT

54.3

Communication:

Phone system	4.0
Fax Machine	2.8
Mailing equipment	3.0

Data Processing Equipment:

PCs, system printer, software for 9 work stations	26.0
--	------

Furniture/Office equipment:

9 offices/work stations file cabinets, bookcases and miscellaneous office equipment	<u>18.5</u> 54.3
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FISCAL NOTE

No. 2
 Bill Version: HB 414
 (H) Publish Date: 1/28/94

STATE OF ALASKA
 1994 LEGISLATIVE SESSION

Revision Date: _____
 Title: Creating the Alaska Health Commission
 Sponsor: _____
 Requestor: _____

Department Affected: Commerce and Economic Development
 BRU: Insurance
 Component: Operations
 COMPONENT SERIAL NO. 354

Expenditures/Revenues:

OPERATING EXPENDITURES	FY 95	FY 96	FY 97	FY 98	FY 99	FY 00
PERSONAL SERVICES	91.5	91.5	91.5	91.5	91.5	91.5
TRAVEL	1.6	1.6	1.6	1.6	1.6	1.6
CONTRACTUAL	20.0	20.0	20.0	20.0	20.0	20.0
SUPPLIES	2.0	2.0	2.0	2.0	2.0	2.0
EQUIPMENT	24.2	--	--	--	--	--
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	139.3	115.1	115.1	115.1	115.1	115.1

CAPITAL EXPENDITURES						
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CHANGE IN REVENUES ()						
------------------------	--	--	--	--	--	--

FUND SOURCE

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts	139.3	115.1	115.1	115.1	115.1	115.1
1006 GF/MHTIA						
Other						
TOTAL	139.3	115.1	115.1	115.1	115.1	115.1

Estimate of current year (FY 94) cost: \$ 0

POSITIONS

FULL-TIME	2.0	2.0	2.0	2.0	2.0	2.0
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary.)

Assumptions:

1. Staff will be located in Anchorage.
2. Office space will be \$1.50 per sq. ft. and 175 sq. ft. per position.
3. There will be two trips costing \$800 each.
4. The furniture and equipment is a one-time cost.

Prepared by: Joan Brown, Administrative Officer
 Division: Insurance

Phone: 465-2597
 Date: 1/26/94

Approved by Commissioner: Paul Fuhs
 Agency: Commerce and Economic Development

Date: 1-21-94

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COMMITTEE COPY

FISCAL NOTE

BILL NO. _____

STATE OF ALASKA
1994 LEGISLATIVE SESSION

ANALYSIS: (continued)

ALASKA HEALTH COMMISSION (CONTINUED)

Personal Services

Insurance Analyst III (Rates)	18A @ 12 months	\$58,168.15	
Clerk Typist III	8A/B @ 12 months	<u>33,333.67</u>	
			\$91,501.82

Travel

2 in-state trips @ \$800.00			1,600.00
-----------------------------	--	--	----------

Contractual

a. Office space rental for staff - \$6,400.00			
12 months x \$1.50 per sq. ft. x 175 sq. ft.			
@ position - \$3.2 per position			
b. Miscellaneous contractual costs \$13,600.00 -			
\$6.8 per position			
Total Contractual			20,000.00

Supplies

\$1.0 per position			2,000.00
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Equipm

\$12.1 per position for office furniture and computer equipment			<u>24,200.00</u>
---	--	--	------------------

TOTAL			<u>\$139,301.82</u>
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Position Title Clerk-Typist III		No. of Positions 1	Range / Step 8A/B	Barg. Unit CCU
Time Status PFT	Staff Months 12	Location Anchorage		Election District 99
TYPE OF EXPENDITURE		AMOUNT		
Salary	22.3	Justification Additional clerical staff will be needed to support the insurance analysts responsible for the review of health insurance rates and forms. <u>Contractual</u> Office space expense 3,200 Miscellaneous 6,800 10,000 <u>Supplies</u> 1,000 <u>Equipment</u> Workstation, computers, and misc. office equipment 12,100		
Benefits	11.0			
Premium Pay				
Other				
Total Personal Services	33.3			
Travel				
Contractual	10.0			
Commodities	1.0			
Equipment	12.1			
Other				
Total Cost	56.4			
FUNDING SOURCE FOR TOTAL COST				
Federal Receipts	1002			
G.F. Match	1003			
General Fund	1004			
I-A Receipts	1007			
CIP Receipts	1061			
Other	1005 GF/PR	56.4		

014.bro

Request For New Position

AGENCY Commerce and Economic Development
BRU Insurance
COMPONENT Operations #354

FY 95

Page 4 of 4
Revised Date: _____

HOUSE COMMITTEE REPORT

(9)

Date Referred: January 28, 1994

FURTHER REFERRALS:

Judiciary
Finance

Date of Committee Action: 3/23/94

The HEALTH, EDUCATION AND SOCIAL SERVICES Committee considered: HB 414
 HOUSE BILL NO. 414 COMPREHENSIVE HEALTH CARE
 "An Act creating the Alaska Health Commission; relating to the delivery, quality, access, and financing of health care; relating to review and approval of rates and charges of health insurers; relating to certain civil actions against health care providers and health insurers; repealing Alaska Rule of Civil Procedure 72.1; and providing for an effective date."

RECOMMENDATIONS: the same title
 be replaced with CS HB 414 (HESS) a new title

- have attached amendments(s)
- do pass
- do not pass
- no recommendations
- individual recommendations
- additional referral to the _____ Committee

ADOPTS: _____ letter of Intent

ATTACHES NEW FISCAL NOTE(S): (Dept) _____ APPROVES PREVIOUS: (Dept/Date) _____
 fiscal impact Governor fiscal note(s) _____
 zero fiscal note Commerce zero fiscal note(s) _____

SIGNING <u>DO</u> PASS	DP	OTHER RECOMMENDATIONS	DNP	NR	AM
John D. ...	<input checked="" type="checkbox"/>	John D. ...		<input checked="" type="checkbox"/>	
		Tom ...		<input checked="" type="checkbox"/>	
		Tom ...		<input checked="" type="checkbox"/>	
		Harley Oliver		<input checked="" type="checkbox"/>	
		Benny ...			<input checked="" type="checkbox"/>
		Tom ...			<input checked="" type="checkbox"/>
		Tom ...			<input checked="" type="checkbox"/>

Car Brude
CHAIRMAN'S SIGNATURE

FISCAL NOTE

STATE OF ALASKA
1994 LEGISLATIVE SESSION

BILL NO. CSHB 414 (HESS)

Revision Date: 3/24/94
Title: "An Act creating the Alaska Health Commission..."
Sponsor: House Rules Committee
Requestor: Governor

Department Affected: Office of the Governor
BRU: Commissions and Special Offices
Component: Alaska Health Commission
COMPONENT SERIAL NO. _____

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 95	FY 96	FY 97	FY 98	FY 99	FY 00
PERSONAL SERVICES	640.2	820.9	884.0	907.4	931.1	956.6
TRAVEL	23.3	23.3	23.3	23.3	23.3	23.3
CONTRACTUAL	274.8	574.8	374.8	374.8	374.8	374.8
SUPPLIES	9.0	10.5	10.5	10.5	10.5	10.5
EQUIPMENT	65.6	10.0	.5	.5	.5	.5
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	1012.9	1439.5	1293.1	1316.5	1340.2	1365.7

CAPITAL EXPENDITURES						
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CHANGE IN REVENUES ()						
------------------------	--	--	--	--	--	--

FUND SOURCE

1002 Federal Receipts						
1003 GF Match						
GF/Program Receipts	1012.9	1439.5	1293.1	1316.5	1340.2	1365.7
1006 GF/MHTIA						
OTHER						
TOTAL	1012.9	1439.5	1293.1	1316.5	1340.2	1365.7

POSITIONS

FULL-TIME	11	13	13	13	13	13
PART-TIME						
TEMPORARY						

Estimate of any current year (FY94) cost: 0

ANALYSIS: (Attach a separate page if necessary.)
See attached analysis

Prepared by: Michael A. Nizich, Director
Division: Division of Administrative Services

Phone: 465-3876
Date: 3/24/94

Approved by Commissioner: Patrick P. Ryan, Chief of Staff
Agency: Office of the Governor

Date: 3/24/94

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PERSONAL SERVICES

640.2

Fiscal note assumes Commissioners appointments on 7/1/94 and provides for 11 months of staff hours and 6 months of two additional research analysts in first year. Subsequent years include merit increases for staff and the addition of a data base manager and a research analyst in FY96.

FY95:

3	Commissioners	Rg. 26C	290.7 (12 mos)
1	Special Assistant	Rg. 23A	70.9 (11 mos)
3	Research Analysts	Rg. 18A	155.9 (11 mos)
1	Secretary I	Rg. 10A/B	32.9 (11 mos)
1	Clerk Typist III	Rg. 08A/B	29.8 (11 mos)
2	Research Analysts	Rg. 18A	60.0 (6 mos)

FY96:

1	Data Base Mngr.	Rg. 22A	55.8 (9 mos)
1	Research Analyst	Rg. 17A	28.8 (6 mos)

TRAVEL

23.3

Travel costs and per diem associated with Commission activities -- research, investigation, public hearings

CONTRACTUAL

274.8

Professional Services:

technical/legal assistance contracts	150.0
data collection contract starting FY96 for 300.0, subsequent years	
100.0	

Communication:

Telephone (toll costs, base/local fixed costs, fax postage) 1000/mo x 12	12.0
Teleconference costs assuming all sites for 3 hrs. per month	31.5

Advertising, Printing:

Public hearing advertising, report printing	5.0
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(Contractual - continued)

Transportation:		
Freight and express charges 75/mo x 12	.9	
Minor Repair, Maintenance:	.8	
Equipment rental:		
Photocopier 600/mo x 12	7.2	
Rental for space:		
1873 sq. ft. x \$3.00/ft x 12 mos.	<u>67.4</u>	
	274.8	
SUPPLIES		9.0
Data processing and office supplies		
EQUIPMENT		65.6
Communication:		
Phone system	6.0	
Fax Machine	2.8	
Mailing equipment	3.0	
Data Processing Equipment:		
PCs, system printer, software for 11 work stations	31.8	
additional 2 workstations in FY96 total 6.0		
Furniture/Office equipment:		
11 offices/work stations file cabinets, bookcases and miscellaneous office equipment	22.0	
2 additional workstations in FY 96 total 3.5		
	<u>65.6</u>	

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To	EILEEN PLATE		
From	JAY LIVERY		
Co.			
Dept.			
Fax #	2135	Fax #	3068

FISCAL IMPACT OF PROPOSED AMENDMENTS TO SB 270/HB 414

Amendment 1: Public Health Committee

Assumptions:

Committee: has six members
 Assume staff work done by either Health Commission staff or
 Division of Public Health employees
 Committee meets 3 times per year in person (2 in FY 95)
 Committee has 4 additional teleconference meetings per year

	FY 95	FY 96 - FY 00
TRAVEL COST:	\$ 4,800	\$ 10,500 (each year)
CONTRACTUAL (Public Notice):	1,000	3,500 (each year)

Amendment 2: Single Payor Analysis

No Cost; Already assumed in original fiscal note

Amendment 3: Erisa Waiver:

Assumptions: Costs to be split between personnel and contracting
 line items. Requires one staff person to prepare application and
 possible contractual funds specialized assistance:

	FY 95	FY 96 - FY00
	\$ 100,000	\$ 100,000 →

Amendment 4: Pooling

No additional cost anticipated

Amendment 5: Disclosure of Prices

Assumptions: One research analyst is required to monitor
 compliance; travel included

	FY 95 (6 months)	FY 96 - FY00
Personnel	\$30,000	\$ 59,000 (inflate 5%)
Travel	1500	3000 ANNUALLY
Supplies	500	1000
Contractual	3.4	6.8
Equipment	12.1	0

A M E N D M E N T

In: House (Hes)

To: HB 414 "An Act Creating the Alaska Health Commission;....; and providing for an effective date."

Page 1, line 8 after "health care" add and maintenance of the public's health [IS] are vital to the public's interest.

Page 1, line 11 after "insurance" delete [, AND]

Page 1, line 12 after "malpractice" add and the lack of coordination of population based public health services.

Page 2, line 14 after "relating to" add the individual and public health care needs

Page 5, after line 6 add a new section (6) as follows:

- (6) Establish a Public Health Advisory Committee which
(A) consists of at least one member of the commission and other individuals with significant public health expertise appointed by the commission; and -
(B) Advises the commission on public health matters and the integration of public health services under AS 44.19.621.

AMENDMENT

IN: House (HES)
TO: HB 414 "An Act Creating the Alaska Health Commission;....; and providing for an effective date.

Page 2, line 23 after "proposals;" add "including a proposal which is based on a single payer strategy."

Page 8, after line 9 add a new section (9) as follows:

(9) "single payer strategy" means a method of financing health services so that every resident would receive at a minimum a uniform set of benefits and payment for services would be made primarily through a single entity.

Post-It™ brand fax transmittal memo 7671 # of pages > 1

To	EILEEN PLATE	From	IAU LIVEY
Co.	"URGENT"	So.	
Dept.		Phone #	
Fax #	2135	Fax #	3068

AMENDMENT

IN: House (HES)
TO: HB 414 "An Act Creating the Alaska Health Commission;...; and providing for an effective date.

Page 5, after line 6 add a new section (6) as follows:

(6) Pursue necessary federal waivers from applicable federal law or other federal health care payers to the extent necessary to maximize the collection and analysis of health care data.

FEB-25-94 FRI 9:25
FEB-25-94 FRI 9:33

ALASKA ATTORNEY GENERAL
ANCHORAGE AGO

FAX NO. 9074656735
FAX NO. 2763897

P. 02
P. 02/02

773-94-0024
8-GH2024.A
4/24/94

AMENDMENT

OFFERED IN THE HOUSE/SENATE

TO: HB 414/SB 270

Page 2, line 20:

Following "pools":

Insert ", including pools for the primary benefit of children,"

Page 13, line 5:

Following "pools":

Insert ", including pools for the primary benefit of children,"

Page 14, line 6

Following "pools":

Insert ", including pools for the primary benefit of children,"

Page 15, line 12:

Following "pools":

Insert ", including pools for the primary benefit of children,"

3/1/94

A M E N D M E N T

FOR CHARGE DISCLOSURE BY HEALTH PROVIDER
OFFERED IN THE HOUSE/SENATE

TO: HB 414
SB 270

Page 2, line 18:

Following "health":

Delete "insurance"

Insert "care"

Page 2, line 19:

Following "insurers":

Insert "and disclosure of charges by health providers"

Page 7, following line 22:

Insert a new section to read:

"Sec. 44.19.635. DISCLOSURE OF PROVIDER CHARGES; FINE FOR NONDISCLOSURE. (a) At least annually, a provider shall compile a list of charges for the 20 health care services most commonly provided by that provider. Charges for hospital services may be prepared on the basis of diagnosis related groups. Upon request of a person who is considering obtaining services from a provider, that provider shall provide the list of charges to the person for use in comparing charges among providers.

(b) Upon the request of a patient and before the commencement of a medical procedure, the provider shall disclose to that patient the estimated charge for that procedure. The estimated charge must be made in good faith and must be based on the provider's history of charges for that procedure. Nothing in this subsection requires a provider to make a charge estimate if the provider does not agree to perform the procedure.

(c) A provider shall place the following statement either on a form to be signed by the patient or in a conspicuous location on an easily readable sign: "You are entitled to a charge estimate for a medical procedure before the procedure is performed by your health provider."

(d) If the commission, after investigation of a complaint by a patient, determines that a provider has not complied with (a) of this section, has not provided a charge estimate as required by (b) of this section, or has failed to comply with (c) of this section, the commission may assess a fine of up to \$500 against the provider. The commission may assess only one fine under this section against a provider in a calendar year. A provider's violation of this section does not preclude the provider from collecting payment for services provided.

(e) A provider aggrieved by a decision of the commission under this section may appeal the decision to the superior court under procedures provided by court rule."

A M E N D M E N T

OFFERED IN THE HOUSE

BY REPRESENTATIVE KOTT

TO: HB 414

#2

Page ¹³2, line ²⁰27, after "~~1996~~,"
"state;"

Insert "a benefit package may not limit the covered health care services on the basis of a preexisting condition;"

DIVISION OF LEGAL SERVICES

LEGISLATIVE AFFAIRS AGENCY STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

130 Seward Street, Suite 409
Juneau, Alaska 99801-2105

MEMORANDUM

March 11, 1994

SUBJECT: Health care reform - (CSHB 414(HES))
TO: Representative Cynthia Toohey
FROM: Michael F. Ford *M.F. Ford*
Legislative Counsel

The attached work draft committee substitute contains the changes you requested to HB 414. The work draft also raises the following constitutional issues that the committee should carefully consider:

1. In sec. 25(b), the governor is permitted to extend certain deadlines on reports, recommendations and regulations. This provision probably constitutes an impermissible delegation of legislative authority, as well as a violation the constitutional separation of powers doctrine. Under our constitution, the legislature is given the power to legislate and the governor the power to execute law created by the legislature. Allowing the governor to change a deadline created by law may be a delegation of legislative authority that is not permissible under the state constitution.
2. In sec, 44.19.628(b), in sec. 16, the director of the division of insurance is allowed to adopt regulations that supersede a conflicting statutory provision in AS 21. This is also an unconstitutional delegation of legislative power. Again, the state constitution vests legislative power in the legislature, and the power to supersede existing law cannot be delegated to the director of the division of insurance.

Also please note that we have added court rule changes for AS 09.55.536(e) and (f). when AS 09.55.536 was enacted, changes to the discovery rules were noted, but since we are changing the panel to a single advisor and repealing the discovery limitation currently found in Civil Rule 72.1(g), we risk having AS 09.55.536(f) be ineffective without a court rule change. The change to the Evidence Rules 802 refers to statutory enactments, but because we are not sure whether that reference is to statutes enacted by a simple majority or only to statutes enacted by two-thirds, we are taking the cautious approach. In both cases, however, we have allowed the changes to become law, even if the two-thirds vote fails, because the need to change court rules is not absolutely certain in this case.

Please contact me if you have further questions.

JBC:gc
94-207.g1

8-GH2024E ✓
Ford
3/11/94

CS FOR HOUSE BILL NO. 414(HES)
IN THE LEGISLATURE OF THE STATE OF ALASKA
EIGHTEENTH LEGISLATURE - SECOND SESSION

BY THE HOUSE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

Offered:
Referred:

Sponsor(s): HOUSE RULES COMMITTEE BY REQUEST OF THE GOVERNOR

A BILL

FOR AN ACT ENTITLED

1 "An Act creating the Alaska Health Commission; relating to the delivery, quality,
2 access, and financing of health care; relating to review and approval of rates and
3 charges of health insurers; relating to certain civil actions against health care
4 providers and health insurers; amending Alaska Rules of Civil Procedure 26 and
5 27 and Alaska Rules of Evidence 802, 803, and 804; repealing Alaska Rule of
6 Civil Procedure 72.1; and providing for an effective date."

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

8 * Section 1. FINDINGS AND INTENT. (a) The legislature finds that the access to
9 quality and affordable health care and maintenance of the public's health are vital to the public
10 interest. The legislature further finds that health care costs have grown at a rate far in excess
11 of the overall inflation rate in the economy due to several factors, including variations in
12 treatment practices of providers, cost shifting by health care providers, administrative costs
13 of insurance claims practices, unavailability of affordable insurance, costs of increasing claims

1 and liability for medical malpractice, and lack of coordination of population based public
2 health services. The legislature therefore finds a present need for long-term reform of the
3 health care system in the state.

4 (b) It is the intent of the legislature to promote access to affordable, quality health
5 care for Alaskans by establishing a mechanism for the review of health insurance rate filings,
6 the implementation of health care reform measures, the stabilization of health care service
7 costs, the collection and analysis of information and data concerning health care services, and
8 the making of recommendations based on that data to the governor and the legislature.

9 * Sec. 2. AS 08.64.326 is amended to read:

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

13 (1) secured a license through deceit, fraud, or intentional
14 misrepresentation;

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

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

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

20 (A) a felony or other crime if the felony or other crime is
21 substantially related to the qualifications, functions, or duties of the licensee;
22 or

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

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

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

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

1 (8) has demonstrated

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

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

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

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

11 (10) has violated AS 18.16.010;

12 (11) has violated any code of ethics adopted by regulation by the board;

13 or

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

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

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

26 * Sec. 3. AS 08.68.270 is amended to read:

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

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

31 (2) has been convicted of a felony or other crime if the felony or other

1 crime is substantially related to the qualifications, functions or duties of the licensee;

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

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

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

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

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

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

14 (9) is professionally incompetent [;

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

19 * Sec. 4. AS 09.55.535 is repealed and reenacted to read:

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

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

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

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

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

7 (f) The provisions of AS 09.43.010 - 09.43.180 (Uniform Arbitration Act)
8 apply to an arbitration under this section to the extent the provisions do not conflict
9 with the provisions of this section.

10 * Sec. 5. AS 09.55.536 is amended to read:

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

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

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

- 1 (1) What was the disorder for which the plaintiff came to medical care?
- 2 (2) What would have been the probable outcome without medical care?
- 3 (3) Was the treatment selected appropriate for the case?
- 4 (4) Did an injury arise from the medical care?
- 5 (5) What is the nature and extent of the medical injury?
- 6 (6) What specifically caused the medical injury?
- 7 (7) Was the medical injury caused by unskillful care?
- 8 (8) If a medical injury had not occurred, how would the plaintiff's
- 9 condition differ from the plaintiff's present condition?

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

26 (e) The report of the advisor [PANEL WITH ANY DISSENTING OR
27 CONCURRING OPINION] is admissible in evidence to the same extent as though its
28 contents were orally testified to by the person [OR PERSONS] preparing it. The court
29 shall delete any portion that would not be admissible because of lack of foundation for
30 opinion testimony, or otherwise. Either party may submit testimony to support or
31 refute the report. The jury shall be instructed in general terms that the report shall be

1 considered and evaluated in the same manner as any other expert testimony. The
2 expert advisor [ANY MEMBER OF THE PANEL] may be called by any party and
3 may be cross-examined as to the contents of the report [OR OF THAT MEMBER'S
4 DISSENTING OR CONCURRING OPINION].

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

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

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

25 * Sec. 6. AS 09.55 is amended by adding a new section to read:

26 ARTICLE 5A. CERTAIN CLAIMS AGAINST HEALTH INSURERS.

27 Sec. 09.55.565. PROCEDURE FOR CERTAIN CLAIMS AGAINST A
28 HEALTH INSURER. (a) Unless preempted by federal law that provides otherwise,
29 a person who files an action against a health insurer resulting from a failure to timely
30 pay a claim or to authorize a health care service under a plan or policy shall also
31 submit the claim to the court for arbitration.

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

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

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

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

16 (f) The provisions of AS 09.43.010 - 09.43.180 (Uniform Arbitration Act)
17 apply to an arbitration under this section to the extent the provisions do not conflict
18 with the provisions of this section.

19 (g) In this section,

20 (1) "health care service" has the meaning given in AS 21.86.900;

21 (2) "health insurer" has the meaning given in AS 44.19.639.

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

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

30 (1) actuarial judgment;

31 (2) interpretation of the statistical data relied upon by the disability

1 insurer;

2 (3) the loss and expense experience of the policy or plan or a similar
3 policy or plan; or

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

5 (b) A filing shall be made at least 75 days before the intended effective date
6 of the rate or rating factor and is subject to the approval of the Alaska Health
7 Commission. Within 45 days after a filing under this section, the director shall review
8 the filing and make a written recommendation to the Alaska Health Commission as to
9 whether the commission should approve or disapprove the filing. This
10 recommendation is not an order of the director and is not appealable under
11 AS 21.06.230.

12 Sec. 21.51.360. RISK SHARING AND PURCHASING POOLS. After
13 consulting with and considering any reports or recommendations of the Alaska Health
14 Commission, the director shall adopt regulations to allow for the creation of pools,
15 including pools for the primary benefit of children, for the purpose of sharing risks or
16 purchasing insurance under this chapter.

17 * Sec. 8. AS 21.86.070(g) is amended to read:

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

21 * Sec. 9. AS 21.86 is amended by adding a new section to read:

22 Sec. 21.86.075. REVIEW AND APPROVAL OF RATES AND CHARGES.

23 (a) A health maintenance organization shall file with the director and the Alaska
24 Health Commission rates, rating factors, premiums, fees for services and enrollee fees,
25 including a change to such a rate, factor, premium, or fee, used in providing health
26 care services to enrollees of the health maintenance organization. The filing must
27 include detailed information that allows the director and the commission to evaluate
28 the appropriateness of the proposed rates, factors, premiums, and fees. A health
29 maintenance organization may furnish the following information in support of a filing:

30 (1) actuarial judgment;

31 (2) interpretation of the statistical data relied upon by the health

1 maintenance organization;

2 (3) the loss and expense experience of the policy or plan or a similar
3 policy or plan; or

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

5 (b) A filing required under this section shall be made at least 75 days before
6 the intended effective date of the rate, rating factor, premium, fee for services, or
7 enrollee fee and is subject to the approval of the Alaska Health Commission. Within
8 45 days after a filing under this section, the director shall review the filing and make
9 a written recommendation to the Alaska Health Commission as to whether the
10 commission should approve or disapprove the filing. This recommendation is not an
11 order of the director and is not appealable under AS 21.06.230.

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

13 Sec. 21.86.320. RISK SHARING AND PURCHASING POOLS. After
14 consulting with and considering any reports or recommendations of the Alaska Health
15 Commission, the director shall adopt regulations to allow for the creation of pools,
16 including pools for the primary benefit of children, for the purpose of sharing risks or
17 purchasing insurance under this chapter.

18 * Sec. 11. AS 21.87.190 is repealed and reenacted to read:

19 Sec. 21.87.190. REVIEW AND APPROVAL OF RATES AND CHARGES.

20 (a) Subscription rates, fees, and payments to be charged by a service corporation to
21 or on account of its subscribers may not be excessive, inadequate, or unfairly
22 discriminatory. Rates of payments to be made to participant providers and participant
23 hospitals for services rendered under a subscriber's contract must be fair and
24 reasonable.

25 (b) A service corporation shall file with the director and the Alaska Health
26 Commission subscription rates, rating factors, fees, and payments, including a change
27 to a rate, factor, fee, or payment, to be charged to or on account of the service
28 corporation's subscribers. The filing must include detailed information that allows the
29 director and the commission to evaluate the appropriateness of the proposed rates,
30 factors, fees, and payments. A service corporation may furnish the following
31 information in support of a filing:

- 1 (1) actuarial judgment;
- 2 (2) interpretation of the statistical data relied upon by the service
- 3 corporation;
- 4 (3) the loss and expense experience of the policy or plan or a similar
- 5 policy or plan; or
- 6 (4) other information or data requested by the director.

7 (c) A filing required under this section shall be made at least 75 days before
8 the intended effective date of the subscription rate, rating factor, fee, or payment and
9 is subject to the approval of the Alaska Health Commission. Within 45 days after a
10 filing under this section, the director shall review the filing and make a written
11 recommendation to the Alaska Health Commission as to whether the commission
12 should approve or disapprove the filing. This recommendation is not an order of the
13 director and is not appealable under AS 21.06.230.

14 (d) If a subscriber contract to be issued by the service corporation provides for
15 indemnity benefits and is permitted under this chapter, the service corporation shall
16 include in the rate, fee, or payment required of the subscriber an adequate additional
17 charge for the indemnity benefit, and shall separately set out the amount of the
18 additional charge in the filing required by this section and AS 44.19.629.

19 * Sec. 12. AS 21.87 is amended by adding a new section to read:

20 Sec. 21.87.285. RISK SHARING AND PURCHASING POOLS. After
21 consulting with and considering any reports or recommendations of the Alaska Health
22 Commission, the director shall adopt regulations to allow for the creation of pools,
23 including pools for the primary benefit of children, for the purpose of sharing risks or
24 purchasing insurance under this chapter.

25 * Sec. 13. AS 36.30.015 is amended by adding a new subsection to read:

26 (h) The Alaska Health Commission shall adopt regulations to manage the
27 procurement of supplies, services, and professional services necessary for its operations
28 under AS 44.19.620 - 44.19.639. The regulations must be based on principles of
29 competitive procurement, consistent with this chapter, to satisfy the requirements of
30 the Alaska Health Commission as determined by that commission.

31 * Sec. 14. AS 36.30.990(1) is amended to read:

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(1) "agency"

(A) means a department, institution, board, commission, division, authority, public corporation, the Alaska Pioneers' Home, or other administrative unit of the executive branch of state government;

(B) does not include

(i) the University of Alaska;

(ii) the Alaska Railroad Corporation;

(iii) the Alaska Housing Finance Corporation;

(iv) a regional Native housing authority created under AS 18.55.996 or a regional electrical authority created under AS 18.57.020;

(v) the Department of Transportation and Public Facilities, in regard to the repair, maintenance, and reconstruction of vessels, docking facilities, and passenger and vehicle transfer facilities of the Alaska marine highway system;

(vi) the Alaska Aerospace Development Corporation;

(vii) the Alaska State Pension Investment Board;

(viii) the Alaska Health Commission;

* Sec. 15. AS 39.25.110(11) is amended to read:

(11) the officers and employees of the following boards, commissions, and authorities:

(A) Alaska Gas Pipeline Financing Authority;

(B) Alaska Permanent Fund Corporation;

(C) Alaska Industrial Development and Export Authority;

(D) Alaska Commercial Fisheries Entry Commission;

(E) Alaska Commission on Postsecondary Education;

(F) Alaska Aerospace Development Corporation;

(G) Alaska Health Commission;

* Sec. 16. AS 44.19 is amended by adding new sections to read:

ARTICLE 12. ALASKA HEALTH COMMISSION.

Sec. 44.19.620. CREATION OF COMMISSION. The Alaska Health

1 Commission is created in the Office of the Governor.

2 Sec. 44.19.621. PURPOSE OF COMMISSION. The purpose of the
3 commission is to improve health care in this state by

4 (1) establishing and implementing a system for collecting and analyzing
5 information and data relating to the individual and public health care needs of and
6 services provided to residents of the state;

7 (2) promoting the use of electronic data transfer and the implementation
8 of uniform procedures for billing, payment, and claim systems;

9 (3) promoting consumer confidence in the health care system through
10 approval of rate filings by health insurers and disclosure of charges by health care
11 providers;

12 (4) promoting the creation of pools, including pools for the primary
13 benefit of children, for the purpose of sharing risks or purchasing insurance for health
14 care services; and

15 (5) analyzing health care reform proposals, including a proposal that
16 is based on a single payor system; recommending health care reform proposals to the
17 governor and the legislature; and reporting to and making recommendations to the
18 governor and legislature on the following:

19 (A) defining a range of potential benefit packages for universal
20 health care coverage for residents of the state;

21 (B) determining the needs and requirements imposed on the
22 state by federal enactments that affect health care reform; the commission shall
23 make the determination required under this subparagraph within 60 days after
24 each measure is enacted into law;

25 (C) determining the prospective costs for recommended
26 comprehensive health care reform proposals, as requested by the governor or
27 as determined by a majority vote of the commission;

28 (D) determining financing plans for recommended proposals;

29 (E) describing administrative structures necessary to implement
30 recommended proposals;

31 (F) identifying a process to implement statewide expenditure

1 measures for health care goods and services;

2 (G) investigating health care standards of practice and
3 determining their effect on medical tort liability and other aspects of health care
4 delivery; and

5 (H) investigating alternatives to existing hospital licensing
6 requirements to allow for less use of acute care facilities.

7 Sec. 44.19.622. COMPOSITION; QUALIFICATIONS; TERMS; REMOVAL;
8 DESIGNATION OF CHAIR. (a) The commission consists of three members
9 appointed by the governor and confirmed by the legislature for six-year terms.

10 (b) A commission member may serve only one six-year term plus the
11 remainder of any unexpired term to which the member was appointed.

12 (c) The governor may remove a member of the commission only for cause.

13 (d) The governor shall designate a member of the commission to serve, at the
14 pleasure of the governor, as chair of the commission for a term of two years. The
15 governor may reappoint the same member for additional terms as chair.

16 (e) A commission member shall comply with the applicable requirements of
17 AS 39.50, and must be a state resident throughout the person's term as a member of
18 the commission.

19 Sec. 44.19.625. STAFF. The commission may employ staff as necessary to
20 carry out the purposes of this chapter. The staff of the commission is in the exempt
21 service.

22 Sec. 44.19.624. COMPENSATION. Members of the commission are in the
23 exempt service and are entitled to a monthly salary equal to Step C, Range 26, of the
24 salary schedule set out in AS 39.27.011(a) for Anchorage, Alaska. Subject to the
25 availability of appropriations, the chair may be paid at a higher step in the same range,
26 if approved by the governor.

27 Sec. 44.19.625. MEETINGS. (a) The commission shall meet publicly not less
28 than quarterly to accomplish its duties under AS 44.19.620 - 44.19.639. The
29 commission shall comply with AS 44.62.310 - 44.62.312.

30 (b) Two members of the commission constitute a quorum for the transaction
31 of business and the exercise of the powers and duties of the commission.

1 Sec. 44.19.626. POWERS AND DUTIES. (a) The commission may

2 (1) enter into contracts and execute instruments necessary for carrying
3 out its business;

4 (2) establish advisory committees to the commission to conduct
5 research or investigation and report back to the commission on findings; an advisory
6 committee must consist of at least one member of the commission and may include
7 other individuals with appropriate expertise appointed by the commission;

8 (3) adopt regulations necessary to interpret or implement
9 AS 44.19.620 - 44.19.639, including regulations establishing reasonable, necessary fees
10 for services provided by the commission.

11 (b) The commission shall

12 (1) conduct public meetings in accordance with AS 44.19.625,
13 including holding public hearings as necessary;

14 (2) collect and analyze data and information from public, private, or
15 other sources relating to the cost, delivery, or financing of health care services
16 provided to state residents;

17 (3) monitor the costs of and the access to health care services to state
18 residents;

19 (4) make reports and recommendations to the governor and legislature
20 in accordance with AS 44.19.620 - 44.19.639;

21 (5) review and either approve or disapprove filings of rates, rate factors,
22 and subscriber and enrollee fees as provided in AS 44.19.629;

23 (6) establish a public health advisory committee that

24 (A) consists of at least one member of the commission and
25 other individuals with significant public health expertise appointed by the
26 commission; the commission shall consider public and private health care
27 professionals, labor organizations, businesses, the education system, the Alaska
28 Public Health Association, the Alaska Mental Health Board, and the Alaska
29 Native Health Board for service on the public health advisory committee, as
30 well as recognizing the need for geographic, ethnic, and cultural diversity;

31 (B) advises the commission on public health matters and the

1 integration of public health services under AS 44.19.621;

2 (C) develops a public health improvement plan as described
3 under (c) of this section;

4 (7) obtain waivers from federal agencies or under applicable federal law
5 to the extent necessary to maximize the collection and analysis of health care data.

6 (c) The plan developed by the committee under (b)(6) of this section may

7 (1) recognize the need for

8 (A) community involvement in health care planning and
9 delivery;

10 (B) attention to local needs that may vary from place to place;

11 (C) accountability for the use of public funds;

12 (D) equity and stability in the distribution of public funds;

13 (E) shared responsibility of all levels of government for
14 administering and financing public health care delivery; and

15 (F) coordination of basic public health services; and

16 (2) include

17 (A) an analysis of the health status of the residents of the state;

18 (B) an assessment of the most appropriate role for various levels
19 of government to play in addressing the health care needs of the residents of
20 the state;

21 (C) a delineation of the standards that should be used in
22 performing assessment, policy development, and quality assurance in the
23 delivery of public health services;

24 (D) documentation of the extent to which the current public
25 health system implements or achieves the standards identified under (C) of this
26 paragraph;

27 (E) identification of interjurisdictional issues involved in health
28 care access and delivery;

29 (F) recommendations, including recommendations for specific
30 legislative action when necessary, pertaining to the following:

31 (i) strategies, time lines, financial needs, and specific

1 sources of stable revenue for bringing the state public health care
2 system up to standards identified by the committee;

3 (ii) appropriate sharing of the responsibility of local,
4 regional, state, and federal government entities to deliver public health
5 care services efficiently and effectively, including recommendations for
6 organization within state government;

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

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

13 Sec. 44.19.627. DUTY TO REPORT. At the request of the governor, the
14 commission shall compile and issue to the governor, the legislature, and the public a
15 report concerning its activities.

16 Sec. 44.19.628. UNIFORM DATA AND PROCEDURES FOR HEALTH
17 CLAIMS. (a) The director of the division of insurance, after considering the advice
18 of the commission, shall adopt by regulation uniform claims forms, uniform standards,
19 and uniform procedures for the processing of data relating to billing for and payment
20 of health care services provided to state residents. All health insurers shall comply
21 with the uniform claims forms, standards, and procedures established under this
22 section.

23 (b) To the extent that there is a conflict or inconsistency between a provision
24 of AS 21 that applies to a health insurer and a provision of a regulation adopted under
25 (a) of this section, the regulation governs. The director of the division of insurance
26 shall ensure that regulations adopted by the director under AS 21 that apply to a health
27 insurer are not in conflict or inconsistent with regulations adopted under (a) of this
28 section.

29 Sec. 44.19.629. REVIEW AND APPROVAL OF RATES AND CHARGES.
30 (a) The commission shall review a rate filing and the recommendation of the division
31 of insurance made under AS 21.51.350, AS 21.86.075, or AS 21.87.190. In reviewing

1 a filing, the commission

2 (1) shall collect and analyze information and data from the health
3 insurer that made the filing;

4 (2) may use any information or data collected under AS 44.19.620 -
5 44.19.639; and

6 (3) shall hold a public hearing for comment on the filing and for
7 verifying the basis for the filing.

8 (b) After the commission completes the requirements of (a) of this section, the
9 commission shall issue a decision on the filing. The commission may approve or
10 disapprove a filing reviewed under this section. If the commission fails to issue a
11 decision within 75 days after the filing was made, the filing is considered to be
12 approved by the commission under this section.

13 Sec. 44.19.630. APPEALS OF COMMISSION DECISIONS. A health insurer
14 aggrieved by a decision of the commission under AS 44.19.629 concerning that
15 insurer's filing may appeal the decision to the superior court.

16 Sec. 44.19.631. DISCLOSURE OF INFORMATION; PENALTY. (a) A
17 person providing or insuring health care services in the state shall provide, upon
18 request or order of the commission, reports, data, health information, insurance
19 schedules, statistics, and other information, as determined necessary by the
20 commission, by regulation, to carry out the purposes of AS 44.19.620 - 44.19.639.
21 This subsection applies to the state and to a municipality; as well as to public and
22 private health care facilities and providers, and health care insurers and self-insurers.

23 (b) Information and data obtained or produced by the commission is subject
24 to AS 09.25.110 and 09.25.120 and regulations adopted under AS 09.25.110 and
25 09.25.120. Information or data that identifies a recipient of health care services is
26 considered to be a medical and related public health record that is subject to the
27 exception to public inspection under AS 09.25.120 and shall be kept confidential.

28 (c) A member, an employee, or an agent of the commission, or a member of
29 an advisory committee to the commission, who wrongfully discloses or who uses or
30 permits the use of confidential information or data in violation of (b) of this section
31 is guilty of a class B misdemeanor.

1 Sec. 44.19.632. IMMUNITY FROM LIABILITY. Members of the
2 commission, its employees, its agents, its advisory committee members, and persons
3 providing information and data to the commission as required under AS 44.19.620 -
4 44.19.639 are not liable for civil damages for an act or omission in the execution of
5 their authorized activities or duties under AS 44.19.620 - 44.19.639. This section does
6 not preclude liability for civil damages as a result of reckless or intentional
7 misconduct.

8 Sec. 44.19.633. OATHS; SUBPOENAS. (a) The commission may administer
9 oaths and may issue subpoenas to persons to require testimony or to require the
10 production of records, information, or data under AS 44.19.629 or 44.19.631.

11 (b) If a person disobeys or resists a lawful subpoena issued by the commission,
12 the commission may certify the facts to the superior court, and upon certification the
13 court shall issue an order directing the person to appear before the court and show
14 cause why the person should not be punished for contempt.

15 Sec. 44.19.634. APPROPRIATIONS. The legislature may appropriate a
16 portion of the proceeds of the tax on insurance premiums collected under
17 AS 21.09.210 to the Alaska Health Commission for the commission's operating costs.

18 Sec. 44.19.635. DISCLOSURE OF PROVIDER CHARGES; FINE FOR
19 NONDISCLOSURE. (a) At least annually, a provider shall compile a list of charges
20 for the 20 health care services most commonly provided by that provider. Charges for
21 hospital services may be prepared on the basis of diagnosis-related groups. Upon
22 request of a person who is considering obtaining services from a provider, the provider
23 shall provide the list of charges to the person for use in comparing charges among
24 providers.

25 (b) Upon the request of a patient and before the commencement of a medical
26 procedure, the provider shall disclose to that patient the estimated charge for the
27 procedure. The estimated charge shall be made in good faith and must be based on
28 the provider's history of charges for that procedure. Nothing in this subsection
29 requires a provider to make a charge estimate if the provider does not agree to perform
30 the procedure.

31 (c) A provider shall place the following statement either on a form to be

1 signed by the patient or in a conspicuous location on an easily readable sign: "You
2 are entitled to a charge estimate for a medical procedure before the procedure is
3 performed by your health provider."

4 (d) If the commission, after investigation of a complaint by a patient,
5 determines that a provider has not complied with this section, the commission may
6 impose a fine of up to \$1,000 against the provider. The commission may impose only
7 one fine under this section against a provider in a calendar year. A provider's
8 violation of this section does not preclude the provider from collecting payment for
9 services provided.

10 (e) A provider aggrieved by a decision of the commission under this section
11 may appeal the decision to the superior court.

12 Sec. 44.19.639. DEFINITIONS. In AS 44.19.620 - 44.19.639, unless the
13 context requires otherwise,

14 (1) "commission" means the Alaska Health Commission;

15 (2) "division of insurance" means the division of insurance in the
16 Department of Commerce and Economic Development;

17 (3) "health care services" has the meaning given in AS 21.86.900;

18 (4) "health information" means all information and data relating to
19 access to or delivery or financing of health care services;

20 (5) "health insurance" has the meaning given "disability insurance" in
21 AS 21.12.050;

22 (6) "health insurer" means an entity transacting the business of health
23 insurance, a health maintenance organization under AS 21.86, a hospital service
24 corporation under AS 21.87, a medical service corporation under AS 21.87, or a
25 combined medical service and hospital service corporation under AS 21.87;

26 (7) "pool" means a mechanism to facilitate or provide for sharing risks
27 or the purchase of health insurance in the event coverage is unavailable or
28 unobtainable;

29 (8) "provider" has the meaning given in AS 21.86.900;

30 (9) "single payor system" means a method of financing health care
31 services in a manner that provides every resident a minimum set of uniform benefits

1 and that requires payment for services be made through a single entity.

2 * Sec. 17. AS 44.62.310(d) is amended to read:

3 (d) This section does not apply to

4 (1) judicial or quasi-judicial bodies when holding a meeting solely to
5 make a decision in an adjudicatory proceeding;

6 (2) juries;

7 (3) parole or pardon boards;

8 (4) meetings of a hospital medical staff; or

9 (5) meetings of the governing body or any committee of a hospital
10 when holding a meeting solely to act upon matters of professional qualifications,
11 privileges or discipline; or

12 (6) meetings of the Alaska Health Commission, except for meetings
13 concerning the adoption of regulations or actions on filings under AS 44.19.629.

14 * Sec. 18. AS 44.66.010(a) is amended by adding a new paragraph to read:

15 (20) Alaska Health Commission (AS 44.19.620) -- June 30, 1999.

16 * Sec. 19. AS 09.55.560(2), 09.55.560(3); AS 21.86.070(e), and 21.86.070(f) are repealed.

17 * Sec. 20. Alaska Rule of Civil Procedure 72.1 is repealed.

18 * Sec. 21. APPLICABILITY. Sections 4, 5, and 6 of this Act apply to a cause of action
19 accruing on or after the effective date of this Act.

20 * Sec. 22. INITIAL APPOINTMENT OF COMMISSION MEMBERS. Notwithstanding
21 AS 44.19.622(a), enacted by sec. 16 of this Act, the terms of persons initially appointed to the
22 Alaska Health Commission under AS 44.19.622 shall be staggered as provided in
23 AS 39.05.055.

24 * Sec. 23. REAPPOINTMENT OF INITIAL APPOINTEES. Notwithstanding
25 AS 44.19.622(b), enacted by sec. 16 of this Act, a person initially appointed to the Alaska
26 Health Commission under (a) of this section may be reappointed to serve no more than one
27 six-year term as a member of the Alaska Health Commission.

28 * Sec. 24. PHASED TRANSITION PERIOD. (a) Notwithstanding the provisions of
29 AS 44.19.621 - 44.19.639, the Alaska Health Commission shall implement the provisions of
30 AS 44.19.621 - 44.19.639 on a orderly and gradual basis as follows:

31 (1) by January 1, 1996, the commission shall complete the research necessary

1 to report recommendations to the governor and the legislature on the issues described under
2 AS 44.19.621(a)(5)(A), (C), (D), (E), and (G);

3 (2) by July 1, 1996, the commission shall complete the research necessary to
4 report recommendations to the governor and the legislature on the issues described under
5 AS 44.19.621(a)(5)(F) and adopt regulations necessary to implement AS 44.19.628(a);

6 (3) by January 1, 1997, the commission shall complete the research necessary
7 to report recommendations to the governor and the legislature on the issues described under
8 AS 44.19.621(a)(5)(H).

9 (b) Upon request of the commission, and for good cause shown, the governor may
10 grant an extension of a deadline set in (a) of this section. The governor shall inform the
11 legislature of a decision on a request to extend a deadline.

12 * Sec. 25. AS 09.55.536(f), amended by sec. 5 of this Act, amends Alaska Rules of Civil
13 Procedure 26 and 27 by providing that discovery may not be undertaken until the expert
14 advisor's report is received.

15 * Sec. 26. AS 09.55.536(e), amended by sec. 5 of this Act, amends Alaska Rules of
16 Evidence 802, 803, and 804 by providing that the expert advisor's report is admissible in
17 evidence to the same extent as though its contents were orally testified to by the advisor.

18 * Sec. 27. Section 20 of this Act takes effect July 1, 1994, only if that section receives the
19 two-thirds majority vote of each house required by art. IV, sec. 15, Constitution of the State
20 of Alaska.

21 * Sec. 28. This Act takes effect July 1, 1994.

#1
AMENDMENT

HB 414

Page 1, line 8

After "health care",

Delete "is a vital public interest."

Insert "and maintenance of the public's health are vital to the public's interest."

Page 1, line 11

After "insurance",

Delete "and"

Page 1, line 12

After "malpractice",

Insert "and the lack of population based public health services"

Page 2, line 14

After "relating to",

Insert "the individual and public"

Page 5, after line 6,

Add a new section

(6) establish a Public Health Advisory Committee which
(A) consists of at least one member of the commission and other individuals with significant public health expertise appointed by the commission; and
(B) advises the commission on public health matters and the integration of public health services under AS 44.19.621.

#2

8-GH2024\A.1
Ford
2/15/94

A M E N D M E N T

OFFERED IN THE HOUSE

BY REPRESENTATIVE BRICE

TO: HB 414

Page 2, line 5, after "services,":

Insert "the creation of a public health improvement plan,"

Page 2, line 21:

Delete "and"

Page 3, line 16, following "1997":

Delete "."

Insert "; and

(6) establishing a public health improvement plan advisory committee and developing a public health improvement plan as required under AS 44.19.636."

Page 5, line 6, after "AS 44.19.629":

Insert ";

(6) establish a public health improvement plan advisory committee to develop a public health improvement plan as required under AS 44.19.636."

Page 7, after line 22:

Insert a new section to read:

"Sec. 44.19.636. PUBLIC HEALTH IMPROVEMENT ADVISORY COMMITTEE. (a) The commission shall establish and appoint the members of an advisory committee for the purpose of developing a public health improvement plan. The committee must include at least one member of the commission. In appointing other members of the committee, the commission shall consider public and private health care professionals, labor organizations, businesses, the education system, the

Alaska Public Health Association, the Alaska Mental Health Board, the Alaska Native Health Board, as well as the need for geographic, ethnic, and cultural diversity on the committee.

- (b) The plan developed by the committee under (a) of this section must
 - (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 performing 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, expressed in terms of a percentage of health care dollars spent or in terms of public dollars per state resident."

Page 17, after line 12:

Insert a new bill section to read:

"* Sec. 22. TRANSITION. Notwithstanding AS 44.19.621(a)(6), enacted in sec. 3 of this Act, the Alaska Health Commission shall develop a public health improvement plan as described under AS 44.19.636 by January 1, 1996."

Renumber the following bill sections accordingly.

Page 17, line 16:

Delete "and 21"

Insert "21, and 22"

3

A M E N D M E N T

OFFERED IN THE HOUSE
TO: HB 414

BY REPRESENTATIVE TOOHEY

Page 7, after line 22:

Insert a new section to read:

"Sec. 44.19.636. REQUIRED AVAILABILITY OF PRICE LIST. (a) A health care provider shall prepare a list of the provider's prices for common health care services that includes the time period in which the prices apply. The price list shall be made available by posting the price list in a conspicuous location in the health care provider's office. The commission shall determine by regulation the health care services that must be disclosed and the contents of the price list required under this section.

(b) If a health care provider charges a price for a health care service that differs from the posted price, the health care provider shall provide an explanation of the deviation to the person receiving the health care service.

(c) At least annually, a health care provider shall submit to the commission copies of the provider's current price list. The commission shall specify by regulation the date for submitting the price lists."

4

8-GH2024VA.3 ✓
Ford
3/9/94

A M E N D M E N T

OFFERED IN THE HOUSE
TO: HB 414

BY REPRESENTATIVE TOOHEY

Page 7, after line 22:

Insert a new section to read:

"Sec. 44.19.635. PROHIBITED PRICE INCREASES. A health care provider may not increase the provider's prices for health care services more than once in a calendar year. The commission shall adopt regulations to implement this section."



Alaska State Legislature

Please enter into the record my testimony to the House H.E.S.S.
committee name

committee on HB 414, dated MARCH 4, 1994
bill/subject

Attached please find a copy of the current Health Care Financing Administration - 1500 medical services billing form (dated 12/90, in lower right corner). This standardized form is one of the things your proposed legislation would mandate. I thought you might like to know that one already exists. Also attached is the previous H.C.F.A.-1500 form (dated 1/84) which was replaced by the current version. I no longer have any copies of the H.C.F.A.-1500 designed in the 1970's.

The preceding is but one example from HB 414 showing that the bills were not researched well. Also note the attached copy of a page from Time Magazine: The graph shows the cost of U.S. medical care began increasing dramatically in 1987. The article (see underlined paragraph) never noted that in 1986 Congress enacted C.O.B.R.A., which forced hospital emergency rooms to treat all patients whether or not they paid. This is one of those "unfunded liabilities" that governments impose on lesser governments and the private sector.

However, notice on the graph that in 1990 the medical care inflation started to decrease dramatically. This was prior to the Clinton campaign's cry of "health care crisis". There was no great increase in HMO's that year that turned things around. The graph after 1990 shows the resourcefulness and responsiveness of the private sector: Medicine took a hit from Congress and still found a way to cut costs and maintain quality of care in only 3 years. And all this without a huge bureaucracy telling Medicine what to do! Has government ever cut costs and improved services at the same time?

Signed: Marlene M. Leak MARLENE M. LEAK
Testifier

SELF

Representing (Optional)

771 8th AVE. FAIRBANKS 99701

Address

452-1015

Phone No.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 is completed, the patient's signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge

submitted. CHAMPUS is not a health insurance program and renders payment for health benefits provided through membership and affiliation with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned "Insured", i.e. items 3, 6, 7, 8, 9, and 11.

BLACK LUNG AND FECA CLAIMS: The provided agrees to accept the amount paid by the Government as payment in full. See Black Lung FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally rendered by me or were rendered incident to my professional service by my employee under immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For services to be considered an 'incident' to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral,

For CHAMPUS claims, I further certify that neither I nor any employee who rendered the services are employees or members of the Uniformed Services (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (20 CFR 422.510).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION

We are authorized by HCFA, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and BLACK LUNG programs. Authority to collect information is in section 205 (a), 1872 and 1875 of the Social Security Act as amended and 44 USC 3101, 41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq.

Federal agencies as necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

With the one exception discussed below, there are no penalties under these Programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards and other organizations or

It is mandatory that you tell us if you are being treated for a work related injury so we can determine whether workers' compensation will pay for treatment. Section 1877 (a) (3) of the Social Security Act provides criminal penalties for withholding this information.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request. I further agree to accept as payment in full the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductibles and coinsurance.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally rendered by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete.

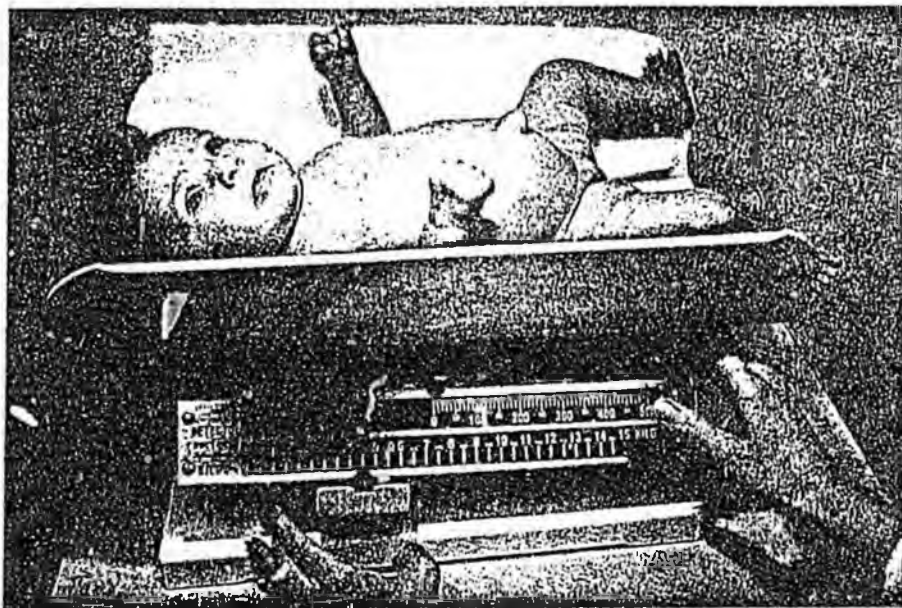
I understand that payment and satisfaction of this claim will be from Federal and/or State funds, and that any false claims, statements, or documents or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

PLACE OF SERVICE CODES:

- 1 - (IH) - Inpatient Hospital
- 2 - (OH) - Outpatient Hospital
- 3 - (O) - Doctor's Office
- 4 - (H) - Patient's Home
- 5 - - Day Care Facility (PSY)
- 6 - - Night Care Facility (PSY)
- 7 - (NH) - Nursing Home
- 8 - (SNF) - Skilled Nursing Facility
- 9 - - Ambulance
- 0 - (OL) - Other Locations
- A - (IL) - Independent Laboratory
- B - (ASC) - Ambulatory Surgical Center
- C - (RTC) - Residential Treatment Center
- D - (STF) - Specialized Treatment Facility
- E - (COR) - Comprehensive Outpatient Rehabilitation Facility
- F - (KDC) - Independent Kidney Disease Treatment Center

TYPE OF SERVICE CODES:

- 1 - Medical Care
- 2 - Surgery
- 3 - Consultation
- 4 - Diagnostic X-Ray
- 5 - Diagnostic Laboratory
- 6 - Radiation Therapy
- 7 - Anesthesia
- 8 - Assistance at Surgery
- 9 - Other Medical Service
- 0 - Blood or Packed Red Cells
- A - Used DME
- F - Ambulatory Surgical Center
- H - Hospice
- L - Renal Supplies in the Home
- M - Alternate Payment for Maintenance Dialysis
- N - Kidney Donor
- V - Pneumococcal Vaccine
- Y - Second Opinion on Elective Surgery
- Z - Third Opinion on Elective Surgery



This infant's mom in California helps keep a lid on medical-cost inflation

■ HEALTH CARE

Crisis? What Crisis?

As medical inflation eases, so does the sense of urgency that Clinton needs to push his revolutionary plan

By ADAM ZAGORIN WASHINGTON

THE LATEST ASSAULT ON BILL CLINTON's top domestic goal began with 10 words on a Sunday-morning talk show last week. "We do not have a health-care crisis in America," declared Daniel Patrick Moynihan, the Senate Finance Committee chairman. His words sent shivers through the White House, where creating a national sense of urgency about health care is regarded as critical to propelling the President's reforms through Congress. As the week progressed, things only got worse. The American Medical Association, it was disclosed, is preparing a plan to lobby for 37 significant changes in Clinton's plan, including the elimination of proposed limits on doctors' fees. Then came a letter, signed by 565 economists, warning about fallout from the price controls contained in the Clinton proposal.

Administration officials quickly tried to dampen the rising rebellion. Senior economic advisers led a hushed but urgent campaign to prevent the influential Business Roundtable from endorsing a more modest alternative to the President's 1,300-page plan. White House economics chief Robert Rubin and Deputy Treasury Secretary Roger Altman telephoned insurance-company CEOs at Prudential, Chubb, American International Group

and CNA to urge them not to endorse the rival plan, backed by Representative Jim Cooper of Tennessee and Senator John Breaux of Louisiana. But the Administration's pre-emptive strike met with resistance. Late Friday an informal straw poll of the Roundtable's policy committee turned up broad support for Cooper-Breaux.

On his return from Europe this week, Clinton aims to launch an all-out campaign for passage with his Jan. 25 State of the Union speech. But attitudes about health-care reform have shifted in the months since Clinton unveiled his plan in September. The economy has rebounded smartly, and a growing number of legislators have been denying the existence of a national medical emergency. Certainly one aspect of the crisis, the skyrocketing cost of care, has abated. Medical inflation fell from an annual rate of 6.3% in the first half of last year to 4.4% in the second half, according to the consumer price index. New projections indicate that the Federal Government will spend \$120 billion less on Medicare and Medicaid through 1998 than was estimated only a year ago.

Behind the slowdown lie aggressive steps by several states including Maryland, Oregon and Florida to contain medical costs. Many private companies are taking their own measures. Typical is Intel, the microchip manufacturer, which suffered 20% annual increases in health-insurance premiums until the introduction of a managed-care program in 1990 that covers 20,000 U.S. employees. Now costs are edging up only 5% a year.

Another ingredient of medical-cost containment involves the decision by many hospitals, pharmaceutical companies and other providers to stabilize or lower their prices, perhaps in hopes of heading off congressional action on health-care reform. This, at least, is the argument advanced by Administration experts who caution that decelerating costs could prove illusory and that only a full-scale, Clinton-style reform with mandatory price restraints can tackle the job in the long run. "Medical inflation slowed in the late 1970s just in time to defeat a previous effort at cost containment," recalls Laura Tyson, chairman of the Council of Economic Advisors. "Later on, prices resumed their former upward spiral."

Moreover, advocates of reform argue, inflation is only one of many health-care problems that need fixing, most notable among them the lack of coverage for 37 million Americans, which the Clinton plan is designed to remedy. Warns Paul Begala, a senior Clinton political adviser: "The American people believe something serious must be done in a country where any one of us could lose our medical insurance tomorrow."

The sentiment among critics of Clinton's plan leans toward proposals that are more incremental, with less ambitious financing and lower costs. The one claiming the most support so far is the Cooper-Breaux plan, also known as "Clinton Lite." The proposal matches many features of the President's proposal but does not put limits on insurance premiums and will not yield universal coverage.

Several Republican legislators have developed their own, mostly incremental plans, hoping to avoid the awkward choice between opposing reform altogether and voting for some variation of the Clinton plan, for which the President will get most of the political credit. But, as the saying goes, you can't beat something with nothing. And the Republicans have yet to agree on an alternative that isn't Democratic in design. —With reporting by Michael Duffy and Dick Thompson/Washington



FEB 18 1994

**Anchorage Chamber of Commerce
Resolution On Health Care Reform
93/94-7**

WHEREAS quality, access, and the costs of health care are all critical to Alaskans; and

WHEREAS the cost of health care is being born by the state, the federal government, public and private sector employers and individuals collectively; and

WHEREAS certain legislation is pending which could significantly alter health care and the allocation of costs to pay for health care for Alaskans.

BE IT RESOLVED that the Anchorage Chamber of Commerce urges Alaska Legislators and the Governor to:

1. To clearly identify the cost implications (to the state, residents, public & private sector employers) of health care reform;
2. Avoid a single payor system;
3. Increase access to coverage for small employers through insurance company reform;
4. Address coverage for non-residents employed in seasonal industries in the state;
5. Thoroughly review entitlement to benefits if provided through taxes, assessments or premiums through employment;
6. Allow freedom of choice of employers to participate or not participate in any state mandated health care plan;
7. Address in advance how school districts, municipalities, boroughs or other public sector employers would have to increase budgets to cover any costs increase associated with health care reform;
8. Address how premiums will be paid by unemployed individuals and if premiums are not paid, who shares the burden of health care costs for those individuals;
9. Adopt a level of benefits which establishes the base benefit payment for all health care providers and allows residents to seek care from any provider in the state recognizing however, some providers will charge an amount greater than allowed by the plan which must be paid by the resident;
10. Address the number of employees/persons covered;
11. Address impact on collective bargaining agreements;
12. Address impact on national employers doing business in Alaska;
13. Address plan sponsors who currently give retiree welfare benefits to non-residents.

Be it further resolved that health care reform and the payment of health care costs should address all of the above areas and town meetings should be held to discuss the ramifications of any proposed amendments or changes prior to voting on reform; and

While the current health care system may need to be fine tuned and some changes made, it does not need to be dismantled.

George Wuerch
Chairman 1993-94

Carol Heyman
President

February 18, 1994



UNIVERSITY OF ALASKA ANCHORAGE

3211 Providence Drive
Anchorage, Alaska 99508-6175

STUDENT HEALTH CENTER
(907) 786-4040

March 4, 1994

Dear Representative Toohey:

Re: Health Care Reform

I am a family nurse practitioner and the manager of the University of Alaska Anchorage Student Health Center.

The University of Alaska Anchorage - Student Health Center is an outpatient facility that provides diagnosis and treatment of episodic illnesses, health education and promotion, physical examination, family planning, mental health services, dispenses medications and provides other health related services.

The role of the Student Health Center is to empower students to make educated decisions regarding their health care needs and health status. The proactive position of health care advocacy, low cost-high quality health care, and accessibility promote a health-oriented lifestyle for students.

Health is viewed as a supporting and facilitating resource through which the welfare of individuals can be enhanced. An individual's health status has a profound effect on his/her ability to function at work, home, school, and in the community.

The Student Health Center is currently staffed by two family nurse practitioners, a mental health nurse practitioner, and two office support personnel. On an average we provide health care services to 60 individuals daily. The vast majority of these individuals do not have health insurance or financial resources to secure necessary health care services. Frequently students do not have money to pay for lab work, diagnostic procedures or prescription drugs. I perceive this to be a health care crisis.

The vast majority of students are in school to improve their lives. Frequently students are single parents who hope to become more financially secure, others are suddenly single people who desire to reclaim their lives or start anew and again hope to improve their life, earning potential and well-being. These individuals are in need of health care that meets their variable needs. This health care must be financially attainable and accessible.

Representative Toohy

March 4, 1994

Page 2

Students taking 6 or more credits on the Anchorage campus currently pay a \$12.00 Health Center fee each semester. This entitles them to health care services that includes: diagnosis and treatment of illnesses, family planning, treatment of sexually transmitted diseases, health screening, immunizations, psychiatric-mental health therapy and health education. These services are provided at minimal cost.

Although the Student Health Center is currently understaffed to meet the demand for services, health care is provided in a prompt and comprehensive manner while maintaining a high quality of health care delivery. A fee increase has been proposed in order to increase the staffing of the Health Center to meet the increased demand for services.

Frequently students come to the Health Center who have not had health care for 5 - 10 years because they have been unable to afford it. For example, we see women who have not had a Pap Test for 10 years. This simple test can detect cancer of the cervix which is treatable before becoming a life threatening disease. An advanced cervical or uterine cancer will cost a tremendous amount of money to maintain a reasonable quality of life for the "victim" of a detectable and treatable disease can cause. Other students have chronic illnesses and have not been able to be monitored and treated to improve their quality of life because of the expense of health services.

When students are asked where they would have been treated for the illness they present with, the answer is frequently, "I would have toughed it out until I needed to go to the emergency room." This is the wrong answer. This is a very expensive way to treat many illnesses. Bronchitis, pneumonia, and many other illness can be treated on an outpatient basis in a cost effective and efficient manner saving a great deal of money.

As you consider "Health Care Reform" keep in mind that preventive care is a way to reduce cost. The old adage, "An ounce of prevention is worth a pound of cure," is true for health care. Prompt, efficient, and cost effective health care is essential.

Health care is both a right and a privilege. As you consider the issue of "HEALTH CARE REFORM," keep your focus on the issue of optimal health care for every individual.

Representative Toohey
March 4, 1994
Page 3

As you continue to map a future for health care delivery in the State of Alaska, do not neglect the important contribution of nurse practitioners. Nurse practitioners and nurses have had a positive impact on the health of Alaska for many years. Often nurse practitioners provide health care in locations where physicians choose not to reside. The services provided help individuals maintain their optimal health.

Although I am sure you are aware of the role of nurse practitioner I would like to include the definition as set forth in the State of Alaska Statute:

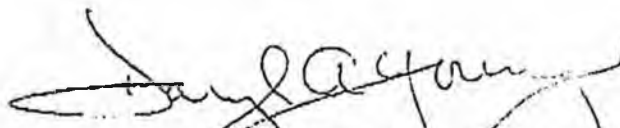
An advance nurse practitioner is a registered nurse authorized to practice in the State, who, because of specialized education and experience, is certified to perform acts of medical diagnosis and the prescription of medical, therapeutic, or corrective measures under regulations adopted by the Board of Nursing. AS03.68.410(1)

Nurse practitioners are primary "health" care providers. They provide health care to individuals, families and communities. The key words are **HEALTH CARE**. "Medicine" or "medical care" is really health care. Health care is provided by nurse practitioners and nurses and is not restricted to physicians. As you the plan for the future of health care delivery in Alaska please remember the important contribution of nurse practitioners.

I believe that health is the individual's obligation to preserve to the best of their ability with the assistance of health care professionals and not something that is surrendered to a physician or other health care provider. There is a health care crisis and it will take a collaborative effort on the part of all health care providers to relieve this crisis.

I appreciate your involvement in health care reform. If I can be of further assistance, please contact me at (907)786-4040.

Sincerely,



Daryl A. Young, MS, RN, CS, ANP
Family Nurse Practitioner

A M E N D M E N T

OFFERED IN THE HOUSE

BY REPRESENTATIVE BRICE

TO: HB 414

Page 2, line 5, after "services,":

Insert "the creation of a public health improvement plan,"

Page 2, line 21:

Delete "and"

Page 3, line 16, following "1997":

Delete "."

Insert "; and

(6) establishing a public health improvement plan advisory committee and developing a public health improvement plan as required under AS 44.19.636."

Page 5, line 6, after "AS 44.19.629":

Insert ";

(6) establish a public health improvement plan advisory committee to develop a public health improvement plan as required under AS 44.19.636."

Page 7, after line 22:

Insert a new section to read:

"Sec. 44.19.636. PUBLIC HEALTH IMPROVEMENT ADVISORY COMMITTEE. (a) The commission shall establish and appoint the members of an advisory committee for the purpose of developing a public health improvement plan. The committee must include at least one member of the commission. In appointing other members of the committee, the commission shall consider public and private health care professionals, labor organizations, businesses, the education system, the

Alaska Public Health Association, the Alaska Mental Health Board, the Alaska Native Health Board, as well as the need for geographic, ethnic, and cultural diversity on the committee.

(b) The plan developed by the committee under (a) of this section must

(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 performing 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, expressed in terms of a percentage of health care dollars spent or in terms of public dollars per state resident."

Page 17, after line 12:

Insert a new bill section to read:

"* Sec. 22. TRANSITION. Notwithstanding AS 44.19.621(a)(6), enacted in sec. 3 of this Act, the Alaska Health Commission shall develop a public health improvement plan as described under AS 44.19.636 by January 1, 1996."

Renumber the following bill sections accordingly.

Page 17, line 16:

Delete "and 21"

Insert "21, and 22"



ALASKA NURSES ASSOCIATION

237 E. 3rd Avenue #3 Anchorage, AK 99501-2523
(907) 274-0827 FAX: (907) 272-0292

March 4, 1994

Representative Cynthia Toohey, Co-Chair
House of Representatives HESS Committee
Room 104-C
Capitol Building
Juneau, Alaska 99801-1182

Dear Representative Toohey:

On behalf of the Alaska Nurses Association (AaNA), I thank you for the opportunity to testify today on HB 414, an act creating the Alaska Health Commission. The AaNa commends governor Hickel in his recognition of the need for health care reform and his efforts to solve what is perhaps the largest long-term problem facing Alaskans.

The Alaska Nurses Association believes that there already has been a great deal of data collected and debate conducted related to the issues of universal coverage, access to care and mix of providers, data collection, cost control and utilization, a public health improvement plan, tort reform and health insurance reform which have occurred in officially sponsored functions of the legislature. Although there may be some disagreement about some of the data that has been collected, there is more than ample information with which to move forward with a specific plan for health care reform.

The Alaska Nurses Association strongly supports universal health care coverage for all Alaskans. We believe this is the single most important aspect of health care reform. The Association, knowing the value of guaranteed coverage to primary care services, supports a single payer approach to ensuring a basic set of benefits for every citizen in this state.

We believe that HB 414 should be amended to require the Alaska Health Commission to develop a plan of universal coverage for all Alaskans within the same time line outlined in the bill for recommendations from the Commission to the Governor and Legislature. The Commission should be specifically directed to present a preferred plan, and alternatives if it deems advisable, which guarantees universal health care under a single payer system. This plan(s) should detail the benefits package of coverage, costs, financing mechanism(s), cost containment measures, and other features which the Commission believes necessary.

Representative Cynthia Toohey

March 4, 1994

Page 2

The Alaska Nurses Association is committed to the belief that a strong consumer presence needs to be an inherent component of the Alaska Health Commission. We are convinced that it is only by empowering more consumers that the system will become more responsive to the concerns of those directly impacted by that system. We believe there needs to be significant consumer representation on the Commission itself and urge you to consider a larger number of commissioners which more broadly represents the concerns of the health care consumer.

As an organization that has long advocated the principles of disease prevention and health promotion we are disturbed that there is not a plan to provide for a strong public health structure within HB414. We strongly recommend that the aspects of HB332 which outline the need for a strong public health component in health care reform be incorporated into HB 414. Further, we believe that health promotion and disease prevention strategies must be recognized as appropriate strategies to address the goals of cost containment and improved health outcomes.

We strongly support Section 7 "Review and Approval of Rates and Rating Factors". We believe that the health insurance industry should receive the same public scrutiny as that enjoyed by other insurance providers in the state. We believe that such public review will aid in the forthcoming deliberations. We are encouraged by the health insurance industry's endorsement of the Governor's proposed legislation, including this particular aspect.

Overall, the Alaska Nurses Association is pleased that the Governor and legislature is addressing the issue of health care reform. However, we do not believe HB 414 in its present form goes far enough to move us forward. We recommend that the committee work to incorporate our suggestions in order to pass legislation which will be effective. Thank you.

Sincerely yours,

A handwritten signature in cursive script, reading "Jackie Pflaum". The signature is written in dark ink and is positioned above the typed name and title.

Jackie Pflaum
Legislative Chair

FEB 18 1994

**Anchorage Chamber of Commerce
Resolution On Health Care Reform
93/94-7**

WHEREAS quality, access, and the costs of health care are all critical to Alaskans; and

WHEREAS the cost of health care is being born by the state, the federal government, public and private sector employers and individuals collectively; and

WHEREAS certain legislation is pending which could significantly alter health care and the allocation of costs to pay for health care for Alaskans.

BE IT RESOLVED that the Anchorage Chamber of Commerce urges Alaska Legislators and the Governor to:

1. To clearly identify the cost implications (to the state, residents, public & private sector employers) of health care reform;
2. Avoid a single payor system;
3. Increase access to coverage for small employers through insurance company reform;
4. Address coverage for non-residents employed in seasonal industries in the state;
5. Thoroughly review entitlement to benefits if provided through taxes, assessments or premiums through employment;
6. Allow freedom of choice of employers to participate or not participate in any state mandated health care plan;
7. Address in advance how school districts, municipalities, boroughs or other public sector employers would have to increase budgets to cover any costs increase associated with health care reform;
8. Address how premiums will be paid by unemployed individuals and if premiums are not paid, who shares the burden of health care costs for those individuals;
9. Adopt a level of benefits which establishes the base benefit payment for all health care providers and allows residents to seek care from any provider in the state recognizing however, some providers will charge an amount greater than allowed by the plan which must be paid by the resident;
10. Address the number of employees/persons covered;
11. Address impact on collective bargaining agreements;
12. Address impact on national employers doing business in Alaska;
13. Address plan sponsors who currently give retiree welfare benefits to non-residents.

Be it further resolved that health care reform and the payment of health care costs should address all of the above areas and town meetings should be held to discuss the ramification of any proposed amendments or changes prior to voting on reform; and

While the current health care system may need to be fine tuned and some changes made, it does not need to be dismantled.

George Wuerch
Chairman 1993-94

Carol Heyman
President

February 18, 1994

WALTER J. HICKEL
GOVERNOR



P. O. Box 110001
Juneau, Alaska 99811-0001
(907) 455-3500

STATE OF ALASKA
OFFICE OF THE GOVERNOR
JUNEAU

January 28, 1994

*The Honorable Ramona Barnes
Speaker of the House
Alaska State Legislature
State Capitol
Juneau, AK 99801-1182*

Dear Speaker Barnes:

Under the authority of art. III, sec. 18, of the Alaska Constitution, I am transmitting a bill relating to health care reform.

Alaskans' access to quality, affordable health care is a vital public interest. This bill addresses improvements to the delivery, quality, access, cost, and financing of health care services. The bill is not intended to be viewed as a comprehensive reform proposal. Rather, it is a measured, responsible step forward to set the stage for comprehensive reform.

At the same time, however, the bill makes immediate improvements to the current health care system. As importantly, it creates a process that will provide the governor, the legislature, and the public with the information necessary to make rational health care reform decisions. The bill does not foreclose any reform options, including those presently being considered by Congress and by the state legislature.

Immediate steps taken through this bill to close gaps in the health care system include: the adoption and implementation of a uniform claim form, the use of mandatory non-binding arbitration as an alternative to litigation in resolving certain health system disputes, facilitating the creation of pools for sharing risks or purchasing insurance relating to health care services, and requiring health insurers and related entities to obtain approval for certain rates or fees charged to consumers.

The creation of the Alaska Health Commission, together with the duties imposed upon it, constitutes a major part of the bill. Along with being given authority to approve

The Honorable Ramona Barnes
January 28, 1994
Page 2

health insurer rates and other filings, the commission is charged with collecting and analyzing health care information and data. This information will serve as the basis for formulating, for the governor's and legislature's consideration, proposals on the primary mechanisms needed to effect meaningful comprehensive health care reform.

This proposal allows a deliberate process for determining how Alaskans will reform their health care system. The proposal focuses on collecting Alaska health care data, and it allows for analysis of what other states have done in the area. It also provides time to synchronize state efforts with those of impending federal health care reform.

This bill requires that its objectives be completed within established time frames. The analysis to be provided by the commission, particularly with regard to the cost, financing, and implementation of health care reform, is critical given the current fiscal circumstances facing the state. It is essential that the fiscal impact of health care reform be fully considered before further action is taken.

Please contact my staff if you need a detailed section-by-section description or additional explanation of the bill.

I urge your favorable action on this important bill.

Sincerely,

A handwritten signature in cursive script, reading "Walter J. Hickel". The signature is written in dark ink and is positioned above the printed name and title.

Walter J. Hickel
Governor

January 31, 1994

SECTIONAL SUMMARY OF
GOVERNOR'S HEALTH COMMISSION BILL
(HB 414/SB 270)

Prepared by: Alaska Department of Law

Note: The bill itself is the best statement of its contents. A sectional summary of a bill is not an authoritative interpretation of the bill.

Section 1. FINDINGS. This section sets out legislative findings regarding access to health care, increases in health care costs, and the need for reform of the health care system in Alaska.

Section 2. INTENT. This section sets out legislative intent concerning the promotion of access to affordable, quality health care for Alaskans.

Section 3. COMMISSION. This section creates the Alaska Health Commission (commission); sets forth the purposes of the commission; establishes the composition, qualifications, terms, removal, and designation of its chairperson; authorizes the commission to hire staff; sets compensation for the members of the commission; establishes requirements for meetings; sets the powers and duties of the commission; and establishes duties of the commissioner to report to the governor, legislature, and the public on commission activities at the request of the governor.

Section 3 also requires the director of insurance to establish uniform forms and procedures for health claims no later than July 31, 1996; requires a health insurer to file with the commission (and the division of insurance) its rates and related data, and changes to the rates; authorizes the commission to review and approve the filings; gives appeal rights to a health insurer aggrieved by commission decision concerning that insurer's filing; sets parameters for reporting and disclosure of information; makes certain patient health records confidential; makes unlawful disclosure or use of commission information a class B misdemeanor; provides immunity from civil damages for commission members and others specified in AS 44.19.632 for negligent acts or omissions; allows the commission to give oaths and issue subpoenas; authorizes the court to issue orders to show cause for failure to comply with lawful subpoenas of the commission; allows the legislature to appropriate a portion of the proceeds of the tax on insurance premiums collected under AS 21.09.210 for commission operating costs; and establishes definitions for certain terms used in AS 44.19.620 - 44.19.639.

Section 4. MANDATORY ARBITRATION. This section mandates that a

person who files a suit for damages for medical malpractice must also submit the claim to the court for mandatory arbitration. The decision of the arbitrator is nonbinding; if it is rejected by either party, the action may then proceed in court. In existing AS 09.55.535, which is repealed and reenacted by this section, arbitration was voluntary only and was conducted by a multimember board, rather than a single arbitrator. This section corresponds with language in sec. 3 of SB 123 (1993), and it is designed to facilitate early resolution of claims before costly legal proceedings are pursued.

Section 5. EXPERT ADVISOR. This section amends AS 09.55.536 to authorize the court to appoint a single expert medical advisor rather than a three-person expert advisory panel as is currently required. The expert medical advisor would make written reports in court cases for medical malpractice claims. Except for minor technical changes, this section corresponds with sec. 4 of SB 123 (1993). This section is designed to reduce costs of obtaining expert advice in medical malpractice cases and facilitate early resolution of claims before costly court actions are pursued.

Section 6. PROCEDURE FOR CERTAIN CLAIMS AGAINST A HEALTH INSURER. This section is similar to sec. 4, except that, unless that practice is preempted by federal law that provides otherwise, it requires a health insurance claimant who files certain court actions against a health insurer to submit the claim to the court for mandatory arbitration. Again, the arbitrator's decision is nonbinding but should facilitate early resolution of claims before costly legal proceedings are pursued.

Section 7. REVIEW AND APPROVAL OF RATES AND RATING FACTORS (TRADITIONAL HEALTH INSURANCE). This section acknowledges the sec. 3 requirement that disability insurers ("health insurers" under AS 44.19.620 - 44.19.639) must file disability insurance rates or rating factors with the commission for approval. The director of insurance makes recommendations to the commission to approve or disapprove the filings.

PURCHASING POOLS. This section requires the director of insurance to adopt regulations to facilitate the creation of pools to share risk or purchase disability insurance. Before adopting regulations, the director must consult with and consider recommendations of the commission.

Section 8. CONFORMING AMENDMENT. This section makes a technical amendment to reflect the repeal of AS 21.86.070(e). The two changes together delete references to the authority of the director of insurance to require additional information concerning, and approve filing of, rates for health maintenance organizations. Under sec. 3 of the bill, the commission will perform that function.

Section 9. REVIEW AND APPROVAL OF RATES AND CHARGES (HMO). This

section establishes the procedure for filing, review, and approval by the commission of health maintenance organizations' rates and charges. The director of insurance must make recommendations to the commission on the approval or disapproval of the rates. This section is similar to sec. 7, but relates to health maintenance organizations.

Section 10. PURCHASING POOLS. This section requires the director of insurance to adopt regulations to allow the creation of pools for the purpose of sharing risks or purchasing insurance relating to health maintenance organizations. This section is similar to sec. 7, but relates to health maintenance organizations.

Section 11. REVIEW AND APPROVAL OF RATES AND CHARGES (SERVICE CORPORATIONS). This section establishes procedures for filing, review, and approval by the commission, of rates, fees, and payments by hospital and medical service corporations. The director of insurance must make a written recommendation to the commission on the approval or disapproval of these items. This section is similar to secs. 7 and 9 but relates to service corporations.

Section 12. PURCHASING POOLS. This section requires the director of insurance to adopt regulations to allow for the creation of pools to share risk or purchase insurance related to service corporations. This section is similar to secs. 7 and 10, but relates to hospital and medical service corporations.

Sections 13 and 14. COMMISSION PROCUREMENT PROCEDURES. These sections together exempt the commission from the state procurement code, but require the commission to adopt its own procurement regulations. The regulations must be consistent with the competitive procurement principles of the procurement code. The exemption is considered necessary to allow the commission to meet the relatively short deadlines for reports and recommendations set by AS 44.19.621.

Section 15. EXEMPT SERVICE. This section places the commission staff in the exempt state service. Commission members also would be in the exempt service under existing AS 39.25.110(10).

Section 16. OPEN MEETINGS ACT LIMITATION. This section would require that commission meetings related to the adoption of regulations or to actions on rate filings fall under the requirements of the Open Meetings Act. Other commission meetings would be exempted from those requirements. This would allow the commission members to conduct day-to-day administrative activities without first issuing a public notice and convening a public meeting.

Section 17. SUNSET PROVISION. This section establishes a sunset date for the commission of June 30, 1999. This would allow for

routine review and evaluation of the effectiveness of the commission.

Section 18. REPEALERS. This section repeals portions of existing statutes, due to changes contained in this bill. AS 09.55.560(2), defining "board" for the purpose of arbitration under AS 09.55.535, is repealed because AS 09.55.535 has been changed to provide for a single arbitrator instead of an arbitration board. AS 09.55.560(3), defining "panel" to mean an expert advisory panel established under AS 09.55.536, is repealed because AS 09.55.536 has been amended to use a single expert instead of a three-person expert advisory panel. In existing insurance statutes regulating health maintenance organizations, AS 21.86.070(e) and (f), dealing with filing of HMO enrollee changes, are repealed because of the new provisions at AS 21.86.075 addressing review and approval of rates and charges by the commission.

Section 19. COURT RULE REPEAL. This section repeals Alaska Rule of Civil Procedure 72.1 in accordance with art. IV, sec. 15, of the Alaska Constitution. The rule, addressing expert advisory panels, is no longer necessary because of the change in AS 09.55.536 replacing the panel with a single expert advisor.

Section 20. APPLICABILITY. This section specifies that the changes made by secs. 4, 5, and 6 of the bill, concerning mandatory arbitration and medical experts, apply only to causes of action accruing on or after the bill's effective date, which sec. 23 designates as July 1, 1994.

Section 21. INITIAL APPOINTMENT OF COMMISSION MEMBERS; REAPPOINTMENT OF INITIAL APPOINTEES. This section requires that the terms of persons initially appointed to the commission must be set in accordance with AS 39.05.055, which addresses requirements for staggering initial terms of commission members. The initial appointees have one-, two-, or three-year terms respectively. This section also allows for initial appointees to be able to be reappointed for one additional six-year term.

Section 22. COURT RULE REQUIREMENT. This section provides that sec. 19 -- repealing Civil Rule 72.1 -- takes effect July 1, 1994 only if sec. 19 receives a two-thirds majority vote of each house as required by art. IV, sec. 15, Alaska Constitution.

Section 23. EFFECTIVE DATE. This section establishes July 1, 1994 as the effective date for all sections of the bill, except sec. 19 on the court rule change.

**GOVERNOR'S
ALASKA HEALTH COMMISSION
LEGISLATION
(SB 270 & HB 414)**

Governor Hickel has introduced legislation to provide a mechanism for focusing on health care in Alaska. This legislation will promote access to affordable health care and provide a means to analyze health care proposals that address the needs of Alaskans.

The Governor's legislation establishes a commission that will analyze state and federal health care systems, implement changes to the present system, and make recommendations for long-term reform. The commission will be comprised of three full-time, paid commissioners appointed by the Governor and confirmed by the Legislature. They will hold staggered, six-year terms. This legislation specifies deadlines by which the commission will complete tasks and report to the Governor and the Legislature. The Commission's budget for the first year is \$885,800 from insurance premium tax receipts. (This amount includes staff appropriate for the commission's functions.)

The commission will identify and implement insurance pools and implement a universal claim form to facilitate data collection and analysis, and to lower administrative costs. They will analyze and collect health care data specific to Alaska on which to base future health care policy decisions and recommendations. Non-binding arbitration will be instituted as an alternative to litigation in resolving malpractice and claim disputes between insurance companies and beneficiaries. Upon review and recommendation by the Division of Insurance the commission can approve changes to health insurance premiums.

The commission will define a potential benefit package for universal coverage and determine the cost of comprehensive reform proposals. They will investigate the use of standard practices to reduce medical tort liability and devise administrative structure to implement reforms. Specific recommendations will be developed and submitted to the Governor for consideration and transmittal to the Legislature.

The commission will conduct public meetings regarding health care issues and commission activities.

GOVERNOR'S ALASKA HEALTH COMMISSION LEGISLATION

PURPOSE

To provide a mechanism for focusing on Alaska's health care system and needs; to promote access to affordable health care; to analyze health care proposals that address the needs of Alaskans; and to make health care recommendations to the Governor and Legislature.

STRATEGY

Establish a commission to analyze state and federal health care systems; implement changes to the present system; and make recommendations for long-term reform.

- * *Membership:* The commission will be comprised of three full-time, paid commissioners appointed by the Governor and confirmed by the Legislature. Staggered, six-year terms. Sunset on the commission for continuation after five years. Governor appoints chair. Members can be removed for cause.
- * *Time frames:* Legislation specifies deadlines by which the commission will complete tasks and report to the Governor and the Legislature.
- * *Cost:* Commission's budget for the first year is \$885,800 from insurance premium tax receipts. Includes staff appropriate for commission's functions.

COMMISSION RESPONSIBILITIES

Authority to implement changes to current health care system:

- * Identify and implement insurance pools.
- * Implement universal claim form to facilitate data collection and analysis and lower administrative costs.
- * Collect health care data specific to Alaska on which to base future health care policy decisions and recommendations.

- * Implement non-binding arbitration as an alternative to litigation in resolving malpractice disputes and claim disputes between insurance companies and beneficiaries.
- * Upon review and recommendation by the Division of Insurance, approve changes to health insurance premiums.
- * Conduct public meetings regarding health care issues and commission activities.

Conduct health care system analysis:

- * Analyze Alaska health care data.
- * Define potential benefit package for universal coverage.
- * Determine cost of comprehensive reform proposals.
- * Investigate the use of standard practices to reduce medical tort liability.
- * Devise administrative structure to implement reforms.

Develop policy recommendations:

- * Develop and submit specific recommendations to the Governor for consideration and transmittal to the Legislature.

5

PROPOSED AMENDMENT TO HB 414

Delete Sections 7, 9, and 11

Section 7 establishes health insurance rate regulation of private insurers as a power and duty of the new Alaska Health Commission .

Section 9 gives the same power and duty for Health Maintenance Organizations

Section 11 gives the same power and duty for service corporations (ie Blue Cross).

HEALTH INSURANCE RATE FILING REQUIREMENTS IN THE STATES

<u>State:</u>	<u>Citation:</u>	<u>Filing Requirement:</u>	<u>Applies to:</u>
Alabama	No provision		
Alaska	No provision		
Arizona	Reg.4-14-607	File and use	Individual health
Arkansas	§23-79-109	Prior approval (30 day deemer provision)	Individual health
California	§10290 tit.10 Reg.2213	File and use (30 days)	Individual health
Colorado	§10-16-107	File and use (30 days)	All health
Connecticut	§38a-481	File and use (30 days)	All health
Delaware	tit.18§§3333, 2504	File and use (90 days)	All health including Med Supp and BC/BS
District of Columbia	§35-517	File and use (30 days)	All health
Florida	Reg.4-68	File and use	All health
Georgia	§33-20-20	Prior approval	All health
Hawaii	No provision		
Idaho	§41-2136	File and use	Individual health
Illinois	I.C. §355	File and use	All health
Indiana	§27-8-5-1	File and use	All health
Iowa	Reg.191-36.9	File and use	All health including Med Supp
Kansas	§40-2215	File and use (30 days)	Individual health
Kentucky	§§304.17-380 to 304.17-383	Prior approval	Individual policies unless contain loss ratio guarantee
Louisiana	R.S.22:211	File and use	All health
Maine	24-A§2736	File and use (60 days)	Individual health Med Supp, LTC

Maryland	Reg.9:30:44.02	File and use (90 days)	All health
Massachusetts	Ch.175§10B	File and use (30 days)	All health
Michigan	§500.3474	File and use	Individual health
Minnesota	§62A.02	File and use (60 days)	All policies
Mississippi	Reg.LA&H 73-4	File and use	All health
Missouri	No provision		
Montana	No provision		
Nebraska	§44-710	File and use	All health
Nevada	§689A.360	File and use	Individual health
New Hampshire	§415:1	File and use (30 days)	All health
New Jersey	Reg.11:4-18.1	File and use	Individual health
New Mexico	§59A-18-13	Prior approval	All health
New York	§3216	File and use	Individual health
North Carolina	§58-51-95 §50-51-85	File and use (90 days) File and use	All health Group health
North Dakota	§26.1-30-19	Prior approval (60 day deemer)	All health
Ohio	§3923.021	File and use (30 days)	All health
Oklahoma	tit.36§4402	File and use	Individual health
Oregon	No provision		
Pennsylvania	§40-39-101	Prior approval	All health
Rhode Island	Reg.XXIII, Part XI	prior approval	All health
South Carolina	§38-71-310	Prior approval (90 day deemer)	Individual health
South Dakota	No provision		
Tennessee	§56-26-102	Prior approval (30 day deemer)	All health except experience rated groups
Texas	Art.3.42	File and use	Individual health

Utah	Reg.R540-85	File and use	Individual health
Vermont	Title 8 §4062	File and use (30 days)	All health
Virginia	§38.2-316	File and use	All health
Washington	No provision		
West Virginia	§33-16B-1	Prior approval (60 day deemer)	All health
Wisconsin	§625.13	Use and file (30 days)	Individual health
Wyoming	§26-18-135	File and use	Individual health

Information supplied by NAIC Chart 7/92

any benefit plan design written, issued, or administered by the carrier at the time of application for a new health benefit plan, or at the time of renewal of a health benefit plan.

(f) The availability, upon request, of a listing of all the carrier's benefit plan designs, including the rates for each benefit plan design.

10717. (a) No carrier shall provide or renew coverage subject to this chapter until it has done all of the following:

(1) A statement has been filed with the commissioner listing all of the carrier's benefit plan designs currently in force that are offered or proposed to be offered for sale in this state, identified by form number, and, if previously approved by the commissioner, the date approved by the commissioner as well as the standard employee risk rate for each risk category for each benefit plan design and the highest and lowest risk adjustment factors that the carrier intends to use in determining rates for each benefit plan design. When filing a new benefit plan design pursuant to Section 10705, carriers may submit both the policy form and the standard employee risk rates for each risk category at the same time.

(2) Either:

(A) Thirty days expires after that statement is filed without written notice from the commissioner specifying the reasons for his or her opinion that the carrier's risk categories or risk adjustment factors do not comply with the requirements of this chapter.

(B) Prior to that time the commissioner gives the carrier written notice that the carrier's risk categories and risk adjustment factors as filed comply with the requirements of this chapter.

(b) No carrier shall issue, deliver, renew, or revise a benefit plan design lawfully provided pursuant to subdivision (a), and no carrier shall change the risk categories, risk adjustment factors, or standard employee risk rates for any benefit plan design until all of the following requirements are met:

(1) The carrier files with the commissioner a statement of the specific changes which the carrier proposes in the risk categories, risk adjustment factors, or standard employee risk rates.

(2) Either:

(A) Thirty days expires after such statement is filed without written notice from the commissioner specifying the reasons for his or her opinion that the carrier's risk categories or risk adjustment factors do not comply with the requirements of this chapter.

(B) Prior to that time the commissioner gives the carrier written notice that the carrier's risk categories and risk adjustment factors as filed comply with the requirements of this chapter.

(c) Notwithstanding any provision to the contrary, when a carrier is changing the standard employee risk rates of a benefit plan design lawfully provided under (a) or (b) above but is not changing the risk categories or risk adjustment factors which have been previously authorized, the carrier need not comply with the requirements of paragraph (2) of subdivision (b), but instead shall submit the revised

3-10-14

To: Reed Stoops	From: Charlie Hunt
Co./Dept.	Co./Dept. Actna

standard employee risk rates for the benefit plan design prior to offering or renewing the benefit plan design.

(d) When submitting filings under subdivision (a), (b), or (c), a carrier may also file with the commissioner at the time of the filings a statement of the standard employee risk rate for each risk category the carrier intends to use for each month in the 12 months subsequent to the date of the filing. Once the requirements of the applicable subdivision (a), (b), or (c), have been met, these rates shall be used by the carrier for the 12-month period unless the carrier is otherwise informed by the commissioner in his or her response to the filings submitted under subdivision (a), (b), or (c), provided that any subsequent change in the standard employee risk rates charged by the carrier which differ from those previously filed with the commissioner must be newly filed in accordance with this subdivision and provided that the carrier does not change the risk categories or risk adjustment factors for the benefit plan design.

(e) If the commissioner notifies the carrier, in writing, that the carrier's risk categories or risk adjustment factors do not comply with the requirements of this chapter, specifying the reasons for his or her opinion, it is unlawful for the carrier, at any time after the receipt of such notice, to utilize the noncomplying health benefit plan, benefit plan design, risk categories, or risk adjustment factors in conjunction with the health benefit plans or benefit plan designs for which the filing was made.

(f) Each carrier shall maintain at its principal place of business copies of all information required to be filed with the commissioner pursuant to this section.

(g) Each carrier shall make the information and documentation described in this section available to the commissioner upon request.

(h) Nothing in this section shall be construed to permit the commissioner to establish or approve the rates charged to policyholders for health benefit plans.

10718. (a) In addition to any other remedy permitted by law, the commissioner shall have the administrative authority to assess penalties against carriers, insurance producers, and other entities engaged in the business of insurance or other persons or entities for violations of this chapter.

(b) Upon a showing of a violation of this chapter in any civil action, a court may also assess the penalties described in this chapter, in addition to any other remedies provided by law.

(c) Any production agent or other person or entity engaged in the business of insurance, other than a carrier, that violates this chapter is liable for administrative penalties of not more than two hundred fifty dollars (\$250) for the first violation.

(d) Any production agent or other person or entity engaged in the business of insurance, other than a carrier, that engages in practices prohibited by this chapter a second or subsequent time, or who commits a knowing violation of this chapter, is liable for

homeowners. It is the first of its kind in the country.

California Insurance Commissioner John Garamendi, along with the Association of California Insurance Companies and the Consumers Union, has asked the Legislature to repeal the earthquake plan. Garamendi, who originally backed the program when he was a state senator, now is concerned about the financial stability of the plan. If the law is repealed, any surcharges collected will be returned.

■ Rate Suppression Found to Affect Health Insurance Availability

A major study of insurance organizations suggests that overly aggressive regulation in some states has contributed to the increase in the number of Americans without medical insurance. The report by Milliman & Robertson, an actuarial firm, found fewer companies writing individual health insurance policies in states with the strongest regulatory climates. As a result, medical coverage was less available in those jurisdictions.

"States with authority to regulate rates generally had the largest growth in the number of uninsured," said Mark Litow, a co-author of the study. "Heavy regulation appears to reduce competition which, in turn, can harm the consumer."

The study surveyed insurance companies, Blue Cross/Blue Shield organizations, HMOs and state risk pools that provided health care coverage for individuals under age 65.

Findings of the 50-state study which covered the period from 1988 through early 1990 indicate:

- The number of uninsureds grew more than twice as fast in states with the authority to regulate rates compared to states that did not have such authority;
- States with the authority to regulate premium rate levels tend to be less competi-

tive than states without such authority; and

- Nationally, one and a half times more companies left the individual major medical insurance market than entered it.

Copies of the study are available from Mark E. Litow, Milliman & Robertson, at 414-784-2250.

■ Maryland Insurance Division to Probe Insurance Fraud

Maryland's Insurance Division has announced the formation of a panel to investigate insurance fraud. Joseph T. Kelly, an assistant state insurance commissioner, who is also a former state police officer with experience in fighting fraud, will head the panel.

Expected to complete its work within 12 months, the panel will include insurance executives, doctors, lawyers, criminal investigators and consumer advocates, among others. Issues under consideration include the creation of a fraud bureau and changes in state law to assist anti-fraud efforts.

■ Texas Regulators to Guide Employers Casualty Co.

Dallas-based Employers Casualty Co., which could be insolvent by as much as \$52.7 million, consented to an order from the Texas regulators on Feb. 10, under which they agreed to stop writing all new policies and renewals. The company also agreed to continue servicing all existing policies until they expire.

State Insurance Commissioner Georgia Flint said, "Immediate action was necessary to assure that this company's \$650 million in assets is managed in the most efficient possible way to protect its policyholders and the taxpayers of Texas."

The company reported a net loss for 1991 of \$39.2 million due to a \$57.2 million shortfall in reserves set aside to cover claims.

**Public Policy Survey
Individual Medical Insurance Market**

AN INDUSTRY STUDY



Milliman & Robertson, Inc.
Actuaries and Consultants

**PUBLIC POLICY SURVEY
INDIVIDUAL MEDICAL
INSURANCE MARKET**

An Industry Study

January 27, 1992

MILLIMAN & ROBERTSON, INC.

Public Policy Survey
Individual Medical Insurance Market

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The views expressed in this report are not necessarily those of Milliman & Robertson, Inc., nor of the sponsors of this report.

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Public Policy Survey
Individual Medical Insurance Market

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Public Policy Survey
Individual Medical Insurance Market

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INTRODUCTION

The Public Policy Survey for the Individual Medical Insurance Market was designed to determine the availability of medical insurance during 1988, 1989 and early 1990, to individuals who were not covered by Medicare or an employer group medical insurance program. Additionally, the survey was designed to provide insight into the impact of state regulation on the individual medical insurance market.

Specific areas addressed by the survey are:

- The number of companies actively writing individual medical insurance by state.
- The market share for insurance companies, Blue Cross/Blue Shield organizations, HMOs and state risk pools by state.
- The use of association/franchise products and one-life group products in the individual insurance market.
- The extent of difficulties encountered in compliance with state regulations, and the impact on the marketplace.

Throughout this study, the term medical insurance means insurance which provides significant medical care benefits to persons under age 65. Medicare supplement, long term care, hospital indemnity, group conversions and specialty coverage, such as cancer, are excluded. The total individual medical insurance market consists of three submarkets or products: individual, association/franchise and one-life group. The individual product includes policies that are sold directly to an individual or family using an individual insurance contract or certificate. The association/franchise product includes policies sold to an individual or family, rather than a group, through an association or franchise. The one-life group product includes policies sold to an individual or family under a multiple-employer trust or similar arrangement, where the group size is one.

SURVEY PROCEDURE

The Public Policy Survey form was mailed to approximately 1,000 companies, including insurance companies, Blue Cross/Blue Shield organizations and state risk pools. This form can be found in Appendix A. Since HMOs typically use different terminology than other companies and few HMOs are marketing individual coverage in a substantial manner, InterStudy, an HMO research organization, was asked to add a question to their annual enrollment survey.

Because a very high response rate was needed to determine items such as the approximate number of companies offering individual medical insurance, a professional telephone survey service was engaged to make follow-up phone calls to those who did not return the Public Policy Survey. As expected, the large majority of those phoned said they had never sold individual medical insurance.

Those companies which did not respond by mail and could not be eliminated by the telephone service were studied further if the company had more than \$1 million of earned accident and health premiums that might be individual medical insurance. Milliman & Robertson, Inc. used Annual Statement materials and follow-up phone calls to estimate the individual medical insurance inforce for the significant non-responding companies. Further details on these procedures and the response rates can be found in Appendix B.

GENERAL CONCLUSIONS

The main conclusions of the study are:

- From 1988 to 1989 policies inforce increased by 3.6% and policies issued increased by 14.2%. While the inforce and issue counts in the Survey increased, it appears the actual change in the number of people insured from 1988 to 1989 was quite small, and may be a decrease.
- At the end of 1989, 64% of the policies inforce were from insurance companies, 32% from Blues organizations, 3% from HMOs, and 1% from state risk pools. Approximately 152 HMOs, 116 insurance companies, 61 (virtually all) Blue Cross/Blue Shield organizations, and 14 state risk pools were issuing policies in 1989. However, no state had more than 30 companies (including Blues organizations) issuing 250 or more policies per year (roughly one issue per working day), and only 3 states had 20 or more companies issuing 500 or more policies per year. By contrast, there were 19 states that had fewer than 10 companies issuing 250 or more policies and 24 states that had fewer than 10 companies selling 500 or more policies. These and other results indicate that the market does not appear to be competitive in certain states while other states appear to be competitive. The least competitive states appear to be Hawaii, Rhode Island, Idaho, District of Columbia, New York and Delaware; the most competitive states appear to be Nebraska, Colorado, Iowa, South Dakota, Kansas and Louisiana.
- In terms of the types of coverage, individual products had 78% of the inforce at year end 1989, association/franchise had 15% and one-life groups 7%. In 1988, comparable numbers were 80% for individual products, 13% for association/franchise and 7% for one-life groups. These results indicate that issues of new policies are shifting to association/franchise and one-life group products. This shift circumvents regulation, which is much greater for individual products than for association/franchise or one-life group products.

For the period of 1987 through 1989, the individual medical insurance market experienced a net loss in that 1.5 times as many companies left the market as entered it.

Within the segments of the market, departures from the individual marketplace were most severe, with 2.1 times as many companies leaving as entering. While some of the individual marketplace departures represented a move to another product form, such as one-life group, the market has suffered a net loss in the number of companies.

The most frequent reasons given for a company ceasing to issue individual major medical policies were lack of profitability and mandated benefit regulation.

Rate regulation and the difficulty experienced by companies in getting rate approval appears to affect the market situation state by state. Observations include:

- Rate regulation and timeliness of rate increase approvals were the most frequent comments by Survey respondents about difficulties with state regulation. States with the authority to regulate rates had more company comments in total and per company than those that lacked such authority;
- States with the authority to regulate rates had relatively low growth in insureds and high growth in uninsured;
- Of the six most competitive states, none have authority to regulate rates; of the six least competitive states, four have such authority. Of the 25 most competitive states, 17 do not have the authority to regulate premium rate levels, while of the 26 least competitive states, 13 do have such authority and two additional states review rate filings as though they have such authority.
- Two-thirds of the states with the authority to regulate rates have fewer than 10 companies issuing 500 or more policies per year, compared to two-thirds of the

states that lack the authority to regulate rates having 10 or more companies issuing 500 or more policies per year;

In summary, the Survey findings lead to a serious concern over the direction of the marketplace, in regard to its ability to attract competitors and be profitable. This direction has resulted in virtually no market growth and caused companies to withdraw entirely from the market. Of particular concern in today's environment of increasing costs is the current trend toward increasing rate regulation and companies trying to circumvent this regulation. This trend is resulting in problems with companies receiving timely rate increases, which often leads to larger aggregate rate increases, larger total lapses and more uninsureds. Also, the real value of regulation--to facilitate the availability of reasonably priced coverage and provide adequate oversight to avoid company insolvencies--may be eroding.

8-GH2024E ✓
Ford
3/14/94

CS FOR HOUSE BILL NO. 414(HES)
IN THE LEGISLATURE OF THE STATE OF ALASKA
EIGHTEENTH LEGISLATURE - SECOND SESSION

BY THE HOUSE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

Offered:
Referred:

Sponsor(s): HOUSE RULES COMMITTEE BY REQUEST OF THE GOVERNOR

A BILL

FOR AN ACT ENTITLED

1 "An Act creating the Alaska Health Commission; relating to the delivery, quality,
2 access, and financing of health care; relating to review and approval of rates and
3 charges of health insurers; relating to certain civil actions against health care
4 providers and health insurers; amending Alaska Rules of Civil Procedure 26 and
5 27 and Alaska Rules of Evidence 802, 803, and 804; repealing Alaska Rule of
6 Civil Procedure 72.1; and providing for an effective date."

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

8 * **Section 1. FINDINGS AND INTENT.** (a) The legislature finds that the access to
9 quality and affordable health care and maintenance of the public's health a vital to the public
10 interest. The legislature further finds that health care costs have grown at a rate far in excess
11 of the overall inflation rate in the economy due to several factors, including variations in
12 treatment practices of providers, cost shifting by health care providers, administrative costs
13 of insurance claims practices, unavailability of affordable insurance, costs of increasing claims

1 and liability for medical malpractice, and lack of coordination of population based public
2 health services. The legislature therefore finds a present need for long-term reform of the
3 health care system in the state.

4 (b) It is the intent of the legislature to promote access to affordable, quality health
5 care for Alaskans by establishing a mechanism for the review of health insurance rate filings,
6 the implementation of health care reform measures, the stabilization of health care service
7 costs, the collection and analysis of information and data concerning health care services, and
8 the making of recommendations based on that data to the governor and the legislature.

9 * Sec. 2. AS 08.64.326 is amended to read:

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

13 (1) secured a license through deceit, fraud, or intentional
14 misrepresentation;

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

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

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

20 (A) a felony or other crime if the felony or other crime is
21 substantially related to the qualifications, functions, or duties of the licensee;
22 or

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

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

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

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

1 (8) has demonstrated

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

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

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

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

11 (10) has violated AS 18.16.010;

12 (11) has violated any code of ethics adopted by regulation by the board;

13 or

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

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

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

26 * Sec. 3. AS 08.68.270 is amended to read:

27 Sec. 08.68.270. GROUND~~S~~ FOR DENIAL, SUSPENSION, OR
28 REVOCATION. The board may deny, suspend, or revoke the license of a person who

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

31 (2) has been convicted of a felony or other crime if the felony or other

- 1 crime is substantially related to the qualifications, functions or duties of the licensee;
- 2 (3) habitually abuses alcoholic beverages, or illegally uses controlled
- 3 substances;
- 4 (4) has impersonated a registered or practical nurse;
- 5 (5) has intentionally or negligently engaged in conduct that has resulted
- 6 in a significant risk to the health or safety of a client or in injury to a client;
- 7 (6) practices or attempts to practice nursing while afflicted with
- 8 physical or mental illness, deterioration, or disability that interferes with the
- 9 individual's performance of nursing functions;
- 10 (7) is guilty of unprofessional conduct as defined by regulations
- 11 adopted by the board;
- 12 (8) has wilfully or repeatedly violated a provision of this chapter or
- 13 regulations adopted under it;
- 14 (9) is professionally incompetent [;
- 15 (10) DENIES CARE OR TREATMENT TO A PATIENT OR PERSON
- 16 SEEKING ASSISTANCE IF THE SOLE REASON FOR THE DENIAL IS THE
- 17 FAILURE OR REFUSAL OF THE PATIENT OR PERSON SEEKING ASSISTANCE
- 18 TO AGREE TO ARBITRATE AS PROVIDED IN AS 09.55.535(a)].

19 * Sec. 4. AS 09.55.535 is repealed and reenacted to read:

20 Sec. 09.55.535. MANDATORY ARBITRATION. (a) A person who files an

21 action for damages against a health care provider resulting from medical malpractice

22 shall also submit the claim to the court for arbitration.

23 (b) When a claim is submitted as required by (a) of this section, the court shall

24 appoint an arbitrator to review the claim. The arbitrator appointed to review the claim

25 shall interview the parties and examine all records or materials relating to the claim

26 and may compel the attendance of witnesses, interview the parties, or consult with

27 medical specialists.

28 (c) An arbitrator appointed under this section shall conduct a prehearing

29 settlement conference within 30 days after the appointment. The arbitrator shall

30 establish a period for discovery and a date for a hearing. The hearing date may not

31 be more than 120 days after the settlement conference.

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

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

7 (f) The provisions of AS 09.43.010 - 09.43.180 (Uniform Arbitration Act)
8 apply to an arbitration under this section to the extent the provisions do not conflict
9 with the provisions of this section.

10 * Sec. 5. AS 09.55.536 is amended to read:

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

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

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

- 1 (1) What was the disorder for which the plaintiff came to medical care?
- 2 (2) What would have been the probable outcome without medical care?
- 3 (3) Was the treatment selected appropriate for the case?
- 4 (4) Did an injury arise from the medical care?
- 5 (5) What is the nature and extent of the medical injury?
- 6 (6) What specifically caused the medical injury?
- 7 (7) Was the medical injury caused by unskillful care?
- 8 (8) If a medical injury had not occurred, how would the plaintiff's
- 9 condition differ from the plaintiff's present condition?

10 (d) In any case in which the answer to one or more of the questions submitted
 11 to the advisor [PANEL] depends upon the resolution of factual questions that
 12 [WHICH] are not the proper subject of expert opinion, the report shall so state and
 13 may answer questions based upon hypothetical facts that are fully set out in the
 14 opinion. The report must [SHALL] include copies of all written statements, opinions,
 15 or records relied upon by the advisor [PANEL] and either a transcription or other
 16 record of any oral statements or opinions; must [SHALL] specify any medical or
 17 scientific authority relied upon by the advisor [PANEL]; and must [SHALL] include
 18 the results of any physical or mental examination performed on the plaintiff. The
 19 advisor [EACH MEMBER] shall sign the report and the signature constitutes the
 20 advisor's [MEMBER'S] adoption of all statements and opinions contained in it. An
 21 advisor [; HOWEVER, A MEMBER] ⁴ INSTEAD OF SIGNING THE REPORT,
 22 SUBMIT A CONCURRING OR DISSENTING REPORT WHICH COMPLIES WITH
 23 THE REQUIREMENTS OF THIS SUBSECTION. A MEMBER] may not attest to
 24 any portion of the report as to which the advisor [MEMBER] is not qualified to give
 25 expert testimony.

26 (e) The report of the advisor [PANEL WITH ANY DISSENTING OR
 27 CONCURRING OPINION] is admissible in evidence to the same extent as though its
 28 contents were orally testified to by the person [OR PERSONS] preparing it. The court
 29 shall delete any portion that would not be admissible because of lack of foundation for
 30 opinion testimony, or otherwise. Either party may submit testimony to support or
 31 refute the report. The jury shall be instructed in general terms that the report shall be

1 considered and evaluated in the same manner as any other expert testimony. The
2 expert advisor [ANY MEMBER OF THE PANEL] may be called by any party and
3 may be cross-examined as to the contents of the report [OR OF THAT MEMBER'S
4 DISSENTING OR CONCURRING OPINION].

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

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

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

25 * Sec. 6. AS 09.55 is amended by adding a new section to read:

26 ARTICLE 5A. CERTAIN CLAIMS AGAINST HEALTH INSURERS.

27 Sec. 09.55.565. PROCEDURE FOR CERTAIN CLAIMS AGAINST A
28 HEALTH INSURER. (a) Unless preempted by federal law that provides otherwise,
29 a person who files an action against a health insurer resulting from a failure to timely
30 pay a claim or to authorize a health care service under a plan or policy shall also
31 submit the claim to the court for arbitration.

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

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

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

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

16 (f) The provisions of AS 09.43.010 - 09.43.180 (Uniform Arbitration Act)
17 apply to an arbitration under this section to the extent the provisions do not conflict
18 with the provisions of this section.

19 (g) In this section,

20 (1) "health care service" has the meaning given in AS 21.86.900;

21 (2) "health insurer" has the meaning given in AS 44.19.639.

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

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

30 (1) actuarial judgment;

31 (2) interpretation of the statistical data relied upon by the disability

1 insurer;

2 (3) the loss and expense experience of the policy or plan or a similar
3 policy or plan; or

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

5 (b) A filing shall be made at least 75 days before the intended effective date
6 of the rate or rating factor and is subject to the approval of the Alaska Health
7 Commission. Within 45 days after a filing under this section, the director shall review
8 the filing and make a written recommendation to the Alaska Health Commission as to
9 whether the commission should approve or disapprove the filing. This
10 recommendation is not an order of the director and is not appealable under
11 AS 21.06.230.

12 Sec. 21.51.360. RISK SHARING AND PURCHASING POOLS. After
13 consulting with and considering any reports or recommendations of the Alaska Health
14 Commission, the director shall adopt regulations to allow for the creation of pools,
15 including pools for the primary benefit of children, for the purpose of sharing risks or
16 purchasing insurance under this chapter.

17 * Sec. 8. AS 21.86.070(g) is amended to read:

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

21 * Sec. 9. AS 21.86 is amended by adding a new section to read:

22 Sec. 21.86.075. REVIEW AND APPROVAL OF RATES AND CHARGES.

23 (a) A health maintenance organization shall file with the director and the Alaska
24 Health Commission rates, rating factors, premiums, fees for services and enrollee fees,
25 including a change to such a rate, factor, premium, or fee, used in providing health
26 care services to enrollees of the health maintenance organization. The filing must
27 include detailed information that allows the director and the commission to evaluate
28 the appropriateness of the proposed rates, factors, premiums, and fees. A health
29 maintenance organization may furnish the following information in support of a filing:

30 (1) actuarial judgment;

31 (2) interpretation of the statistical data relied upon by the health

1 maintenance organization;

2 (3) the loss and expense experience of the policy or plan or a similar
3 policy or plan; or

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

5 (b) A filing required under this section shall be made at least 75 days before
6 the intended effective date of the rate, rating factor, premium, fee for services, or
7 enrollee fee and is subject to the approval of the Alaska Health Commission. Within
8 45 days after a filing under this section, the director shall review the filing and make
9 a written recommendation to the Alaska Health Commission as to whether the
10 commission should approve or disapprove the filing. This recommendation is not an
11 order of the director and is not appealable under AS 21.06.230.

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

13 Sec. 21.86.320. RISK SHARING AND PURCHASING POOLS. After
14 consulting with and considering any reports or recommendations of the Alaska Health
15 Commission, the director shall adopt regulations to allow for the creation of pools,
16 including pools for the primary benefit of children, for the purpose of sharing risks or
17 purchasing insurance under this chapter.

18 * Sec. 11. AS 21.87.190 is repealed and reenacted to read:

19 Sec. 21.87.190. REVIEW AND APPROVAL OF RATES AND CHARGES.

20 (a) Subscription rates, fees, and payments to be charged by a service corporation to
21 or on account of its subscribers may not be excessive, inadequate, or unfairly
22 discriminatory. Rates of payments to be made to participant providers and participant
23 hospitals for services rendered under a subscriber's contract must be fair and
24 reasonable.

25 (b) A service corporation shall file with the director and the Alaska Health
26 Commission subscription rates, rating factors, fees, and payments, including a change
27 to a rate, factor, fee, or payment, to be charged to or on account of the service
28 corporation's subscribers. The filing must include detailed information that allows the
29 director and the commission to evaluate the appropriateness of the proposed rates,
30 factors, fees, and payments. A service corporation may furnish the following
31 information in support of a filing:

- 1 (1) actuarial judgment;
- 2 (2) interpretation of the statistical data relied upon by the service
- 3 corporation;
- 4 (3) the loss and expense experience of the policy or plan or a similar
- 5 policy or plan; or
- 6 (4) other information or data requested by the director.

7 (c) A filing required under this section shall be made at least 75 days before
8 the intended effective date of the subscription rate, rating factor, fee, or payment and
9 is subject to the approval of the Alaska Health Commission. Within 45 days after a
10 filing under this section, the director shall review the filing and make a written
11 recommendation to the Alaska Health Commission as to whether the commission
12 should approve or disapprove the filing. This recommendation is not an order of the
13 director and is not appealable under AS 21.06.230.

14 (d) If a subscriber contract to be issued by the service corporation provides for
15 indemnity benefits and is permitted under this chapter, the service corporation shall
16 include in the rate, fee, or payment required of the subscriber an adequate additional
17 charge for the indemnity benefit, and shall separately set out the amount of the
18 additional charge in the filing required by this section and AS 44.19.629.

19 * Sec. 12. AS 21.87 is amended by adding a new section to read:

20 Sec. 21.87.285. RISK SHARING AND PURCHASING POOLS. After
21 consulting with and considering any reports or recommendations of the Alaska Health
22 Commission, the director shall adopt regulations to allow for the creation of pools,
23 including pools for the primary benefit of children, for the purpose of sharing risks or
24 purchasing insurance under this chapter.

25 * Sec. 13. AS 36.30.015 is amended by adding a new subsection to read:

26 (h) The Alaska Health Commission shall adopt regulations to manage the
27 procurement of supplies, services, and professional services necessary for its operations
28 under AS 44.19.619 - 44.19.639. The regulations must be based on principles of
29 competitive procurement, consistent with this chapter, to satisfy the requirements of
30 the Alaska Health Commission as determined by that commission.

31 * Sec. 14. AS 36.30.990(1) is amended to read:

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(1) "agency"

(A) means a department, institution, board, commission, division, authority, public corporation, the Alaska Pioneers' Home, or other administrative unit of the executive branch of state government;

(B) does not include

(i) the University of Alaska;

(ii) the Alaska Railroad Corporation;

(iii) the Alaska Housing Finance Corporation;

(iv) a regional Native housing authority created under AS 18.55.996 or a regional electrical authority created under AS 18.57.020;

(v) the Department of Transportation and Public Facilities, in regard to the repair, maintenance, and reconstruction of vessels, docking facilities, and passenger and vehicle transfer facilities of the Alaska marine highway system;

(vi) the Alaska Aerospace Development Corporation;

(vii) the Alaska State Pension Investment Board;

(viii) the Alaska Health Commission;

* Sec. 15. AS 39.25.110(11) is amended to read:

(11) the officers and employees of the following boards, commissions, and authorities:

(A) Alaska Gas Pipeline Financing Authority;

(B) Alaska Permanent Fund Corporation;

(C) Alaska Industrial Development and Export Authority;

(D) Alaska Commercial Fisheries Entry Commission;

(E) Alaska Commission on Postsecondary Education;

(F) Alaska Aerospace Development Corporation;

(G) Alaska Health Commission;

* Sec. 16. AS 44.19 is amended by adding new sections to read:

ARTICLE 12. ALASKA HEALTH COMMISSION.

Sec. 44.19.619. CREATION OF COMMISSION. The Alaska Health

1 Commission is created in the Office of the Governor.

2 Sec. 44.19.621. PURPOSE OF COMMISSION. The purpose of the
3 commission is to improve health care in this state by

4 (1) establishing and implementing a system for collecting and analyzing
5 information and data relating to the individual and public health care needs of and
6 services provided to residents of the state;

7 (2) promoting the use of electronic data transfer and the implementation
8 of uniform procedures for billing, payment, and claim systems;

9 (3) promoting consumer confidence in the health care system through
10 approval of rate filings by health insurers and disclosure of charges by health care
11 providers;

12 (4) promoting the creation of pools, including pools for the primary
13 benefit of children, for the purpose of sharing risks or purchasing insurance for health
14 care services; and

15 (5) analyzing health care reform proposals, including a proposal that
16 is based on a single payor system; recommending health care reform proposals to the
17 governor and the legislature; and reporting to and making recommendations to the
18 governor and legislature on the following:

19 (A) defining a range of potential benefit packages for universal
20 health care coverage for residents of the state; a benefit package must include
21 coverage for health care services without containing an exclusion based on a
22 preexisting condition;

23 (B) determining the needs and requirements imposed on the
24 state by federal enactments that affect health care reform; the commission shall
25 make the determination required under this subparagraph within 60 days after
26 each measure is enacted into law;

27 (C) determining the prospective costs for recommended
28 comprehensive health care reform proposals, as requested by the governor or
29 as determined by a majority vote of the commission;

30 (D) determining financing plans for recommended proposals;

31 (E) describing administrative structures necessary to implement

1 recommended proposals;

2 (F) identifying a process to implement statewide expenditure
3 measures for health care goods and services;

4 (G) investigating health care standards of practice and
5 determining their effect on medical tort liability and other aspects of health care
6 delivery; and

7 (H) investigating alternatives to existing hospital licensing
8 requirements to allow for less use of acute care facilities.

9 Sec. 44.19.622. COMPOSITION; QUALIFICATIONS; TERMS; REMOVAL;
10 DESIGNATION OF CHAIR. (a) The commission consists of three members
11 appointed by the governor and confirmed by the legislature for six-year terms. Not
12 more than one member of the commission may be

13 (1) a health care provider; or

14 (2) employed by a health insurance company.

15 (b) A commission member may serve only one six-year term plus the
16 remainder of any unexpired term to which the member was appointed.

17 (c) The governor may remove a member of the commission only for cause.

18 (d) The governor shall designate a member of the commission to serve, at the
19 pleasure of the governor, as chair of the commission for a term of two years. The
20 governor may reappoint the same member for additional terms as chair.

21 (e) A commission member shall comply with the applicable requirements of
22 AS 39.50, and must be a state resident throughout the person's term as a member of
23 the commission.

24 Sec. 44.19.623. STAFF. The commission may employ staff as necessary to
25 carry out the purposes of this chapter. The staff of the commission is in the exempt
26 service.

27 Sec. 44.19.624. COMPENSATION. Members of the commission are in the
28 exempt service and are entitled to a monthly salary equal to Step C, Range 26, of the
29 salary schedule set out in AS 39.27.011(a) for Anchorage, Alaska. Subject to the
30 availability of appropriations, the chair may be paid at a higher step in the same range,
31 if approved by the governor.

1 Sec. 44.19.625. MEETINGS. (a) The commission shall meet publicly not less
2 than quarterly to accomplish its duties under AS 44.19.619 - 44.19.639. The
3 commission shall comply with AS 44.62.310 - 44.62.312.

4 (b) Two members of the commission constitute a quorum for the transaction
5 of business and the exercise of the powers and duties of the commission.

6 Sec. 44.19.626. POWERS AND DUTIES. (a) The commission may

7 (1) enter into contracts and execute instruments necessary for carrying
8 out its business;

9 (2) establish advisory committees to the commission to conduct
10 research or investigation and report back to the commission on findings; an advisory
11 committee must consist of at least one member of the commission and may include
12 other individuals with appropriate expertise appointed by the commission;

13 (3) adopt regulations necessary to interpret or implement
14 AS 44.19.619 - 44.19.639, including regulations establishing reasonable, necessary fees
15 for services provided by the commission.

16 (b) The commission shall

17 (1) conduct public meetings in accordance with AS 44.19.625,
18 including holding public hearings as necessary;

19 (2) collect and analyze data and information from public, private, or
20 other sources relating to the cost, delivery, or financing of health care services
21 provided to state residents;

22 (3) monitor the costs of and the access to health care services to state
23 residents;

24 (4) make reports and recommendations to the governor and legislature
25 in accordance with AS 44.19.619 - 44.19.639;

26 (5) review and either approve or disapprove filings of rates, rate factors,
27 and subscriber and enrollee fees as provided in AS 44.19.629;

28 (6) establish a public health advisory committee that

29 (A) consists of at least one member of the commission and
30 other individuals with significant public health expertise appointed by the
31 commission; the commission shall consider public and private health care

- 1 professionals, labor organizations, businesses, the education system, the Alaska
2 Public Health Association, the Alaska Mental Health Board, and the Alaska
3 Native Health Board for service on the public health advisory committee, as
4 well as recognizing the need for geographic, ethnic, and cultural diversity;
- 5 (B) advises the commission on public health matters and the
6 integration of public health services under AS 44.19.621;
- 7 (C) develops a public health improvement plan as described
8 under (c) of this section;
- 9 (7) obtain waivers from federal agencies or under applicable federal law
10 to the extent necessary to maximize the collection and analysis of health care data.
- 11 (c) The plan developed by the committee under (b)(6) of this section may
- 12 (1) recognize the need for
- 13 (A) community involvement in health care planning and
14 delivery;
- 15 (B) attention to local needs that may vary from place to place;
- 16 (C) accountability for the use of public funds;
- 17 (D) equity and stability in the distribution of public funds;
- 18 (E) shared responsibility of all levels of government for
19 administering and financing public health care delivery; and
- 20 (F) coordination of basic public health services; and
- 21 (2) include
- 22 (A) an analysis of the health status of the residents of the state;
- 23 (B) an assessment of the most appropriate role for various levels
24 of government to play in addressing the health care needs of the residents of
25 the state;
- 26 (C) a delineation of the standards that should be used in
27 performing assessment, policy development, and quality assurance in the
28 delivery of public health services;
- 29 (D) documentation of the extent to which the current public
30 health system implements or achieves the standards identified under (C) of this
31 paragraph;

1 (E) identification of interjurisdictional issues involved in health
2 care access and delivery;

3 (F) recommendations, including recommendations for specific
4 legislative action when necessary, pertaining to the following:

5 (i) strategies, time lines, financial needs, and specific
6 sources of stable revenue for bringing the state public health care
7 system up to standards identified by the committee;

8 (ii) appropriate sharing of the responsibility of local,
9 regional, state, and federal government entities to deliver public health
10 care services efficiently and effectively, including recommendations for
11 organization within state government;

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

14 (iv) the committee's estimate of the optimal share that
15 public health should represent in the total health care delivery system
16 of the state, expressed in terms of a percentage of health care dollars
17 spent or in terms of public dollars per state resident.

18 Sec. 44.19.627. DUTY TO REPORT. At the request of the governor, the
19 commission shall compile and issue to the governor, the legislature, and the public a
20 report concerning its activities.

21 Sec. 44.19.628. UNIFORM DATA AND PROCEDURES FOR HEALTH
22 CLAIMS. (a) The director of the division of insurance, after considering the advice
23 of the commission, shall adopt by regulation uniform claims forms, uniform standards,
24 and uniform procedures for the processing of data relating to billing for and payment
25 of health care services provided to state residents. All health insurers shall comply
26 with the uniform claims forms, standards, and procedures established under this
27 section.

28 (b) To the extent that there is a conflict or inconsistency between a provision
29 of AS 21 that applies to a health insurer and a provision of a regulation adopted under
30 (a) of this section, the regulation governs. The director of the division of insurance
31 shall ensure that regulations adopted by the director under AS 21 that apply to a health

1 insurer are not in conflict or inconsistent with regulations adopted under (a) of this
2 section.

3 Sec. 44.19.629. REVIEW AND APPROVAL OF RATES AND CHARGES.

4 (a) The commission shall review a rate filing and the recommendation of the division
5 of insurance made under AS 21.51.350, AS 21.86.075, or AS 21.87.190. In reviewing
6 a filing, the commission

7 (1) shall collect and analyze information and data from the health
8 insurer that made the filing;

9 (2) may use any information or data collected under AS 44.19.619 -
10 44.19.639; and

11 (3) shall hold a public hearing for comment on the filing and for
12 verifying the basis for the filing.

13 (b) After the commission completes the requirements of (a) of this section, the
14 commission shall issue a decision on the filing. The commission may approve or
15 disapprove a filing reviewed under this section. If the commission fails to issue a
16 decision within 75 days after the filing was made, the filing is considered to be
17 approved by the commission under this section.

18 Sec. 44.19.630. APPEALS OF COMMISSION DECISIONS. A health insurer
19 aggrieved by a decision of the commission under AS 44.19.629 concerning that
20 insurer's filing may appeal the decision to the superior court.

21 Sec. 44.19.631. DISCLOSURE OF INFORMATION; PENALTY. (a) A
22 person providing or insuring health care services in the state shall provide, upon
23 request or order of the commission, reports, data, health information, insurance
24 schedules, statistics, and other information, as determined necessary by the
25 commission, by regulation, to carry out the purposes of AS 44.19.619 - 44.19.639.
26 This subsection applies to the state and to a municipality; as well as to public and
27 private health care facilities and providers, and health care insurers and self-insurers.

28 (b) Information and data obtained or produced by the commission is subject
29 to AS 09.25.110 and 09.25.120 and regulations adopted under AS 09.25.110 and
30 09.25.120. Information or data that identifies a recipient of health care services is
31 considered to be a medical and related public health record that is subject to the

1 exception to public inspection under AS 09.25.120 and shall be kept confidential.

2 (c) A member, an employee, or an agent of the commission, or a member of
3 an advisory committee to the commission, who wrongfully discloses or who uses or
4 permits the use of confidential information or data in violation of (b) of this section
5 is guilty of a class B misdemeanor.

6 Sec. 44.19.632. IMMUNITY FROM LIABILITY. Members of the
7 commission, its employees, its agents, its advisory committee members, and persons
8 providing information and data to the commission as required under AS 44.19.619 -
9 44.19.639 are not liable for civil damages for an act or omission in the execution of
10 their authorized activities or duties under AS 44.19.619 - 44.19.639. This section does
11 not preclude liability for civil damages as a result of reckless or intentional
12 misconduct.

13 Sec. 44.19.633. OATHS; SUBPOENAS. (a) The commission may administer
14 oaths and may issue subpoenas to persons to require testimony or to require the
15 production of records, information, or data under AS 44.19.629 or 44.19.631.

16 (b) If a person disobeys or resists a lawful subpoena issued by the commission,
17 the commission may certify the facts to the superior court, and upon certification the
18 court shall issue an order directing the person to appear before the court and show
19 cause why the person should not be punished for contempt.

20 Sec. 44.19.634. APPROPRIATIONS. The legislature may appropriate a
21 portion of the proceeds of the tax on insurance premiums collected under
22 AS 21.09.210 to the Alaska Health Commission for the commission's operating costs.

23 Sec. 44.19.635. DISCLOSURE OF PROVIDER CHARGES; FINE FOR
24 NONDISCLOSURE. (a) At least annually, a provider shall compile a list of charges
25 for the 20 health care services most commonly provided by that provider. Charges for
26 hospital services may be prepared on the basis of diagnosis-related groups. Upon
27 request of a person who is considering obtaining services from a provider, the provider
28 shall provide the list of charges to the person for use in comparing charges among
29 providers.

30 (b) Upon the request of a patient and before the commencement of a medical
31 procedure, the provider shall disclose to that patient the estimated charge for the

1 procedure. The estimated charge shall be made in good faith and must be based on
2 the provider's history of charges for that procedure. Nothing in this subsection
3 requires a provider to make a charge estimate if the provider does not agree to perform
4 the procedure.

5 (c) A provider shall place the following statement either on a form to be
6 signed by the patient or in a conspicuous location on an easily readable sign: "You
7 are entitled to a charge estimate for a medical procedure before the procedure is
8 performed by your health provider."

9 (d) If the commission, after investigation of a complaint by a patient,
10 determines that a provider has not complied with this section, the commission may
11 impose a fine of up to \$1,000 against the provider. The commission may impose only
12 one fine under this section against a provider in a calendar year. A provider's
13 violation of this section does not preclude the provider from collecting payment for
14 services provided.

15 (e) A provider aggrieved by a decision of the commission under this section
16 may appeal the decision to the superior court.

17 Sec. 44.19.639. DEFINITIONS. In AS 44.19.619 - 44.19.639, unless the
18 context requires otherwise,

19 (1) "commission" means the Alaska Health Commission;

20 (2) "division of insurance" means the division of insurance in the
21 Department of Commerce and Economic Development;

22 (3) "health care services" has the meaning given in AS 21.86.900;

23 (4) "health information" means all information and data relating to
24 access to or delivery or financing of health care services;

25 (5) "health insurance" has the meaning given "disability insurance" in
26 AS 21.12.050;

27 (6) "health insurer" means an entity transacting the business of health
28 insurance, a health maintenance organization under AS 21.86, a hospital service
29 corporation under AS 21.87, a medical service corporation under AS 21.87, or a
30 combined medical service and hospital service corporation under AS 21.87;

31 (7) "pool" means a mechanism to facilitate or provide for sharing risks

1 or the purchase of health insurance in the event coverage is unavailable or
2 unobtainable;

3 (8) "provider" has the meaning given in AS 21.86.900;

4 (9) "single payor system" means a method of financing health care
5 services in a manner that provides every resident a minimum set of uniform benefits
6 and that requires payment for services be made through a single entity.

7 * Sec. 17. AS 44.62.310(d) is amended to read:

8 (d) This section does not apply to

9 (1) judicial or quasi-judicial bodies when holding a meeting solely to
10 make a decision in an adjudicatory proceeding;

11 (2) juries;

12 (3) parole or pardon boards;

13 (4) meetings of a hospital medical staff; or

14 (5) meetings of the governing body or any committee of a hospital
15 when holding a meeting solely to act upon matters of professional qualifications,
16 privileges or discipline; or

17 (6) meetings of the Alaska Health Commission, except for meetings
18 concerning the adoption of regulations or actions on filings under AS 44.19.629.

19 * Sec. 18. AS 44.66.010(a) is amended by adding a new paragraph to read:

20 (20) Alaska Health Commission (AS 44.19.619) -- June 30, 1999.

21 * Sec. 19. AS 09.55.560(2), 09.55.560(3); AS 21.86.070(e), and 21.86.070(f) are repealed.

22 * Sec. 20. Alaska Rule of Civil Procedure 72.1 is repealed.

23 * Sec. 21. APPLICABILITY. Sections 4, 5, and 6 of this Act apply to a cause of action
24 accruing on or after the effective date of this Act.

25 * Sec. 22. INITIAL APPOINTMENT OF COMMISSION MEMBERS. Notwithstanding
26 AS 44.19.622(a), enacted by sec. 16 of this Act, the terms of persons initially appointed to the
27 Alaska Health Commission under AS 44.19.622 shall be staggered as provided in
28 AS 39.05.055.

29 * Sec. 23. REAPPOINTMENT OF INITIAL APPOINTEES. Notwithstanding
30 AS 44.19.622(b), enacted by sec. 16 of this Act, a person initially appointed to the Alaska
31 Health Commission under (a) of this section may be reappointed to serve no more than one

1 six-year term as a member of the Alaska Health Commission.

2 * **Sec. 24. PHASED TRANSITION PERIOD.** (a) Notwithstanding the provisions of
3 AS 44.19.621 - 44.19.639, the Alaska Health Commission shall implement the provisions of
4 AS 44.19.621 - 44.19.639 on a orderly and gradual basis as follows:

5 (1) by January 1, 1996, the commission shall complete the research necessary
6 to report recommendations to the governor and the legislature on the issues described under
7 AS 44.19.621(a)(5)(A), (C), (D), (E), and (G);

8 (2) by July 1, 1996, the commission shall complete the research necessary to
9 report recommendations to the governor and the legislature on the issues described under
10 AS 44.19.621(a)(5)(F) and adopt regulations necessary to implement AS 44.19.628(a);

11 (3) by January 1, 1997, the commission shall complete the research necessary
12 to report recommendations to the governor and the legislature on the issues described under
13 AS 44.19.621(a)(5)(H).

14 (b) Upon request of the commission, and for good cause shown, the governor may
15 grant an extension of a deadline set in (a) of this section. The governor shall inform the
16 legislature of a decision on a request to extend a deadline.

17 * **Sec. 25.** AS 09.55.536(f), amended by sec. 5 of this Act, amends Alaska Rules of Civil
18 Procedure 26 and 27 by providing that discovery may not be undertaken until the expert
19 advisor's report is received.

20 * **Sec. 26.** AS 09.55.536(e), amended by sec. 5 of this Act, amends Alaska Rules of
21 Evidence 802, 803, and 804 by providing that the expert advisor's report is admissible in
22 evidence to the same extent as though its contents were orally testified to by the advisor.

23 * **Sec. 27.** Section 20 of this Act takes effect July 1, 1994, only if that section receives the
24 two-thirds majority vote of each house required by art. IV, sec. 15, Constitution of the State
25 of Alaska.

26 * **Sec. 28.** This Act takes effect July 1, 1994.

8-GH2024N
Ford
3/22/94

CS FOR HOUSE BILL NO. 414(HES)

IN THE LEGISLATURE OF THE STATE OF ALASKA

EIGHTEENTH LEGISLATURE - SECOND SESSION

BY THE HOUSE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

Offered:

Referred:

Sponsor(s): **HOUSE RULES COMMITTEE BY REQUEST OF THE GOVERNOR**

A BILL

FOR AN ACT ENTITLED

1 "An Act creating the Alaska Health Commission; relating to the delivery, quality,
2 access, and financing of health care; relating to health insurers, health
3 maintenance organizations, and medical service corporations; relating to certain
4 civil actions against health care providers and health insurers; amending Alaska
5 Rules of Civil Procedure 26 and 27 and Alaska Rules of Evidence 802, 803, and
6 804; repealing Alaska Rule of Civil Procedure 72.1; and providing for an effective
7 date."

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

9 * Section 1. FINDINGS AND INTENT. (a) The legislature finds that the access to
10 quality and affordable health care and maintenance of the public's health are vital to the public
11 interest. The legislature further finds that health care costs have grown at a rate far in excess
12 of the overall inflation rate in the economy due to several factors, including variations in
13 treatment practices of providers, cost shifting by health care providers, administrative costs

1 of insurance claims practices, unavailability of affordable insurance, costs of increasing claims
2 and liability for medical malpractice, and lack of coordination of population based public
3 health services. The legislature therefore finds a present need for long-term reform of the
4 health care system in the state.

5 (b) It is the intent of the legislature to promote access to affordable, quality health
6 care for Alaskans by the implementation of health care reform measures, the stabilization of
7 health care service costs, the collection and analysis of information and data concerning health
8 care services, and the making of recommendations based on that data to the governor and the
9 legislature.

10 * Sec. 2. 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
13 that a licensee

14 (1) secured a license through deceit, fraud, or intentional
15 misrepresentation;

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

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

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

21 (A) a felony or other crime if the felony or other crime is
22 substantially related to the qualifications, functions, or duties of the licensee;
23 or

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

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

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

31 (7) failed to comply with this chapter, a regulation adopted under this

1 chapter, or an order of the board;

2 (8) has demonstrated

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

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

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

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

12 (10) has violated AS 18.16.010;

13 (11) has violated any code of ethics adopted by regulation by the board;

14 or

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

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

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

27 * Sec. 3. AS 08.68.270 is amended to read:

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

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

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

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

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

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

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

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

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

15 (9) is professionally incompetent [;

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

20 * Sec. 4. AS 09.55.535 is repealed and reenacted to read:

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

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

29 (c) An arbitrator appointed under this section shall conduct a prehearing
30 settlement conference within 30 days after the appointment. The arbitrator shall
31 establish a period for discovery and a date for a hearing. The hearing date may not

1 be more than 120 days after the settlement conference.

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

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

8 (f) The provisions of AS 09.43.010 - 09.43.180 (Uniform Arbitration Act)
9 apply to an arbitration under this section to the extent the provisions do not conflict
10 with the provisions of this section.

11 * Sec. 5. AS 09.55.536 is amended to read:

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

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

30 (c) Not more than 30 days after selection of the advisor, the advisor [PANEL,
31 IT] shall make a written report to the parties and to the court, answering the following

1 questions and other questions submitted to the advisor [PANEL] by the court:

- 2 (1) What was the disorder for which the plaintiff came to medical care?
3 (2) What would have been the probable outcome without medical care?
4 (3) Was the treatment selected appropriate for the case?
5 (4) Did an injury arise from the medical care?
6 (5) What is the nature and extent of the medical injury?
7 (6) What specifically caused the medical injury?
8 (7) Was the medical injury caused by unskillful care?
9 (8) If a medical injury had not occurred, how would the plaintiff's
10 condition differ from the plaintiff's present condition?

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

27 (e) The report of the advisor [PANEL WITH ANY DISSENTING OR
28 CONCURRING OPINION] is admissible in evidence to the same extent as though its
29 contents were orally testified to by the person [OR PERSONS] preparing it. The court
30 shall delete any portion that would not be admissible because of lack of foundation for
31 opinion testimony, or otherwise. Either party may submit testimony to support or

1 refute the report. The jury shall be instructed in general terms that the report shall be
2 considered and evaluated in the same manner as any other expert testimony. The
3 expert advisor [ANY MEMBER OF THE PANEL] may be called by any party and
4 may be cross-examined as to the contents of the report [OR OF THAT MEMBER'S
5 DISSENTING OR CONCURRING OPINION].

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

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

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

26 * Sec. 6. AS 09.55 is amended by adding a new section to read:

27 ARTICLE 5A. CERTAIN CLAIMS AGAINST HEALTH INSURERS.

28 Sec. 09.55.565. PROCEDURE FOR CERTAIN CLAIMS AGAINST A
29 HEALTH INSURER. (a) Unless preempted by federal law that provides otherwise,
30 a person who files an action against a health insurer resulting from a failure to timely
31 pay a claim or to authorize a health care service under a plan or policy shall also

1 submit the claim to the court for arbitration.

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

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

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

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

17 (f) The provisions of AS 09.43.010 - 09.43.180 (Uniform Arbitration Act)
18 apply to an arbitration under this section to the extent the provisions do not conflict
19 with the provisions of this section.

20 (g) In this section,

21 (1) "health care service" has the meaning given in AS 21.86.900;

22 (2) "health insurer" has the meaning given in AS 44.19.639.

23 * Sec. 7. AS 21.51 is amended by adding new sections 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. 21.51.360. RISK SHARING AND PURCHASING POOLS. After

1 consulting with and considering any reports or recommendations of the Alaska Health
2 Commission, the director shall adopt regulations to allow for the creation of pools,
3 including pools for the primary benefit of children, for the purpose of sharing risks or
4 purchasing insurance under this chapter.

5 * Sec. 8. AS 21.86.070(g) is amended to read:

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

9 * Sec. 9. AS 21.86 is amended by adding a new section to read:

10 Sec. 21.86.075. PREMIUM RATES AND CHARGES. A health maintenance
11 organization

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

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

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

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

20 Sec. 21.86.320. RISK SHARING AND PURCHASING POOLS. After
21 consulting with and considering any reports or recommendations of the Alaska Health
22 Commission, the director shall adopt regulations to allow for the creation of pools,
23 including pools for the primary benefit of children, for the purpose of sharing risks or
24 purchasing insurance under this chapter.

25 * Sec. 11. AS 21.87.190 is repealed and reenacted to read:

26 Sec. 21.87.190. RATES AND CHARGES. 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;

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

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

3 * Sec. 12. AS 21.87 is amended by adding a new section to read:

4 Sec. 21.87.285. RISK SHARING AND PURCHASING POOLS. After
5 consulting with and considering any reports or recommendations of the Alaska Health
6 Commission, the director shall adopt regulations to allow for the creation of pools,
7 including pools for the primary benefit of children, for the purpose of sharing risks or
8 purchasing insurance under this chapter.

9 * Sec. 13. AS 36.30.015 is amended by adding a new subsection to read:

10 (h) The Alaska Health Commission shall adopt regulations to manage the
11 procurement of supplies, services, and professional services necessary for its operations
12 under AS 44.19.619 - 44.19.639. The regulations must be based on principles of
13 competitive procurement, consistent with this chapter, to satisfy the requirements of
14 the Alaska Health Commission as determined by that commission.

15 * Sec. 14. AS 36.30.990(1) is amended to read:

16 (1) "agency"

17 (A) means a department, institution, board, commission,
18 division, authority, public corporation, the Alaska Pioneers' Home, or other
19 administrative unit of the executive branch of state government;

20 (B) does not include

21 (i) the University of Alaska;

22 (ii) the Alaska Railroad Corporation;

23 (iii) the Alaska Housing Finance Corporation;

24 (iv) a regional Native housing authority created under
25 AS 18.55.996 or a regional electrical authority created under
26 AS 18.57.020;

27 (v) the Department of Transportation and Public
28 Facilities, in regard to the repair, maintenance, and reconstruction of
29 vessels, docking facilities, and passenger and vehicle transfer facilities
30 of the Alaska marine highway system;

31 (vi) the Alaska Aerospace Development Corporation;

(vii) the Alaska State Pension Investment Board;

(viii) the Alaska Health Commission;

* Sec. 15. AS 39.25.110(11) is amended to read:

(11) the officers and employees of the following boards, commissions, and authorities:

(A) Alaska Gas Pipeline Financing Authority;

(B) Alaska Permanent Fund Corporation;

(C) Alaska Industrial Development and Export Authority;

(D) Alaska Commercial Fisheries Entry Commission;

(E) Alaska Commission on Postsecondary Education;

(F) Alaska Aerospace Development Corporation;

(G) Alaska Health Commission;

* Sec. 16. AS 44.19 is amended by adding new sections to read:

ARTICLE 12. ALASKA HEALTH COMMISSION.

Sec. 44.19.619. CREATION OF COMMISSION. The Alaska Health Commission is created in the Office of the Governor.

Sec. 44.19.621. PURPOSE OF COMMISSION. The purpose of the commission is to improve health care in this state by

(1) establishing and implementing a system for collecting and analyzing information and data relating to the individual and public health care needs of and services provided to residents of the state;

(2) promoting the use of electronic data transfer and the implementation of uniform procedures for billing, payment, and claim systems;

(3) promoting consumer confidence in the health care system through rate filings by health insurers and disclosure of charges by health care providers;

(4) promoting consumer confidence in the health care system by requiring insurers and managed care plans to fully disclose the health care benefits provided under the policy or plan and explain any exclusions or restrictions on benefits; disclosure should include an explanation of limitations on

(A) referral to a specialty physician or other provider;

(B) the insured's choice of provider;

- 1 (C) diagnostic tests, including mammography;
2 (D) prescription drugs;
3 (E) dental services;
4 (F) laboratory tests;
5 (G) mental health services; and
6 (H) reproductive tests;
- 7 (5) promoting the creation of pools, including pools for the primary
8 benefit of children, for the purpose of sharing risks or purchasing insurance for health
9 care services; and
- 10 (6) analyzing health care reform proposals, including a proposal that
11 is based on a market based single payer system; recommending health care reform
12 proposals to the governor and the legislature; and reporting to and making
13 recommendations to the governor and legislature on the following:
- 14 (A) defining a range of potential benefit packages for universal
15 health care coverage for residents of the state; a benefit package must include
16 coverage for health care services without containing an exclusion based on a
17 preexisting condition;
- 18 (B) determining the needs and requirements imposed on the
19 state by federal enactments that affect health care reform; the commission shall
20 make the determination required under this subparagraph within 60 days after
21 each measure is enacted into law;
- 22 (C) determining the prospective costs for recommended
23 comprehensive health care reform proposals, as requested by the governor or
24 as determined by a majority vote of the commission;
- 25 (D) determining financing plans for recommended proposals;
- 26 (E) describing administrative structures necessary to implement
27 recommended proposals;
- 28 (F) identifying a process to implement statewide expenditure
29 measures for health care goods and services;
- 30 (G) investigating health care standards of practice and
31 determining their effect on medical tort liability and other aspects of health care

1 delivery; and

2 (H) investigating alternatives to existing hospital licensing
3 requirements to allow for less use of acute care facilities.

4 Sec. 44.19.622. COMPOSITION; QUALIFICATIONS; TERMS; REMOVAL;
5 DESIGNATION OF CHAIR. (a) The commission consists of three members
6 appointed by the governor and confirmed by the legislature for six-year terms. Not
7 more than one member of the commission may be

8 (1) a health care provider; or

9 (2) employed by a health insurance company.

10 (b) A commission member may serve only one six-year term plus the
11 remainder of any unexpired term to which the member was appointed.

12 (c) The governor may remove a member of the commission only for cause.

13 (d) The governor shall designate a member of the commission to serve, at the
14 pleasure of the governor, as chair of the commission for a term of two years. The
15 governor may reappoint the same member for additional terms as chair.

16 (e) A commission member shall comply with the applicable requirements of
17 AS 39.50, and must be a state resident throughout the person's term as a member of
18 the commission.

19 Sec. 44.19.623. STAFF. The commission may employ staff as necessary to
20 carry out the purposes of this chapter. The staff of the commission is in the exempt
21 service.

22 Sec. 44.19.624. COMPENSATION. Members of the commission are in the
23 exempt service and are entitled to a monthly salary equal to Step C, Range 26, of the
24 salary schedule set out in AS 39.27.011(a) for Anchorage, Alaska. Subject to the
25 availability of appropriations, the chair may be paid at a higher step in the same range,
26 if approved by the governor.

27 Sec. 44.19.625. MEETINGS. (a) The commission shall meet publicly not less
28 than quarterly to accomplish its duties under AS 44.19.619 - 44.19.639. The
29 commission shall comply with AS 44.62.310 - 44.62.312.

30 (b) Two members of the commission constitute a quorum for the transaction
31 of business and the exercise of the powers and duties of the commission.

1 Sec. 44.19.626. POWERS AND DUTIES. (a) The commission may

2 (1) enter into contracts and execute instruments necessary for carrying
3 out its business;

4 (2) establish advisory committees to the commission to conduct
5 research or investigation and report back to the commission on findings; an advisory
6 committee must consist of at least one member of the commission and may include
7 other individuals with appropriate expertise appointed by the commission;

8 (3) adopt regulations necessary to interpret or implement
9 AS 44.19.619 - 44.19.639, including regulations establishing reasonable, necessary fees
10 for services provided by the commission.

11 (b) The commission shall

12 (1) conduct public meetings in accordance with AS 44.19.625,
13 including holding public hearings as necessary;

14 (2) collect and analyze data and information from public, private, or
15 other sources relating to the cost, delivery, or financing of health care services
16 provided to state residents;

17 (3) monitor the costs of and the access to health care services to state
18 residents;

19 (4) make reports and recommendations to the governor and legislature
20 in accordance with AS 44.19.619 - 44.19.639;

21 (5) establish a public health advisory committee that

22 (A) consists of at least one member of the commission and
23 other individuals with significant public health expertise appointed by the
24 commission; the commission shall consider public and private health care
25 professionals, labor organizations, businesses, the education system, the Alaska
26 Public Health Association, the Alaska Mental Health Board, and the Alaska
27 Native Health Board for service on the public health advisory committee, as
28 well as recognizing the need for geographic, ethnic, and cultural diversity;

29 (B) advises the commission on public health matters and the
30 integration of public health services under AS 44.19.621;

31 (C) develops a public health improvement plan as described

1 under (c) of this section;

2 (6) obtain waivers from federal agencies or under applicable federal law
3 to the extent necessary to maximize the collection and analysis of health care data.

4 (c) The plan developed by the committee under (b)(5) of this section may

5 (1) recognize the need for

6 (A) community involvement in health care planning and
7 delivery;

8 (B) attention to local needs that may vary from place to place;

9 (C) accountability for the use of public funds;

10 (D) equity and stability in the distribution of public funds;

11 (E) shared responsibility of all levels of government for
12 administering and financing public health care delivery; and

13 (F) coordination of basic public health services; and

14 (2) include

15 (A) an analysis of the health status of the residents of the state;

16 (B) an assessment of the most appropriate role for various levels
17 of government to play in addressing the health care needs of the residents of
18 the state;

19 (C) a delineation of the standards that should be used in
20 performing assessment, policy development, and quality assurance in the
21 delivery of public health services;

22 (D) documentation of the extent to which the current public
23 health system implements or achieves the standards identified under (C) of this
24 paragraph;

25 (E) identification of interjurisdictional issues involved in health
26 care access and delivery;

27 (F) recommendations, including recommendations for specific
28 legislative action when necessary, pertaining to the following:

29 (i) strategies, time lines, financial needs, and specific
30 sources of stable revenue for bringing the state public health care
31 system up to standards identified by the committee;

1 (ii) appropriate sharing of the responsibility of local,
2 regional, state, and federal government entities to deliver public health
3 care services efficiently and effectively, including recommendations for
4 organization within state government;

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

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

11 (v) a program designed to give incentives to primary
12 care providers to practice in the state, especially in rural and under
13 served areas of the state.

14 Sec. 44.19.627. DUTY TO REPORT. At the request of the governor, the
15 commission shall compile and issue to the governor, the legislature, and the public a
16 report concerning its activities.

17 Sec. 44.19.628. UNIFORM DATA AND PROCEDURES FOR HEALTH
18 CLAIMS. (a) The director of the division of insurance, after considering the advice
19 of the commission, shall adopt by regulation uniform claims forms, uniform standards,
20 and uniform procedures for the processing of data relating to billing for and payment
21 of health care services provided to state residents. All health insurers shall comply
22 with the uniform claims forms, standards, and procedures established under this
23 section.

24 (b) To the extent that there is a conflict or inconsistency between a provision
25 of AS 21 that applies to a health insurer and a provision of a regulation adopted under
26 (a) of this section, the regulation governs. The director of the division of insurance
27 shall ensure that regulations adopted by the director under AS 21 that apply to a health
28 insurer are not in conflict or inconsistent with regulations adopted under (a) of this
29 section.

30 Sec. 44.19.631. DISCLOSURE OF INFORMATION; PENALTY. (a) A
31 person providing or insuring health care services in the state shall provide, upon

1 request or order of the commission, reports, data, health information, insurance
2 schedules, statistics, and other information, as determined necessary by the
3 commission, by regulation, to carry out the purposes of AS 44.19.619 - 44.19.639.
4 This subsection applies to the state and to a municipality; as well as to public and
5 private health care facilities and providers, and health care insurers and self-insurers.

6 (b) Information and data obtained or produced by the commission is subject
7 to AS 09.25.110 and 09.25.120 and regulations adopted under AS 09.25.110 and
8 09.25.120. Information or data that identifies a recipient of health care services is
9 considered to be a medical and related public health record that is subject to the
10 exception to public inspection under AS 09.25.120 and shall be kept confidential.

11 (c) A member, an employee, or an agent of the commission, or a member of
12 an advisory committee to the commission, who wrongfully discloses or who uses or
13 permits the use of confidential information or data in violation of (b) of this section
14 is guilty of a class B misdemeanor.

15 Sec. 44.19.632. IMMUNITY FROM LIABILITY. Members of the
16 commission, its employees, its agents, its advisory committee members, and persons
17 providing information and data to the commission as required under AS 44.19.619 -
18 44.19.639 are not liable for civil damages for an act or omission in the execution of
19 their authorized activities or duties under AS 44.19.619 - 44.19.639. This section does
20 not preclude liability for civil damages as a result of reckless or intentional
21 misconduct.

22 Sec. 44.19.633. OATHS; SUBPOENAS. (a) The commission may administer
23 oaths and may issue subpoenas to persons to require testimony or to require the
24 production of records, information, or data under AS 44.19.631.

25 (b) If a person disobeys or resists a lawful subpoena issued by the commission,
26 the commission may certify the facts to the superior court, and upon certification the
27 court shall issue an order directing the person to appear before the court and show
28 cause why the person should not be punished for contempt.

29 Sec. 44.19.634. APPROPRIATIONS. The legislature may appropriate a
30 portion of the proceeds of the tax on insurance premiums collected under
31 AS 21.09.210 to the Alaska Health Commission for the commission's operating costs.

1 Sec. 44.19.635. DISCLOSURE OF PROVIDER CHARGES; FINE FOR
2 NONDISCLOSURE. (a) At least annually, a provider shall compile a list of charges
3 for the 20 health care services most commonly provided by that provider. Charges for
4 hospital services may be prepared on the basis of diagnosis-related groups. Upon
5 request of a person who is considering obtaining services from a provider, the provider
6 shall provide the list of charges to the person for use in comparing charges among
7 providers.

8 (b) Upon the request of a patient and before the commencement of a medical
9 procedure, the provider shall disclose to that patient the estimated charge for the
10 procedure. The estimated charge shall be made in good faith and must be based on
11 the provider's history of charges for that procedure. Nothing in this subsection
12 requires a provider to make a charge estimate if the provider does not agree to perform
13 the procedure.

14 (c) A provider shall place the following statement either on a form to be
15 signed by the patient or in a conspicuous location on an easily readable sign: "You
16 are entitled to a charge estimate for a medical procedure before the procedure is
17 performed by your health provider."

18 (d) If the commission, after investigation of a complaint by a patient,
19 determines that a provider has not complied with this section, the commission may
20 impose a fine of up to \$1,000 against the provider. The commission may impose only
21 one fine under this section against a provider in a calendar year. A provider's
22 violation of this section does not preclude the provider from collecting payment for
23 services provided.

24 (e) A provider aggrieved by a decision of the commission under this section
25 may appeal the decision to the superior court.

26 Sec. 44.19.639. DEFINITIONS. In AS 44.19.619 - 44.19.639, unless the
27 context requires otherwise,

- 28 (1) "commission" means the Alaska Health Commission;
29 (2) "division of insurance" means the division of insurance in the
30 Department of Commerce and Economic Development;
31 (3) "health care services" has the meaning given in AS 21.86.900;

1 (4) "health information" means all information and data relating to
2 access to or delivery or financing of health care services;

3 (5) "health insurance" has the meaning given "disability insurance" in
4 AS 21.12.050;

5 (6) "health insurer" means an entity transacting the business of health
6 insurance, a health maintenance organization under AS 21.86, a hospital service
7 corporation under AS 21.87, a medical service corporation under AS 21.87, or a
8 combined medical service and hospital service corporation under AS 21.87;

9 (7) "market based single payer system" means a system in which a
10 single entity provides health insurance to all residents of the state and the insurance
11 is based on market forces, and may include provider defined fees, defined patient
12 copayments, sliding scale copayments for the indigent, provider fees that are posted
13 or made otherwise available at the point of services, published or disseminated fees in
14 comparative lists that allow fee comparison by consumers, voluntary expenditure
15 targets, provider peer review and control of volume, utilization, and quality of health
16 services, and a regularly published description of the various types of providers
17 licensed to provide services in the benefit package;

18 (8) "pool" means a mechanism to facilitate or provide for sharing risks
19 or the purchase of health insurance in the event coverage is unavailable or
20 unobtainable;

21 (9) "provider" has the meaning given in AS 21.86.900.

22 * Sec. 17. AS 44.62.310(d) is amended to read:

23 (d) This section does not apply to

24 (1) judicial or quasi-judicial bodies when holding a meeting solely to
25 make a decision in an adjudicatory proceeding;

26 (2) juries;

27 (3) parole or pardon boards;

28 (4) meetings of a hospital medical staff; or

29 (5) meetings of the governing body or any committee of a hospital
30 when holding a meeting solely to act upon matters of professional qualifications,
31 privileges or discipline; or

1 (6) meetings of the Alaska Health Commission. except for meetings
2 concerning the adoption of regulations.

3 * Sec. 18. AS 44.66.010(a) is amended by adding a new paragraph to read:

4 (20) Alaska Health Commission (AS 44.19.619) -- June 30, 1999.

5 * Sec. 19. AS 09.55.560(2), 09.55.560(3); AS 21.86.070(e), and 21.86.070(f) are repealed.

6 * Sec. 20. Alaska Rule of Civil Procedure 72.1 is repealed.

7 * Sec. 21. APPLICABILITY. Sections 4, 5, and 6 of this Act apply to a cause of action
8 accruing on or after the effective date of this Act.

9 * Sec. 22. INITIAL APPOINTMENT OF COMMISSION MEMBERS. Notwithstanding
10 AS 44.19.622(a), enacted by sec. 16 of this Act, the terms of persons initially appointed to the
11 Alaska Health Commission under AS 44.19.622 shall be staggered as provided in
12 AS 39.05.055.

13 * Sec. 23. REAPPOINTMENT OF INITIAL APPOINTEES. Notwithstanding
14 AS 44.19.622(b), enacted by sec. 16 of this Act, a person initially appointed to the Alaska
15 Health Commission under (a) of this section may be reappointed to serve no more than one
16 six-year term as a member of the Alaska Health Commission.

17 * Sec. 24. PHASED TRANSITION PERIOD. (a) Notwithstanding the provisions of
18 AS 44.19.621 - 44.19.639, the Alaska Health Commission shall implement the provisions of
19 AS 44.19.621 - 44.19.639 on a orderly and gradual basis as follows:

20 (1) by July 1, 1995, the director of the division of insurance shall adopt
21 regulations necessary to implement AS 44.19.628(a);

22 (2) by January 1, 1996, the commission shall complete the research necessary
23 to report recommendations to the governor and the legislature on the issues described under
24 AS 44.19.621(a)(6)(A), (C), (D), (E), and (G);

25 (3) by July 1, 1996, the commission shall complete the research necessary to
26 report recommendations to the governor and the legislature on the issues described under
27 AS 44.19.621(a)(6)(F);

28 (4) by January 1, 1997, the commission shall complete the research necessary
29 to report recommendations to the governor and the legislature on the issues described under
30 AS 44.19.621(a)(6)(H).

31 (b) Upon request of the commission, and for good cause shown, the governor may

1 grant an extension of a deadline set in (a) of this section. The governor shall inform the
2 legislature of a decision on a request to extend a deadline.

3 * Sec. 25. AS 09.55.536(f), amended by sec. 5 of this Act, amends Alaska Rules of Civil
4 Procedure 26 and 27 by providing that discovery may not be undertaken until the expert
5 advisor's report is received.

6 * Sec. 26. AS 09.55.536(e), amended by sec. 5 of this Act, amends Alaska Rules of
7 Evidence 802, 803, and 804 by providing that the expert advisor's report is admissible in
8 evidence to the same extent as though its contents were orally testified to by the advisor.

9 * Sec. 27. Section 20 of this Act takes effect July 1, 1994, only if that section receives the
10 two-thirds majority vote of each house required by art. IV, sec. 15, Constitution of the State
11 of Alaska.

12 * Sec. 28. This Act takes effect July 1, 1994.

24

AMENDMENT

OFFERED IN THE HOUSE

BY REPRESENTATIVE BRICE

TO: CSHB 414(HES)

Page ¹⁴~~4~~, line ¹⁰~~25~~, following "commission":

Insert a new paragraph to read:

"(4) fly to the moon."

Renumber the following paragraph accordingly.

25

8-GH2024J.1 ✓
Ford
3/22/94

A M E N D M E N T

OFFERED IN THE HOUSE
TO: CSHB 414(HES)

BY REPRESENTATIVE B.DAVIS
Tom Bruce

Page 10, line 12:

Delete "AS 44.19.619 - 44.19.639"

Insert "AS 44.19.619 - 44.19.701"

Page 13, line 28:

Delete "AS 44.19.619 - 44.19.639"

Insert "AS 44.19.619 - 44.19.701"

Page 14, line 10:

Delete "."

Insert ";

(4) exercise the powers granted to insurers under the laws of the state when allowed under AS 44.19.636(c); if the commission acts as an insurer, the commission shall comply with the requirements applicable to insurers under AS 21."

Page 14, line 20:

Delete "AS 44.19.619 - 44.19.639"

Insert "AS 44.19.619 - 44.19.701"

Page 15, line 3:

Delete "."

Insert ";

(7) establish and provide uniform health insurance coverage for all residents of the state and monitor and control health care expenditures in the state;

(8) establish the cost control system required under AS 44.19.642,

44.19.648, 44.19.652, 44.19.656, 44.19.660, 44.19.664, and the voluntary cost control system required under AS 44.19.651 and 44.19.662;

(9) implement the state health insurance plan as a market based single payor system."

Page 17, line 3:

Delete "AS 44.19.619 - 44.19.639"

Insert "AS 44.19.619 - 44.19.701"

Page 17, lines 17 - 18:

Delete "AS 44.19.619 - 44.19.639"

Insert "AS 44.19.619 - 44.19.701"

Page 17, line 19:

Delete "AS 44.19.619 - 44.19.639"

Insert "AS 44.19.619 - 44.19.701"

Page 18, after line 25:

Insert new sections to read:

"Sec. 44.19.636. PROCUREMENT OR PROVISION OF INSURANCE. (a)

The commission shall

(1) solicit proposals from insurance companies that are licensed to transact health insurance in the state under the procurement procedures adopted by the commission under AS 36.30.015(e); and

(2) if the commission does not act as an insurer as provided under (c) of this section, select one or more companies with which it will contract to provide insurance, after considering the cost of the insurance, the availability from the company of program features directed at reducing the cost of providing health care services, and other relevant factors as determined by the commission.

(b) The commission may contract for insurance coverage for enrollees for a term that it considers to be the most advantageous to the commission and its enrollees, for a period not exceeding three years.

(c) If, after the proposal process under (a) of this section has been completed, the commission determines that the desired coverage or benefits are not available from insurers licensed in this state or the commission can provide the desired coverage and benefits at a lower cost per eligible person, the commission may act as an insurer.

Sec. 44.19.638. ENROLLEES. (a) A person is eligible to be an enrollee in the state health insurance plan provided under AS 44.19.641 in a given year if the person is a resident of the state and has complied with the procedures established by the commission under (d) of this section. For purposes of enrollment, the commission shall by regulation define residency in a manner that is consistent with AS 01.10.055 and with this chapter.

(b) A person who is eligible to be an enrollee shall be enrolled by the commission in the state health insurance plan.

(c) The commission shall cancel an enrollee's coverage if, during the fiscal year, the enrollee becomes ineligible to be an enrollee.

(d) The commission shall establish by regulation appropriate procedures for processing applications for enrollment, for determining the eligibility of enrollees, for enrolling enrollees, for determining and collecting the applicable fees, for canceling an enrollee's coverage, and for processing appeals by enrollees of adverse decisions by the commission regarding eligibility, enrollment, determination or collection of applicable fees, or cancellation of coverage.

Sec. 44.19.641. HEALTH INSURANCE PLAN. (a) The commission shall adopt regulations specifying the health care services required to be covered by the state health insurance plan, taking into consideration the services requested by the public, the needs and characteristics unique to state residents, the goal of prevention of illness and promotion of wellness, the cost of providing the benefits package, the cost of providing or procuring the insurance coverage, and the funds available in the state health insurance fund.

(b) The commission shall conduct a comprehensive public involvement process designed to solicit information and opinions regarding the services required to be covered under (a) of this section.

Sec. 44.19.642. DEDUCTIBLES AND COPAYMENTS. Subject to AS 44.19.641, the commission shall establish the deductible and copayment amounts

applicable under the state health insurance plan.

Sec. 44.19.644. **PREMIUMS.** A premium may be charged to an enrollee for coverage as established by the commission by regulation. In establishing a premium, the commission shall establish a standard fee and a sliding scale fee and shall consider the cost of coverage, funding available, and other factors the commission determines are relevant.

Sec. 44.19.646. **HEALTH CARE DATA SYSTEM.** (a) The commission shall develop and periodically update a health care data system. To the extent practicable, the data system base year shall be calendar year 1993 and the system must 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 commission may, by regulation, require health care providers, including providers not being reimbursed by the commission, to submit claims data and additional information necessary to develop or update the data system required under (a) of this section.

Sec. 44.19.648. **STATEWIDE HEALTH CARE EXPENDITURE TARGET.** (a) The commission shall prescribe by regulation a statewide health care expenditure target, based on the data obtained under AS 44.19.646. To the extent practicable, the base year for the statewide health care expenditure target shall be calendar year 1993.

(b) The commission annually shall adjust the health care expenditure target established under this section to reflect changes in the Consumer Price Index and the following factors:

- (1) changes in the size and demographic characteristics of the state's population including aging;
- (2) changes in medical technology;

- (3) changes that improve access to health care services;
- (4) changes in the burden of disease resulting from epidemics, disasters, and reduction or elimination of disease;
- (5) elimination of unnecessary care;
- (6) changes in costs associated with professional liability insurance;
- (7) changes in administrative costs;
- (8) changes in patterns of utilization.

Sec. 44.19.651. **VOLUNTARY HEALTH CARE PROVIDER COMPLIANCE.** The health care expenditure target adopted by the commission under AS 44.19.648 shall constitute a recommended target for expenditures within each specified category or subcategory of health care services or products. Health care providers may voluntarily comply with the expenditure target and may take all appropriate steps not prohibited by law to attempt to ensure that annual expenditures for health care in the state do not exceed the expenditure target adopted by the commission.

Sec. 44.19.652. **REVIEW AND REPORT ON HEALTH CARE EXPENDITURES.** The commission shall annually review and report to the legislature and the governor on

- (1) the total amount of health care expenditures in the state;
- (2) the amount of increase or decrease in health care and capital medical expenditures in the state;
- (3) changes in health care provider prices;
- (4) changes in patterns of utilization or expenditures; and
- (5) factors that are responsible for changes in patterns of utilization or expenditures.

Sec. 44.19.654. **MANDATORY HEALTH CARE PROVIDER COMPLIANCE.** (a) Based on the data compiled under AS 44.19.646, the commission shall monitor the success of voluntary compliance under AS 44.19.651. At any time beginning three years after the voluntary expenditure target has been in effect, if the commission concludes that voluntary compliance has failed substantially to achieve the adopted expenditure target, the commission shall impose by regulation a mandatory expenditure limit as provided under (b) of this section.

- (b) The commission may, by regulation,
- (1) impose a mandatory expenditure limit on one or more subcategories or on specific items within the expenditure limit;
 - (2) directly assume all or part of the cost control functions described in this section;
 - (3) establish mandatory price and utilization controls or guidelines;
 - (4) annually monitor health care expenditures, patterns of utilization, and factors contributing to changes in expenditures or utilization;
 - (5) establish cost sharing recommendations relevant to the mandatory expenditure limit.

(c) A health care provider shall comply with the mandatory cost control provisions that may be established by the commission under (a) and (b) of this section. An enrollee who receives a charge that does not comply with the mandatory cost control provisions that are imposed under this section is not required to pay the portion of the charge that exceeds the mandatory cost control provisions. A health care provider shall refund an amount received that exceeds the mandatory cost control provisions.

(d) The commission shall establish by regulation procedures for monitoring compliance with the mandatory cost control provisions and for providing notice to a person who is determined to have been overcharged.

Sec. 44.19.656. PEER REVIEW OF UTILIZATION AND QUALITY. The commission shall contract with health care providers in the state to develop utilization and quality controls. The contract must include the use of peer specialty groups that are given the goal of controlling utilization within a specialty. The commission shall ensure that the contract stresses the development of the use of incentives to control costs.

Sec. 44.19.658. CLAIMS CLEARINGHOUSE. (a) The commission shall establish a claims clearinghouse in the state. A provider of health care services shall submit all claims for payment for health care services under the state health insurance plan to the claims clearinghouse. The commission may, by regulation, require providers to submit specified additional information pertaining to providing health care services in the state to the claims clearinghouse.

(b) Subject to appropriation, the claims clearinghouse shall pay claims approved for payment by the commission.

(c) The claims clearinghouse may deny a claim only for a reason that has been specified as an acceptable reason under regulations adopted by the commission.

Sec. 44.19.661. REQUIRED AVAILABILITY OF PRICE LIST. (a) 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 corporation shall determine by regulation the contents of the price list required under this section.

(b) At least annually, a health care provider shall submit to the corporation copies of the provider's current price list. The corporation shall specify by regulation the date for submitting the price lists.

Sec. 44.19.662. INFORMATION ON PRICES FOR HEALTH CARE SERVICES. The corporation shall at least annually publish a description of types of health care providers licensed to provide covered services and a comparative list of provider prices. The corporation shall make the publications available to the public upon request.

Sec. 44.19.664. COMPARATIVE LISTS OF PRICES. (a) At least annually, the corporation shall compile comparative lists of prices for commonly provided health care services based on abstracted data provided by the claims clearinghouse under AS 44.19.658, on the price lists submitted to the corporation under AS 44.19.661, and on other relevant information as determined by the corporation.

(b) The lists required under this section shall be prepared to allow identification and comparison of prices made by individual providers for the listed services. Hospital services may be compared on the basis of diagnosis related groups."

Page 18, line 26:

Delete "Sec. 44.19.639. DEFINITIONS. In AS 44.19.619 - 44.19.639"

Insert "Sec. 44.19.701. DEFINITIONS. In AS 44.19.619 - 44.19.701"

Page 19, line 21:

Delete "has the meaning given in AS 21.86.900"

Insert "means an acupuncturist licensed under AS 08.06; an audiologist licensed under AS 08.11; a chiropractor licensed under AS 08.20; a dental hygienist licensed under AS 08.32; a dentist licensed under AS 08.36; a marital or family therapist licensed under AS 08.63; a direct-entry midwife certified under AS 08.65; a nurse licensed under AS 08.68; a dispensing optician licensed under AS 08.71; a naturopath licensed under AS 08.45; an optometrist licensed under AS 08.72; a pharmacist licensed under AS 08.80; a physical therapist or occupational therapist licensed under AS 08.84; or a physician's assistant certified under AS 08.64; a physician licensed under AS 08.64; a podiatrist; a psychologist and a psychological associate licensed under AS 08.86; a clinical social worker licensed under AS 08.95; an emergency medical technician certified under AS 18.08.082; a mobile intensive care paramedic trained as required under AS 18.08.082; a hospital as defined in AS 18.20.130, including a governmentally owned or operated hospital; and an employee of a health care provider acting within the course and scope of employment"

Page 20, line 17, through page 21, line 2:

Delete all material.

Insert a new bill section to read:

"* **Sec. 24. PHASED TRANSITION PERIOD.** Notwithstanding the provisions of AS 44.19.619 - 44.19.701, the Alaska Health Commission shall implement the provisions of AS 44.19.619 - 44.19.701 on an orderly and gradual basis as follows:

(1) by December 31, 1994, the commission shall establish the data system required under AS 44.19.646 and begin collecting data and determine the federal waivers necessary to implement AS 44.19.619 - 44.19.701;

(2) by December 31, 1995, the commission shall determine the health care services required under AS 44.19.641 and begin monitoring health care expenditures and utilization patterns;

(3) by January 1, 1996, the commission shall implement the peer review system for utilization and quality required under AS 44.19.656 and shall adopt regulations that establish eligibility criteria for enrollment in the state health insurance plan, including a definition of the term "resident" that is consistent with AS 01.10.055 and the purposes of

this Act;

(4) by December 31, 1996, the commission shall establish the voluntary cost control system required under AS 44.19.651;

(5) by January 1, 1997, the commission shall establish the deductible and copayment amounts required under AS 44.19.642 and present options to the governor and the legislature on how to finance a state health insurance plan under a market based single payer system; in considering options on financing a state health insurance plan the commission shall strive to structure the options in a manner that provides protection for benefits provided to retired employees through public or private retirement systems;

(6) by January 1, 1998, the commission shall establish the statewide health care expenditure target required under AS 44.19.648, and, subject to appropriation, begin to provide health insurance coverage for state residents as required under AS 44.19.619 - 44.19.701."

#26

8-GH2024J.2 ✓
Ford
3/2/94

A M E N D M E N T

Rep Bettye Davis
Tom Brice

OFFERED IN THE HOUSE
TO: CSHB 414(HES)

Page 1, line 1, through page 21, line 12:

Delete all material and insert:

""An Act establishing the Alaska Health Insurance Corporation and requiring licensed health care providers to comply with certain statutes and regulations relating to the corporation; relating to disability insurance claims processing and to approval of rates for disability insurance, including health insurance; and providing for an effective date."

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

*** Section 1. FINDINGS AND PURPOSE.** (a) The legislature finds that

(1) health care services and health insurance in the state are becoming prohibitively costly, and a growing number of our citizens are unable to obtain health insurance or pay for needed care;

(2) the reasons that health care expenditures are increasing are complex and are accounted for by general inflation; by inflation specific to the health care industry or changes in the cost of labor, capital, and other industry factors; by population growth; by utilization or the number of times people use health care services; by increasingly complex and costly technology and other resources; by the aging of the population; and the practice of defensive medicine;

(3) the primary responsibility for controlling health care expenditures in the state should be borne by Alaska health care providers, particularly physicians, on whose orders and recommendations most health care expenditures are incurred; at present, federal and state antitrust laws effectively preclude health care providers from engaging in voluntary self-regulation regarding fees and volume of services; this Act mandates the participation by health care providers in the peer review process of cost control and volume control to assure that health care expenditures do not increase faster than the general inflation rate; if voluntary

self-regulation fails to control health care costs, mandatory cost controls should be imposed;

(4) in order to increase access to health care by containing the rate of increase of health care expenditures and by making basic health insurance available to the people in the state, it is essential that the factors contributing to the increasing costs of health care and the unavailability of health insurance be addressed comprehensively and consistently;

(5) there is a compelling need for a strong, clear focus on public health issues in the interest of protecting and promoting the public health of the residents of the state;

(6) there are inherent problems in our health system infrastructure, including the lack of physical access to services in many areas of the state;

(7) the state should immediately begin to create a system that will provide health insurance to all residents of the state, control health care expenditures, preserve the high quality of care that residents demand, preserve the individual's choice of health care provider, and, by doing so, avoid the imposition of a federally mandated health care reform system on the state;

(8) because the state constitution's single subject rule precludes the consideration of comprehensive tort reform in the same legislative enactment as health care reform, tort reform should be addressed in a separate legislative enactment;

(9) a market based single payer system is preferable to either an employer mandate or a "pay or play" approach because

(A) both of the employer mandate approaches are based on the current mix of public, employer, and individual financing that inevitably creates coverage gaps for some people, particularly when their employment status changes;

(B) health care financing approaches that require all businesses to provide health care benefits or that levy additional taxes on those businesses threaten the economic viability of many small businesses in the state;

(C) multiple payer systems would not necessarily address the problems of cost shifting that exist in our current system; and

(D) systems that are built upon the existing public and private financing arrangements can be expected to inherit the inefficiencies in those arrangements.

(b) The purpose of this Act is to

(1) increase access to health care by containing the rate of increase of health

care expenditures and by making health insurance available to the people in the state;

(2) create a market based single payer state health insurance system that provides health insurance to all residents of the state, that utilizes market forces to make consumers more aware of the actual costs of health services, and that provides consumers with information enabling them to make more informed purchasing decisions;

(3) provide a structure for addressing the health care needs of the state including

(A) developing a comprehensive long-term care plan that integrates support services and that promotes human dignity;

(B) use of preventive and wellness programs to reduce health care costs; and

(C) the different health care needs of urban and rural areas of the state.

(c) It is not the purpose of this Act to change the existing agreements between employers and employees, including retirees, in a manner that would diminish health care benefits.

* Sec. 2. AS 08.02 is amended by adding a new section to read:

Sec. 08.02.025. COMPLIANCE WITH REQUIREMENTS OF STATE HEALTH INSURANCE CORPORATION. A health care provider shall comply with the required price list availability provisions of AS 21.58.230 and the health care data system provisions of AS 21.58.260 that are applicable to health care providers including regulations adopted by the Alaska Health Insurance Corporation under those provisions. Notwithstanding another provision of law, the license of a health care provider is not valid unless the health care provider complies with this section. In this section, "health care provider" has the meaning given in AS 21.58.400.

* Sec. 3. AS 21.39.020 is amended to read:

Sec. 21.39.020. APPLICABILITY. (a) This chapter applies to disability insurance, to all forms of casualty insurance, including fidelity, surety, and guaranty bonds, to all forms of fire, marine, and inland marine insurance, and to a combination of any of them, or risks or operations in this state. Inland marine insurance includes insurance defined by statute, or by interpretation of statute, or if not defined or interpreted, by ruling of the director, or as established by general custom of the

business, as inland marine insurance.

(b) This chapter does not apply to

(1) reinsurance, other than joint reinsurance to the extent stated in AS 21.39.110;

(2) [DISABILITY INSURANCE;

(3)] insurance of vessels or craft, their cargoes, marine builders' risks, marine protection and indemnity, or other risks commonly insured under marine, as distinguished from inland marine insurance policies;

(3) [(4)] insurance against loss of or damage to aircraft or against liability, other than workers' compensation and employer's liability, arising out of the ownership, maintenance, or use of aircraft; or, to insurance of hulls of aircraft, including their accessories and equipment.

* Sec. 4. AS 21.39.030(a) is amended to read:

(a) Rates shall be made in accordance with the following provisions:

(1) rates ~~may~~ [SHALL] not be excessive, inadequate, or unfairly discriminatory;

(2) consideration shall be given to past and prospective loss experience inside and outside this state, to the conflagration and catastrophe hazards, to a reasonable margin for underwriting profit and contingencies, to dividends, savings, or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members, or subscribers, to past and prospective expenses both countrywide and those specially applicable to this state, and to all other relevant factors inside and outside this state;

(3) the systems of expense provisions included in the rates for use by an insurer or group of insurers may differ from those of other insurers or group of insurers to reflect the requirements of the operating methods of the insurer or group of insurers with respect to any kind of insurance, or with respect to a subdivision or combination of them [THEREOF] for which subdivision or combination separate expense provisions are applicable;

(4) risks may be grouped by classifications for the establishment of rates and minimum premiums; classification rates may be modified to produce rates for individual risks in accordance with rating plans that establish standards for

measuring variations in hazards or expense provisions, or both; the standards may measure any differences among risks that can be demonstrated to have a probable effect upon losses or expenses;

(5) in the case of fire insurance rates, consideration may be given to the experience of the fire insurance business during a period of not more than the most recent five-year period for which experience is available;

(6) when there is an established program to inspect new and existing dwellings and the program has been certified by the director as likely to reduce the incidence of fires in inspected dwellings, then in any rate plan used in this state, dwellings that have been found by the inspection to meet the standards established by the program shall have credits applied to the rate in amounts approved by the director;

(7) in the case of disability insurance rates, rates shall be made on a statewide basis: rates may vary depending on age and family status.

* Sec. 5. AS 21.54 is amended by adding a new section to read:

Sec. 21.54.025. CLAIMS PROCESSING. (a) An insurer authorized to transact disability insurance in the state shall

(1) pay each claim within 15 business days after a claim is received or, within that same time period, give the person that submitted the claim notice that the claim is denied; and

(2) adopt a claims grievance procedure and submit the procedure to the division for approval; after the procedure has been approved, the insurer shall follow the procedure.

(b) If a claim form is fully completed and an insurer fails to pay a claim or give notice that the claim is denied within the time specified in (a) of this section, the insurer shall pay interest at the rate specified in AS 45.45.010, from the 16th business day after the claim was received until paid, on the amount finally determined to be due.

(c) If an insurer denies a claim, the notice that the claim is denied must include a statement of the reason for the denial. The statement must be sufficiently clear to allow the provider to understand the reason for the denial and to take corrective action, including resubmission of the claim, if appropriate.

* Sec. 6. AS 21 is amended by adding a new chapter to read:

CHAPTER 58. ALASKA HEALTH INSURANCE CORPORATION.

Sec. 21.58.010. CREATION AND PURPOSE. (a) The Alaska Health Insurance Corporation is established. The corporation is a public corporation and an instrumentality of the state in the Department of Commerce and Economic Development but has a legal existence independent of and separate from the state. The exercise by the corporation of the powers conferred by this chapter is considered an essential function of the state.

(b) The purposes of the corporation are to establish and provide uniform health insurance coverage for all residents of the state and to monitor and control all health care expenditures in the state.

Sec. 21.58.020. BOARD OF DIRECTORS. The corporation is managed by a board of seven directors.

Sec. 21.58.030. APPOINTMENT AND REMOVAL OF DIRECTORS. (a) The directors of the corporation are appointed by the governor, subject to confirmation by the legislature. A director may be removed only for good cause.

(b) In appointing directors to the board, the governor shall ensure that

(1) a majority of the board are experts in health care issues and fairly represent the interests of the general public in having access to quality and affordable health care;

(2) the interests of consumers and health care providers are fairly represented;

(3) the director is a resident of the state; and

(4) the board has a gender and geographic composition that approximates the population of the state.

Sec. 21.58.040. TERM OF SERVICE. The term of a director is four years. Terms of directors shall be staggered. A director may be appointed to successive terms. A director appointed to fill a vacancy serves for the unexpired term of the director. A term shall be measured from January 1 of the year in which the term of the vacant position begins, regardless of when the vacancy is filled.

Sec. 21.58.050. COMPENSATION AND EXPENSES. A director is entitled to receive compensation at the rate of \$400 for each day spent in performing duties as a board member and to travel and per diem expenses authorized by law for boards

and commissions under AS 39.20.180.

Sec. 21.58.060. OFFICERS. At the first meeting of each year, the board of the corporation shall elect a chair and a vice-chair from among its members. The corporation shall prescribe their duties by regulation.

Sec. 21.58.070. MEETINGS AND QUORUM. The board of the corporation shall meet at least once every three months. Four members of the board constitute a quorum for the transaction of business and the exercise of the powers and duties of the corporation.

Sec. 21.58.080. ADMINISTRATIVE PROCEDURE. Actions of the corporation under this chapter are subject to AS 44.62 (Administrative Procedure Act).

Sec. 21.58.090. STAFF AND PROFESSIONAL SERVICES CONTRACTS. The corporation shall employ an executive director who serves at the pleasure of the corporation as its chief administrative officer. The executive director may, with the approval of the corporation, select and employ additional staff as necessary. The executive director is in the exempt service under AS 39.25.110. Employees of the corporation other than the executive director are in the classified service under AS 39.25.100. In addition to its staff of regular employees, the corporation may contract for the services of consultants and professional, technical, and financial advisors the corporation considers necessary for the purpose of developing information, conducting hearings, studies, investigations, or other proceedings, or otherwise exercising its powers.

Sec. 21.58.100. GENERAL POWERS. The corporation may

(1) exercise the powers granted to insurers under the laws of the state when allowed under AS 21.58.130(c); if the corporation acts as an insurer, the corporation shall comply with the requirements applicable to insurers under this title;

(2) sue or be sued;

(3) make contracts and execute all instruments necessary or convenient for carrying out its business;

(4) establish administrative or accounting procedures;

(5) acquire, own, hold, dispose of, and encumber personal property and lease real property in the exercise of its powers;

(6) establish appropriate levels of reserves to cover expenses of the

corporation;

(7) perform all other acts necessary and proper to carry out the duties of the corporation.

Sec. 21.58.110. DUTIES. The corporation shall

(1) adopt regulations to implement this chapter;

(2) create and implement the formal public involvement process required under AS 21.58.320, for the purpose of gathering broad input on the state health insurance plan, options for financing the cost of coverage, cost-sharing of the health insurance plan, and the cost of plan administration;

(3) establish the comprehensive health care data system required under AS 21.58.260;

(4) create and implement a uniform claims form;

(5) develop and update the public health improvement plan for the state required under AS 21.58.310;

(6) establish the claims clearinghouse required under AS 21.58.220;

(7) develop a benefits package of health care services that enrollees in the state health insurance plan are entitled to receive and determine the eligibility requirements for enrollment;

(8) annually determine the appropriate fee to be paid by an enrollee, after considering the enrollee's income, assets, financial obligations, or other criteria, as determined by the corporation;

(9) define acceptable reasons for denial of claims under the state health insurance plan;

(10) at least annually, review the health care benefits package and revise it as determined by the corporation, taking into consideration the health needs of the state, available funding, and other relevant factors as determined by the corporation;

(11) establish the cost control system required under AS 21.58.180, 21.58.230, 21.58.250, 21.58.270, 21.58.290, and 21.58.330, and the voluntary cost control system required under AS 21.58.240 and 21.58.280;

(12) periodically review options to finance the state health insurance plan and present options to the legislature;

(13) with funds from the state health fund, provide or procure coverage required under the state health insurance plan; as provided under AS 21.58.130, the corporation may act as an insurer or procure coverage from one or more companies licensed to transact health insurance in the state for all persons who are eligible to be enrollees of the state health insurance plan;

(14) pursue necessary federal waivers from applicable federal law or other federal health care payers in order to incorporate both claims data and revenue streams into the corporation's data system and additional revenue into the state health insurance fund;

(15) implement the state health insurance plan as a market based single payer system;

(16) design a program to give incentives to primary care providers to practice in the state, especially in rural and under served areas of the state; incentives may include added premiums on prices for primary care providers, a student loan forgiveness program, an in-state family practice residency program, training and rotations for midlevel practitioners, and other appropriate incentives;

(17) impose a mandatory cost control system in part or overall if the corporation determines that the voluntary cost control system described under AS 21.58.280 has failed to substantially achieve the adopted expenditure target;

(18) establish committees of experts and others as needed to make recommendations to the corporation regarding how to contain the cost of health care, including incorporating a greater emphasis on healthful lifestyles, prevention of disease and injury, promoting effective medical treatments, identifying the optimal provider mix within the state, or other matters determined by the corporation;

(19) develop a plan that comprehensively addresses the needs of residents of the state for long-term care; and

(20) hold public meetings and annually report to enrollees, the governor, and the legislature.

Sec. 21.58.120. HEALTH INSURANCE FUND. The state health insurance fund is established as a separate account in the general fund. The fund shall be administered by the corporation and used to provide or to purchase insurance under AS 21.58.110 or 21.58.130. The fund consists of appropriations by the legislature,

individual or employer contributions, and private or government grants.

Sec. 21.58.130. PROCUREMENT OR PROVISION OF INSURANCE. (a)

The corporation shall

(1) solicit proposals from insurance companies that are licensed to transact health insurance in the state under the procurement procedures adopted by the corporation under AS 36.30.015(e); and

(2) if the corporation does not act as an insurer as provided under (c) of this section, select one or more companies with which it will contract to provide insurance, after considering the cost of the insurance, the availability from the company of program features directed at reducing the cost of providing health care services, and other relevant factors as determined by the corporation.

(b) The corporation may contract for insurance coverage for enrollees for a term that it considers to be the most advantageous to the corporation and its enrollees, for a period not exceeding three years.

(c) If, after the proposal process under (a) of this section has been completed, the corporation determines that the desired coverage or benefits are not available from insurers licensed in this state or the corporation can provide the desired coverage and benefits at a lower cost per eligible person, the corporation may act as an insurer.

Sec. 21.58.140. ENROLLEES. (a) A person is eligible to be an enrollee in the state health insurance plan under this chapter in a given year if the person is a resident of the state and has complied with the procedures established by the corporation under (d) of this section. For purposes of enrollment, the corporation shall by regulation define residency in a manner that is consistent with AS 01.10.055 and with this chapter.

(b) A person who is eligible to be an enrollee shall be enrolled by the corporation in the state health insurance plan.

(c) The corporation shall cancel an enrollee's coverage if, during the fiscal year, the enrollee becomes ineligible to be an enrollee.

(d) The corporation shall establish by regulation appropriate procedures for processing applications for enrollment, for determining the eligibility of enrollees, for enrolling enrollees, for determining and collecting the applicable fees, for canceling an enrollee's coverage, and for processing appeals by enrollees of adverse decisions

by the corporation regarding eligibility, enrollment, determination or collection of applicable fees, or cancellation of coverage.

Sec. 21.58.150. DISCRIMINATION AGAINST ENROLLEES PROHIBITED.

A health care provider may not discriminate against an enrollee with respect to the availability, cost, or quality of health care services wholly or in part on the basis of the person's status as an enrollee.

Sec. 21.58.160. CONFIDENTIALITY OF ENROLLEE INFORMATION.

Medical and financial information regarding applicants or current or former enrollees is confidential and is not subject to public disclosure. The corporation by regulation may establish reasonable standards for the release of limited information in specified circumstances, including the release of reasonably necessary information to insurance companies and the release of information with the written authorization of the applicant or enrollee.

Sec. 21.58.170. HEALTH INSURANCE PLAN. (a) The corporation shall adopt regulations specifying the health care services required to be covered by the state health insurance plan, taking into consideration the services requested by the public, the needs and characteristics unique to state residents, the goal of prevention of illness and promotion of wellness, the cost of providing the benefits package, the cost of providing or procuring the insurance coverage, and the funds available in the state health insurance fund.

(b) The corporation shall conduct a comprehensive public involvement process designed to solicit information and opinions regarding the services required to be covered under (a) of this section.

Sec. 21.58.180. DEDUCTIBLES AND COPAYMENTS. Subject to AS 21.58.170, the corporation shall establish the deductible and copayment amounts applicable under the state health insurance plan.

Sec. 21.58.190. PREMIUMS. A premium may be charged to an enrollee for coverage as established by the corporation by regulation. In establishing a premium, the corporation shall establish a standard fee and a sliding scale fee and shall consider the cost of coverage, funding available, and other factors the corporation determines are relevant.

Sec. 21.58.200. PROHIBITED DISCRIMINATION BETWEEN HEALTH

CARE PROVIDERS. The corporation may not discriminate between health care providers who are licensed to perform a covered health care service unless the type of health care service provided is not included under the state health insurance plan.

Sec. 21.58.210. SOLICITATION OF ELIGIBLE PERSONS. (a) The corporation, under a plan approved by the director, shall disseminate appropriate information to the residents of the state regarding the existence of the state health insurance plan and the means of enrollment.

(b) The corporation shall devise and implement a means of maintaining public awareness of the provisions of this chapter regarding the state health insurance plan and shall administer this chapter in a manner that facilitates public participation in the state health insurance plan.

Sec. 21.58.220. CLAIMS CLEARINGHOUSE. (a) The corporation shall establish a claims clearinghouse in the state. A provider of health care services shall submit all claims for payment under the state health insurance plan to the claims clearinghouse. The corporation may, by regulation, require providers to submit specified additional information pertaining to providing health care services in the state to the claims clearinghouse.

(b) Subject to appropriation, the claims clearinghouse shall pay claims approved for payment by the corporation under the state health insurance plan.

(c) The claims clearinghouse shall comply with the provisions of AS 21.54.025, except that the claims grievance procedure required by AS 21.54.025(a)(2) shall be submitted to the board of directors of the corporation for approval.

(d) The claims clearinghouse may deny a claim only for a reason that has been specified as an acceptable reason by the corporation under AS 21.58.110(9).

Sec. 21.58.230. REQUIRED AVAILABILITY OF PRICE LIST. (a) 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 corporation shall determine by regulation the contents of the price list required under this section.

(b) At least annually, a health care provider shall submit to the corporation copies of the provider's current price list. The corporation shall specify by regulation the date for submitting the price lists.

Sec. 21.58.240. INFORMATION ON PRICES FOR HEALTH CARE SERVICES. The corporation shall at least annually publish a description of types of health care providers licensed to provide covered services and a comparative list of provider prices. The corporation shall make the publications available to the public upon request.

Sec. 21.58.250. COMPARATIVE LISTS OF PRICES. (a) At least annually, the corporation shall compile comparative lists of prices for commonly provided health care services based on abstracted data provided by the claims clearinghouse under AS 21.58.220, on the price lists submitted to the corporation under AS 21.58.230, and on other relevant information as determined by the corporation.

(b) The lists required under this section shall be prepared to allow identification and comparison of prices made by individual providers for the listed services. Hospital services may be compared on the basis of diagnosis related groups.

Sec. 21.58.260. HEALTH CARE DATA SYSTEM. (a) The corporation shall develop and periodically update a health care data system. To the extent practicable, the data system base year shall be calendar year 1993 and the system must 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 corporation may, by regulation, require health care providers, including providers not being reimbursed by the corporation, to submit claims data and additional information necessary to develop or update the data system required under (a) of this section.

Sec. 21.58.270. STATEWIDE HEALTH CARE EXPENDITURE TARGET.

(a) The corporation shall prescribe by regulation a statewide health care expenditure target, based on the data obtained under AS 21.58.260. To the extent practicable, the base year for the statewide health care expenditure target shall be calendar year 1993.

(b) The corporation annually shall adjust the health care expenditure target established under this section to reflect changes in the Consumer Price Index and the following factors:

- (1) changes in the size and demographic characteristics of the state's population including aging;
- (2) changes in medical technology;
- (3) changes that improve access to health care services;
- (4) changes in the burden of disease resulting from epidemics, disasters, and reduction or elimination of disease;
- (5) elimination of unnecessary care;
- (6) changes in costs associated with professional liability insurance;
- (7) changes in administrative costs;
- (8) changes in patterns of utilization.

Sec. 21.58.280. VOLUNTARY HEALTH CARE PROVIDER COMPLIANCE. The health care expenditure target adopted by the corporation under AS 21.58.270 shall constitute a recommended target for expenditures within each specified category or subcategory of health care services or products. Health care providers may voluntarily comply with the expenditure target and may take all appropriate steps not prohibited by law to attempt to ensure that annual expenditures for health care in the state do not exceed the expenditure target adopted by the corporation.

Sec. 21.58.290. REVIEW AND REPORT ON HEALTH CARE EXPENDITURES. The corporation shall annually review and report to the legislature and the governor on

- (1) the total amount of health care expenditures in the state;
- (2) the amount of increase or decrease in health care and capital medical expenditures in the state;
- (3) changes in health care provider prices;
- (4) changes in patterns of utilization or expenditures; and

(5) factors that are responsible for changes in patterns of utilization or expenditures.

Sec. 21.58.300. MANDATORY HEALTH CARE PROVIDER COMPLIANCE. (a) Based on the data compiled under AS 21.58.260, the corporation shall monitor the success of voluntary compliance under AS 21.58.280. At any time beginning three years after the voluntary expenditure target has been in effect, if the corporation concludes that voluntary compliance has failed substantially to achieve the adopted expenditure target, the corporation shall impose by regulation a mandatory expenditure limit as provided under (b) of this section.

(b) The corporation may, by regulation,

(1) impose a mandatory expenditure limit on one or more subcategories or on specific items within the expenditure limit;

(2) directly assume all or part of the cost control functions specified under AS 21.58.110(11);

(3) establish mandatory price and utilization controls or guidelines;

(4) annually monitor health care expenditures, patterns of utilization, and factors contributing to changes in expenditures or utilization;

(5) establish cost sharing recommendations relevant to the mandatory expenditure limit.

(c) A health care provider shall comply with the mandatory cost control provisions that may be established by the corporation under (a) and (b) of this section. An enrollee who receives a charge that does not comply with the mandatory cost control provisions that are imposed under this section is not required to pay the portion of the charge that exceeds the mandatory cost control provisions. A health care provider shall refund an amount received that exceeds the mandatory cost control provisions.

(d) The corporation shall establish by regulation procedures for monitoring compliance with the mandatory cost control provisions and for providing notice to a person who is determined to have been overcharged.

Sec. 21.58.310. PUBLIC HEALTH IMPROVEMENT PLAN. (a) The corporation shall develop and annually update a public health improvement plan for the state. The plan required under this section must recognize the need for

- (1) community involvement in health care planning and delivery;
- (2) attention to local needs that may vary from place to place;
- (3) accountability for the use of public funds;
- (4) equity and stability in the distribution of public funds;
- (5) shared responsibility of all levels of government for administering and financing public health care delivery; and
- (6) coordination of basic public health services.

(b) The plan required under this section must include

- (1) an analysis of the health status of the residents of the state;
- (2) 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;
- (3) a delineation of the standards that should be used in performing assessment, policy development, and quality assurance in the delivery of public health services;
- (4) documentation of the extent to which the current public health system implements or achieves the standards identified under (3) of this subsection;
- (5) identification of interjurisdictional issues involved in health care access and delivery;
- (6) recommendations, including recommendations for specific legislative action when necessary, pertaining to the following:
 - (A) 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 corporation;
 - (B) 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;
 - (C) integration of the public health care system with state and national health care reform efforts;
 - (D) the corporation's estimate of the optimal share that public health should represent in the total health care delivery system of the state, expressed in terms of a percentage of health care expenditures in the state.

Sec. 21.58.320. **REQUIRED PUBLIC INVOLVEMENT PROCESS.** The corporation shall design, implement, and maintain an extensive community based public involvement process for the purpose of providing residents with an ongoing opportunity to participate in decisions made by the corporation's board of directors regarding

- (1) health care services residents want included in the benefit package;
- (2) financing options;
- (3) revenue sources that should be used to finance the health plan;
- (4) cost-sharing options; and
- (5) administration of the health care plan.

Sec. 21.58.330. **PEER REVIEW OF UTILIZATION AND QUALITY.** The corporation shall contract with health care providers in the state to develop utilization and quality controls. The contract must include the use of peer specialty groups that are given the goal of controlling utilization within a specialty. The corporation shall ensure that the contract stresses the development of the use of incentives to control costs.

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

- (1) "clearinghouse" means the claims clearinghouse designated by the corporation under AS 21.58.220;
- (2) "Consumer Price Index" means the Consumer Price Index for Anchorage, All Items Index, compiled by the Bureau of Labor Statistics, United States Department of Labor;
- (3) "corporation" means the Alaska Health Insurance Corporation established in AS 21.58.010;
- (4) "enrollee" means a person whose application for coverage under the state health insurance plan has been accepted by the corporation, who has completed applicable enrollment procedures, who is covered by insurance under the program;
- (5) "health care provider" means an acupuncturist licensed under AS 08.06; an audiologist licensed under AS 08.11; a chiropractor licensed under AS 08.20; a dental hygienist licensed under AS 08.32; a dentist licensed under AS 08.36; a marital or family therapist licensed under AS 08.63; a direct-entry

midwife certified under AS 08.65; a nurse licensed under AS 08.68; a dispensing optician licensed under AS 08.71; a naturopath licensed under AS 08.45; an optometrist licensed under AS 08.72; a pharmacist licensed under AS 08.80; a physical therapist or occupational therapist licensed under AS 08.84; or a physician's assistant certified under AS 08.64; a physician licensed under AS 08.64; a podiatrist; a psychologist and a psychological associate licensed under AS 08.86; a clinical social worker licensed under AS 08.95; an emergency medical technician certified under AS 18.08.082; a mobile intensive care paramedic trained as required under AS 18.08.082; a hospital as defined in AS 18.20.130, including a governmentally owned or operated hospital; and an employee of a health care provider acting within the course and scope of employment;

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

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

(8) "health insurance company" means an insurer that is authorized to transact health insurance;

(9) "market based single payer system" means a system in which a single entity provides health insurance to all residents of the state and the insurance is based on market forces, including provider defined fees, defined patient copayments, sliding scale copayments for the indigent, provider fees that are posted or made otherwise available at the point of services, published or disseminated fees in comparative lists that allow fee comparison by consumers, voluntary expenditure targets, provider peer review and control of volume, utilization, and quality of health services, and a regularly published description of the various types of providers

licensed to provide services in the benefit package;

(10) "state health insurance fund" is the fund established in AS 21.58.120.

* Sec. 7. AS 24.20.206 is amended to read:

Sec. 24.20.206. DUTIES. The Legislative Budget and Audit Committee shall

(1) report to the legislature its recommendations relating to the confirmation of appointees to the Board of Trustees of the Alaska Permanent Fund Corporation;

(2) annually review the long-range operating plans of all agencies of the state which perform lending or investment functions;

(3) review periodic reports from all agencies of the state which perform lending or investment functions;

(4) present a complete report of investment programs, plans, performance, and policies of all agencies of the state which perform lending or investment functions to the legislature within 30 days after the convening of each regular session;

(5) present to the legislature within 30 days after the convening of each regular session a review of the report of the governor under AS 37.07.020(d) with recommendations for needed legislation;

(6) in conjunction with the finance committee of each house recommend annually to the legislature the investment policy for the general fund surplus and for the income from the permanent fund;

(7) provide for an annual post audit and annual operational and performance evaluation of the Alaska Permanent Fund Corporation investments and investment programs;

(8) provide for an annual operational and performance evaluation of the Alaska Housing Finance Corporation and the Alaska Industrial Development and Export Authority; the performance evaluation shall include, but is not limited to, a comparison of the effect on various sectors of the economy by public and private lending, the effect on resident and nonresident employment, the effect on real wages, and the effect on state and local operating and capital budgets of the programs of the Alaska Housing Finance Corporation and the Alaska Industrial Development and

Export Authority;

(9) provide assistance to the trustees of the trust established in AS 37.14.400 - 37.14.450 in carrying out their duties under AS 37.14.415;

(10) provide for an annual post audit and annual operational and performance evaluation of the Alaska Health Insurance Corporation.

* Sec. 8. AS 36.30.015(e) is amended to read:

(e) The board of directors of the Alaska Railroad Corporation, [AND] the board of directors of the Alaska Aerospace Development Corporation, **and the board of directors of the Alaska Health Insurance Corporation** shall adopt procedures to govern the procurement of supplies, services, professional services, and construction. The procedures must be substantially equivalent to the procedures prescribed in this chapter and in regulations adopted under this chapter.

* Sec. 9. AS 37.07.030 is amended to read:

Sec. 37.07.030. RESPONSIBILITIES OF THE LEGISLATURE. The legislature shall

(1) provide for a budget review function;

(2) analyze the comprehensive operating and capital improvements programs and financial plans recommended by the governor;

(3) adopt legislation to authorize implementation of the governor's comprehensive operating and capital improvements programs and financial plans or appropriate alternatives to those plans;

(4) provide for a post-audit function to cover financial transactions, program accomplishment, and compliance with legislative intent;

(5) adopt or revise the estimate of receipts required to balance the succeeding fiscal year's budget in order that proposed expenditures do not exceed estimated receipts for that fiscal year;

(6) adopt, revise, or initiate revenue measures in order to balance the succeeding fiscal year's budget and the capital improvements section of the budget for the succeeding six years;

(7) appropriate funds for the operation of the Alaska Health Insurance Corporation.

* Sec. 10. AS 39.25.110 is amended by adding a new paragraph to read:

(30) the executive director of the Alaska Health Insurance Corporation.

* **Sec. 11.** AS 44.62.330(a) is amended by adding a new paragraph to read:

(59) Alaska Health Insurance Corporation.

* **Sec. 12.** PHASED TRANSITION PERIOD. Notwithstanding the provisions of AS 21.58, the Alaska Health Insurance Corporation shall implement the provisions of AS 21.58 on an orderly and gradual basis as follows:

(1) by December 31, 1994, the corporation shall begin to implement the public involvement process required under AS 21.58.320, establish the data system required under AS 21.58.260 and begin collecting data, begin the first public health improvement plan required under AS 21.58.310, determine the federal waivers necessary to implement AS 21.58, and begin to develop incentives to attract health care providers required under AS 21.58.110(16);

(2) by June 31, 1995, the corporation shall complete the uniform claims form required under AS 21.58.110(4);

(3) by December 31, 1995, the corporation shall establish the claims clearinghouse required under AS 21.58.220, determine the health care services required under AS 21.58.170, begin monitoring health care expenditures and utilization patterns, and begin collecting fee information required under AS 21.58.230;

(4) by January 1, 1996, the corporation shall implement the peer review system for utilization and quality required under AS 21.58.330 and shall adopt regulations that establish eligibility criteria for enrollment in the state health insurance plan, including a definition of the term "resident" that is consistent with AS 01.10.055 and the purposes of this Act;

(5) by December 31, 1996, the corporation shall establish the voluntary cost control system required under AS 21.58.280;

(6) by January 1, 1997, the corporation shall develop a long-term health care plan required under AS 21.58.110(19), and establish the deductible and copayment amounts required under AS 21.58.180 and present options to the governor and the legislature on how to finance a state health insurance plan under a market based single payer system; in considering options on financing a state health insurance plan the corporation shall strive to structure the options in a manner that provides protection for benefits provided to retired employees through public or private retirement systems;

(7) by January 1, 1998, the corporation shall establish the statewide health care expenditure target required under AS 21.58.270, and, subject to appropriation, begin to provide health insurance coverage for state residents as required under AS 21.58.

* Sec. 13. Notwithstanding AS 21.58.270(b), enacted in sec. 6 of this Act, the corporation shall increase the health care expenditure target by the following percentages of the target established under AS 21.58.270:

- (1) in 1998, 1.5 percent;
- (2) in 1999, 1.0 percent; and
- (3) in 2000, 0.5 percent.

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

FISCAL NOTE

STATE OF ALASKA
1994 LEGISLATIVE SESSION

BILL NO. CS HB 414 (HESS)

Revision Date: _____

Department Affected: Office of the Governor

Title: "An Act creating the Alaska Health Commission..."

BRU: Commissions and Special Offices

Component: Alaska Health Commission

Sponsor: House Rules Committee

Requestor: Governor

COMPONENT SERIAL NO. _____

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 95	FY 96	FY 97	FY 98	FY 99	FY 00
PERSONAL SERVICES	640.2	734.3	749.9	766.6	783.3	801.3
TRAVEL	23.3	30.5	30.5	30.5	30.5	30.5
CONTRACTUAL	330.7	336.6	336.6	336.6	336.6	336.6
SUPPLIES	8.5	9.0	9.0	9.0	9.0	9.0
EQUIPMENT	78.5	.5	.5	.5	.5	.5
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	1081.2	1110.9	1126.5	1143.2	1159.9	1177.9

CAPITAL EXPENDITURES						
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CHANGE IN REVENUES ()						
------------------------	--	--	--	--	--	--

FUND SOURCE

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts	1081.2	1110.9	1126.5	1143.2	1159.9	1177.9
1006 GF/MHTIA						
OTHER						
TOTAL	1081.2	1110.9	1126.5	1143.2	1159.9	1177.9

POSITIONS

FULL-TIME	11	11	11	11	11	11
PART-TIME						
TEMPORARY						

Estimate of any current year (FY94) cost: 0

ANALYSIS: (Attach a separate page if necessary.)
See attached analysis

Prepared by: Michael A. Nizich, Director
Division: Division of Administrative Services

Phone: 465-3876
Date: 3/11/94

Approved by Commissioner: Patrick P. Ryan, Chief of Staff
Agency: Office of the Governor

Date: 3/11/94

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Fiscal impact of proposed amendments to HB414:

Amendment 1: Public Health Committee

Assumptions:

Committee has six members
 Assume staff work done by Health Commission staff and Division of
 Public Health employees
 Committee meets 3 times per year in person (2 in FY95)
 Committee has 4 additional teleconference meetings per year

	FY95	FY96 - 00
Personal Services:		
1 Research Analyst	30,000 (6 mos.)	59,000 (inflate 5% annually)
Travel:	4,800	10,500
Contractual:		
Public Notices	1,000	3,500
Equipment:	12,100	-0-

Amendment 2: Single Payor Analysis

No cost - already assumed in original fiscal note

Amendment 3: Erisa Waiver:

Assumptions: contracting for specialized assistance

	FY95	FY96 - 00
Contractual:	100,000	100,000 (each year)

Amendment 4: Pooling

No additional cost anticipated

Amendment 5: Disclosure of Prices

Assumptions: One research analyst is required to monitor
 compliance; travel included

	FY95	FY96 - 00
Personal Services:		
1 Research Analyst	30,000 (6 mos.)	59,000 (inflate 5% annually)
Travel:	1,500	3,000
Supplies:	500	1,000
Contractual:	3,400	6,800
Equipment:	12,100	-0-

PERSONAL SERVICES

580.2

Fiscal note assumes Commissioners appointments on 7/1/94 and provides for 11 months of staff within first year. Subsequent years include merit increases for staff.

3	Commissioners	Rg. 26C	290.7
1	Special Assistant	Rg. 23A	70.9
3	Research Analysts	Rg. 18A	155.9
1	Secretary I	Rg. 10A/B	32.9
1	Clerk Typist III	Rg. 08A/B	29.8

TRAVEL

17.0

Travel costs and per diem associated with Commission activities -- research, investigation, public hearings

CONTRACTUAL

226.3

Professional Services:

technical/legal assistance contracts	150.0
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Communication:

Telephone (toll costs, base/local fixed costs, fax postage) 900/mo x 12	10.8
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Advertising, Printing:

Public hearing advertising, report printing	5.0
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Transportation:

Freight and express charges 75/mo x 12	.9
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Minor Repair, Maintenance:

.8

Equipment rental:

Photocopier 600/mo x 12	7.2
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Rental for space:

1433 sq. ft. x \$3.00/ft x 12 mos.	<u>51.6</u>
	226.3

SUPPLIES 8.0

Data processing and office supplies

EQUIPMENT 54.3

Communication:

Phone system	4.0
Fax Machine	2.8
Mailing equipment	3.0

Data Processing Equipment:

PCs, system printer, software for 9 work stations	26.0
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Furniture/Office equipment:

9 offices/work stations file cabinets, bookcases and miscellaneous office equipment	<u>18.5</u> 54.3
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