

SB

201

DIVISION OF LEGAL SERVICES

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MEMORANDUM

March 2, 1994

SUBJECT: Sectional Summary of SB 201

TO: Senator Tim Kelly

FROM: Michael F. Ford *M.F.*
Legislative Counsel

You have requested a sectional summary of the above-described bill.

As a preliminary matter, note that a sectional summary of a bill should not be considered an authoritative interpretation of the bill and the bill itself is the best statement of its contents. If you would like an interpretation of the bill as it may apply to a particular set of circumstances, please advise.

Section 1. Findings.

Section 2. Technical amendment regarding health maintenance organizations.

Section 3. Technical amendment regarding hospital and medical service corporations.

Section 4.

Sec. 21.89.100. Requires that an insured who has coverage under two or more insurance plans that provide for coordination of benefits, that the coverage from those plans must be coordinated so that the insured receives the maximum allowable benefit from each plan. Specifies certain provisions that must be included in an insurance plan that provides for coordination of benefits.

Sec. 21.89.110. Requires that certain insurers maintain and use a profile of health care fees used to determine the payment of claims. Requires disclosure of the methods used to determine the amount paid on a claim. Requires disclosure of the methodology used in determining a usual, customary and reasonable fee.

Section 5. Applicability section.

Section 6. Effective date.

MFF:gc
94-164.glc

Problem Statement/Proposed Solution

LET THE CONSUMER MAKE INFORMED DECISIONS BEFORE THEY BUY HEALTH CARE COVERAGE

PROBLEM: CONSUMERS CANNOT MAKE INFORMED DECISIONS WHEN COMPARING AND PURCHASING HEALTH CARE COVERAGE. MANY PROPOSALS FOR (AND POLICIES OF) INSURANCE TELL YOU THE INSURER WILL PAY X% OF THE USUAL, CUSTOMARY AND REASONABLE FEE FOR A HEALTH CARE SERVICE - THE QUESTION IS: USUAL, CUSTOMARY AND REASONABLE AS COMPARED TO WHAT? CONSUMERS CAN UNDERSTAND THIS ISSUE AND THEY CAN MAKE INFORMED BUYING DECISIONS - BUT ONLY IF THEY ARE GIVEN THE GROUND RULES UP FRONT.

RESOLVE: THE PROPOSED LEGISLATION WOULD ALLOW ANY CONSUMER TO OBJECTIVELY MEASURE THE DIFFERENCE IN U.C.R. REIMBURSEMENT LEVELS BETWEEN COMPETING INSURERS/PROPOSALS AT THE PURCHASE LEVEL - BEFORE THE CLAIM. SOME PEOPLE WILL OPT FOR SMALLER REIMBURSEMENT LEVELS AND CORRESPONDINGLY LOWER PREMIUMS; OTHERS WILL OPT FOR HIGHER REIMBURSEMENT LEVELS. THE PROPOSED LEGISLATION WILL REQUIRE INSURERS TO STATE IN PROPOSALS FOR AND POLICIES OF INSURANCE (A) THE FREQUENCY WITH WHICH THE INSURER DETERMINES THE USUAL, CUSTOMARY, AND REASONABLE FEE; (B) A GENERAL DESCRIPTION OF THE METHODOLOGY USED TO DETERMINE THE USUAL, CUSTOMARY, AND REASONABLE FEE; (C) THE PERCENTILE OF USUAL, CUSTOMARY, AND REASONABLE FEES AT WHICH THE INSURER WILL REIMBURSE THE INSURED, OR THE CONTRACT HEALTH CARE PROVIDER. THE PROPOSED LEGISLATION DOES NOT ASK INSURERS TO CHANGE WHAT THEY ALREADY DO - JUST TO DECLARE IT UP FRONT.

CONTROL CLAIMS COST/SPEED CLAIM PAYMENT WITH COMMON RULES FOR DETERMINING USUAL, CUSTOMARY AND REASONABLE FEES

PROBLEM: ALASKA HAS A MULTITUDE OF INSURANCE COMPANIES, MANY OF WHOM CALCULATE USUAL, CUSTOMARY AND REASONABLE IN A DIFFERENT FASHION. WHEN MULTIPLIED BY HUNDREDS OF THOUSANDS OF ALASKAN HEALTH CARE CLAIMS REQUIRING MULTIPLE INTERACTIONS BETWEEN INSURER, INSURED AND HEALTH CARE PROVIDER TO RESOLVE DIFFERENCES, LACK OF COMMON RULES INCREASES THE "TRANSACTION COST" OF PAYING CLAIMS; THE INSURER HAS AN INCREASE IN OVERHEAD AND PERSONNEL TO RESOLVE THE DISPUTES, CAUSING HIGHER PREMIUMS; THE HEALTH CARE PROVIDER MUST HIRE ADDITIONAL STAFF TO INTERFACE WITH BOTH INSURER AND PATIENT, INCREASING THE COST OF CARE. CONTROLLING TRANSACTION COST IS A KEY ELEMENT IN CONTROLLING SPIRALING HEALTH CARE COSTS.

RESOLVE: COMMON GROUND RULES, WITH BROAD PARAMETERS, THE PROPOSED LEGISLATION WOULD REQUIRE ONLY THOSE INSURANCE COMPANIES PAYING CLAIMS ON A U.C.R. BASIS TO USE THE HEALTH CARE PROVIDER FEES FROM THE GEOGRAPHICAL AREA IN WHICH SERVICE IS DELIVERED; IF THERE ARE NOT A SUFFICIENT NUMBER OF PROVIDERS IN A GIVEN AREA TO DETERMINE A U.C.R. FEE, THE INSURER MAY OBTAIN FEES FROM ANOTHER GEOGRAPHIC AREA, BUT THEM MUST USE THE MEDICAL COST COMPONENT OF THE CONSUMER PRICE INDEX (OR OTHER REASONABLE BASIS STATED IN WRITING AND APPROVED BY THE DIRECTOR OF INSURANCE) TO ADJUST THE U.C.R. PAYMENT TO THE LOCAL ZIP CODE.

CONTROL TRANSACTION COST/SPEED CLAIM PAYMENT WITH COMMON RULES FOR COORDINATING BENEFITS AMONG MULTIPLE INSURERS

COORDINATION (OR REDUCTION) OF BENEFITS ONLY OCCURS WHEN A PRIMARY AND SECONDARY INSURANCE COMPANY INSURE THE SAME PERSON. THE PURPOSE OF COORDINATING (REDUCING) BENEFITS IS TO MAKE SURE THE INSURED OR PATIENT IS NOT UNJUSTLY ENRICHED BY RECEIVING MORE THAN 100% REIMBURSEMENT OF THEIR COST. THE OBJECTIVE IS (OR OUGHT TO BE) TO MAKE SURE THAT THE INSURED/PATIENT RECEIVES AS CLOSE TO 100% REIMBURSEMENT AS POSSIBLE.

PROBLEM: ALASKA HAS A MULTITUDE OF INSURANCE COMPANIES, MANY OF WHOM COORDINATE BENEFITS IN A DIFFERENT FASHION. THIS CAUSES UNREASONABLE DELAYS IN PAYMENT OF CLAIMS, AND GREATLY ADDS TO THE ADMINISTRATIVE/CLAIM TRANSACTION COST, INCREASING INSURANCE PREMIUMS AND INCREASING HEALTH CARE PROVIDER FEES, AND CAUSING PATIENTS TO BE REIMBURSED FOR LESS THAN 100% OF THE HEALTH CARE CLAIM, EVEN THOUGH THEY HAVE PAID A PREMIUM TO BOTH INSURERS FOR THE COVERAGE.

RESOLVE: AGREE UPON A SET OF COMMON GROUND RULES FOR DETERMINING - IN A VARIETY OF CIRCUMSTANCES - WHICH INSURER IS PRIMARY AND WHICH INSURER IS SECONDARY. THIS WILL ALLOW FOR QUICK AND EASY PAYMENT OF CLAIMS AND SHOULD HELP CONTROL SPIRALING INSURANCE PREMIUMS AND PROVIDER FEES.

PUBLICLY STATING THE RULES IN PROPOSAL FOR AND POLICIES OF INSURANCE

IT'S COMMON SENSE THAT INSURERS PROVIDE THE CONSUMER THESE RULES IN PROPOSALS FOR, POLICIES OF, EVIDENCES OF, CERTIFICATES OF INSURANCE, EMPLOYEE BENEFIT BOOKLETS, ETC.

BACKGROUND/CROSS REFERENCES

SIMILAR LEGISLATION WAS INTRODUCED IN SB414 BY SENATOR HOFFMAN, BY REQUEST, 03/04/92. RULES FOR U.C.R. FEE DETERMINATION AND COORDINATION OF BENEFITS ALREADY EXIST IN ALASKA REGULATION. U.C.R. RULES ARE FOUND 3 AAC 26.110 AND .300(11); SEE ALSO BULLETIN NO. 87-6. ILLINOIS WAS THE PIONEER STATE WITH REGARD TO U.C.R. LEGISLATION, ADOPTING SIMILAR LEGISLATION IN 1991; LOUISIANA ENACTED A LAW EXACTLY LIKE THE ILLINOIS LEGISLATION IN 1992; OKLAHOMA ENACTED A SIMILAR LAW IN 1992. C.O.B. RULES ARE FOUND IN BULLETIN NO. 85-3. THE COORDINATION OF BENEFITS RULES GENERALLY FOLLOW THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS MODEL REGULATIONS; MIKE FORD DRAFTED SECTION (B) OF THE PROPOSED C.O.B. LEGISLATION, BASED UPON THE NAIC MODEL.

USUAL, CUSTOMARY AND REASONABLE FEE DETERMINATION

DETERMINATION AND DISCLOSURE OF USUAL, CUSTOMARY, AND REASONABLE FEES. An insurer who pays a claim under a disability policy on the basis of a usual, customary, or reasonable fee shall

- (1) maintain and use a statistically credible profile of fees of health care providers in this state on which to base payment of the claim; the profile must
 - (A) be updated at least once every six months and may not contain fees for services performed more than one year before the date of the most recent profile;
 - (B) contain fees for the geographic area in which a claimant might receive treatment; and
 - (C) shall not include any fees clearly marked "DO NOT PROFILE";

if statistically credible data for a particular health care service in a certain geographic area does not exist, the insurer may include in the profile a sufficient number of fees for that service from another geographic area in order to establish a reliable data base;

however, the final basis for payment must be adjusted to reflect the general cost difference between the geographic area where the service was performed and the other geographic area used in establishing the statistically credible profile; the adjustment may be based upon the Consumer Price Index, the medical care component of the Consumer Price Index, or a reasonable basis stated in writing and determined acceptable by the director;

- (2) respond to the inquirer within 15 working days after receiving a written request from an insured, a health care provider with a valid assignment of payments, or a health care provider engaged to provide services under a professional services contract, with a full written disclosure of the methods employed under (1) of this section that resulted in the difference between the amount paid on a claim for benefits and the actual charges submitted; and
- (3) disclose in a proposal for insurance, a policy of insurance, a certificate of insurance, an employee benefit description or supplemental document, or a professional service contract between an insurer and a health care provider
 - (A) the frequency with which the insurer determines the usual, customary, and reasonable fee;
 - (B) a general description of the methodology used to determine the usual, customary, and reasonable fee;
 - (C) the percentile of usual, customary, and reasonable fees at which the insurer will reimburse the insured, or the contract health care provider.

COORDINATION OF BENEFITS

REQUIRED PROVISIONS REGARDING COORDINATION OF BENEFITS. When an insured has coverage under two or more plans that provide for coordination of benefits, the coverage from those plans must be coordinated so that the patient receives the maximum allowable benefit from each plan. The aggregate benefit should be more than that offered by any of the plans individually, but not such that the insured receives more than the total charges for the health care services received.

A plan that provides for coordination of benefits must contain a provision that-

- (1) discloses that coordination of benefits applies when the insured has health care coverage under more than one plan;
- (2) states what benefits from the plan and other sources are recognized under the coordinating provision and that indicates if one or more plan benefits are exempt from the coordinating provision;
- (3) states what health care expenses are allowable and what expenses are excluded under the coordinating provision;
- (4) states the period to be used in applying the coordinating benefits provision; a claim period may not be less than 12 months, but may exclude a period before coverage starts or after coverage ends;
- (5) indicates the manner in which benefits are reduced by coordination; a reduction in benefits is subject to the following order of benefit provisions;
 - (A) plan benefits applicable to an insured as an employee, member, or subscriber, and also as a dependent, are first determined as benefits applicable to the insured as employee, member, or subscriber;
 - (B) if a minor is eligible for benefits as a dependent of more than one insured, the plan of the insured whose date of birth falls earlier in the year is applied first, unless a different order of application is required by a court;
 - (C) benefits not determined under this paragraph that are applicable under more than one plan, are determined under that plan applicable to the insured for the longer period of time;
 - (D) when one of the plans is a medical plan and the other is a dental plan, and a determination cannot be made in accordance with provisions (A)-(C), the medical plan shall be considered as primary.
 - (E) if under the provisions of (A)-(D) of this paragraph the plan is secondary to another source of benefits, the benefits of the plan may not be reduced unless the sum of benefits payable for allowable expenses and the benefits payable for allowable expenses under the other source exceed the allowable expenses in a claim determination period;
- (6) provides that the insurer has the right to receive and to release information necessary to expedite a claim payment when coordinating benefits;
- (7) allows the insurer to make a payment necessary to repay another insurer for a payment that should have been made under the policy applicable to the insured; and
- (8) gives the insurer the right to recover excess payments from the insured paid or another insurer providing benefits to the insured.

COORDINATION OF BENEFITS

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

- (1) when the reduced-fee plan is primary and treatment is provided by a participating health care provider, the reduced fee is that health care provider's full fee. The secondary plan shall pay the lesser of: its allowed benefit or the difference between the primary plan's benefit and the reduced fee;
- (2) when the reduced-fee plan is primary and treatment is provided by a non-participating health care provider, the reduced fee plan shall provide its allowed amount for non-participating health care providers and the secondary plan should pay the lesser of: its allowed benefit for the service or the difference between the primary plan's benefits and the health care provider's full fee.
- (3) when a full-fee plan is primary and a reduced-fee plan is secondary, the full-fee plan should provide its allowed amount for the service and the secondary plan should pay the lesser of: its allowed benefit for the service or the difference between the primary plan's benefits and the health care provider's full fee.

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

- (1) when the capitation plan is primary, the capitation payments to the treating health care provider remain the capitation plan's usual benefits; the indemnity plan shall pay benefits for the patient's surcharges or copayments up to the indemnity plan's allowable benefit.
- (2) when the indemnity plan is primary, and treatment is received from a capitation-participating health care provider, the indemnity plan shall pay its allowable benefits; the capitation payments to the health care provider are the secondary coverage since they constitute benefits up to the capitation plan allowable amount.
- (3) when the indemnity plan or policy is primary, and treatment is received from a non-capitation-participating health care provider, the indemnity plan shall pay its allowable benefits; the capitation plan will pay benefits, in keeping with the capitation plan's allowed amount for treatment by non-participating health care providers.
- (4) no plan should contractually direct a health care provider to charge a secondary carrier for more than the amount which would be charged to the patient absent secondary coverage.

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

Legislative Intent

The legitimate interests of Alaska's citizens are best served by use of precise, accurate, standardized and publicly announced methodologies for determining payment of the usual, customary and reasonable fees for health care services and coordinating benefits among multiple insurers.

The Insurance Code - Title 21 - Alaska Statutes
Affected Types Of Health Insurance Policies

Type of Policy	Ins Code Title 21 Chapter #	U.C.R. Provision Applies	C.O.B. Provision Applies
Individual Indemnity Policies (Issued To Individuals)	51	Yes	No
Group/Blanket Indemnity Policies (Employer/Association Sponsored)	54	Yes	Yes
Health Maintenance Corporation (Employer/Association Sponsored)	86	Yes	Yes
Hospital And Medical Service Corp (Blue Cross/Delta Dental/Others)	87	Yes	Yes

The Usual, Customary And Reasonable Proposal Requires An Insurer To

1. Maintain and use a statistically credible profile of fees of health care providers in this state.
2. Respond to inquires within 15 working days with a full written disclosure of the methods the insurer employed which resulted in the difference between the amount paid on a claim for benefits and the actual charges submitted; and
3. Disclose in proposal for, a policy of, a certificate of insurance, or a professional service contract between an insurer and a health care provider the frequency with which the insurer determines the usual, customary, and reasonable fee; a general description of the methodology used to determine the usual, customary, and reasonable fee; the percentile of usual, customary, and reasonable fees at which the insurer will reimburse the insured, or the contract health care provider.

The Coordination Of Benefits Proposal Requires An Insurer To

1. Disclose when the coordination of benefits applies; states what benefits are recognized under the coordinating provision; states what health care expenses are allowable and what expenses are excluded under the coordinating provision; states the period to be used in applying the coordinating benefits provision; indicates the manner in which benefits are reduced by coordination.
2. Provides that the insurer has the right to receive and to release information necessary to expedite a claim payment when coordinating benefits; allows the insurer to make a payment necessary to repay another insurer for a payment that should have been made under the policy applicable to the insured; and gives the insurer the right to recover excess payments from the insured paid or another insurer providing benefits to the insured.
3. Establishes rules to determine primacy and coordinate benefits between traditional indemnity plans (this is what most health care policies are), a plan which contractually reduces the fees such a Preferred Provider Organization, a capitation plan such as a Health Maintenance Corporation.