SB

367

IRST COMMITTEE OF REFERRAL

DATE: 3/24/94

FURTHER: Judiciary
Finance

Date of 5-Day Notice: 3/24/94
(in accordance with Uniform Rule 23)

DATE TURNED
INTO OFFICE: 4/7/94

HESS Committee considered SB 367

Relating to health care and insurance for health care; to rates and rating factors and civil actions against health care providers; amending Alaska Rules of Civil Procedure and Evidence; efd.

and recommends:

[ ] replace with _____ CS SB 367 (HES)

[ ] attaches amendment(s)

[ ] same title
[✓] new title
[ ] technical title change (HB only)

[ ] adopts _____ Letter of Intent

[ ] further referral to the _____

forthcoming FN from HSS or Gov.

[ ] do pass

[ ] do not pass

[ ] no recommendation

[ ] individual recommendations

FISCAL NOTE INFORMATION

Department	Date	Zero	Fiscal
Revenue	3/25/94		✓

Department	Date	Zero	Fiscal

[ ] Appropriation No Fiscal Note

[ ] Governor's Bill with Previous Fiscal Notes (enter information above)

DO PASS: Mike Miller

OTHER RECOMMENDATIONS:

Duncan - Do NOT PASS

Ellis - DoNotPass - constitutionally flawed & not comprehensive

Hank Brown for NO Rec

Drew & Florian Amend to limit basic plan to non-elective procedu

Steve Rogers Do Pass

Chair: Signature and Recommendation

8-LS1498\K
Ford
4/6/94

CS FOR SENATE BILL NO. 367(HES)

IN THE LEGISLATURE OF THE STATE OF ALASKA

EIGHTEENTH LEGISLATURE - SECOND SESSION

BY THE SENATE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

Offered:
Referred:

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

A BILL

FOR AN ACT ENTITLED

"An Act relating to health care and insurance for health care; to review and approval of health insurance rates and rating factors; relating to certain civil actions against health care providers; to coordination of insurance benefits and to determination and disclosure of fees paid to an insured or health care provider; relating to the offense of operating a commercial motor vehicle while intoxicated and the offense of operating a motor vehicle, aircraft, or watercraft while intoxicated; relating to presumptions arising from the amount of alcohol in a person's breath or blood; relating to the rate of interest on certain judgments and decrees; to excise taxes on cigarettes; amending Alaska Rules of Civil Procedure 26, 27, 68, 79, and 82 and Alaska Rules of Evidence 802, 803, and 804; repealing Alaska Rule of Civil Procedure 72.1; and providing for an effective date."

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

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

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

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

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

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

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

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

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

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

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

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

(8) has demonstrated

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

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

(C) unfitness because of physical or mental disability;

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

(10) has violated AS 18.16.010;

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

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

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

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

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

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

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

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

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

(4) has impersonated a registered or practical nurse;

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

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

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

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

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

(9) is professionally incompetent [;

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

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

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

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

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

(2) intentional concealment; or

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

(c) In this section,

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(6) What specifically caused the medical injury?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CHAPTER 58. HEALTH CARE.

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

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

(1) health care expenditures, including capital expenditures associated with receiving health care;

(2) demographic data;

(3) clinical information, including patient diagnosis, type of provider, type of service, location and length of care, referral patterns, quality of care, and result of care;

(4) billing and payment data; and

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

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

system required under (a) of this section.

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

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

(e) Information or data regarding health care services

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

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

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

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

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

Sec. 21.58.400. DEFINITIONS. In this chapter,

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

(2) "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 health maintenance organization as defined in AS 21.86.900; a hospital or medical service corporation as defined in AS 21.87.330; 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;

(3) "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;

(4) "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;

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

transact health insurance.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) AS 21.03;

(2) AS 21.06;

(3) AS 21.09, except AS 21.09.090;

(4) AS 21.18.010;

(5) AS 21.18.030;

(6) AS 21.18.040;

(7) AS 21.18.120;

(8) AS 21.21.321;

(9) AS 21.36;

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

(11) AS 21.51.120;

(12) AS 21.53;

(13) AS 21.54.020;

(14) AS 21.56;

(15) AS 21.69.400;

(16) AS 21.69.520;

(17) AS 21.69.600, 21.69.620, and 21.69.630;

(18) AS 21.78;

(19) AS 21.89.040;

(20) AS 21.89.060 **and 21.89.100 - 21.89.120**;

(21) AS 21.90.

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

Sec. 21.89.100. REQUIRED PROVISIONS REGARDING COORDINATION OF BENEFITS. (a) 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 insured receives the maximum allowable benefit from each plan. The aggregate benefit should be more than that offered by any of the plans individually, but the insured may not receive more than the total of the charges for the health care services received.

(b) 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 health care expenses are excluded under the coordinating provision;

(4) states the claim 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 under the provisions of (A) - (C) of this paragraph, the medical plan shall be considered as the primary coverage;

(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 to another insurer providing benefits to the insured.

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

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

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

(A) its allowed benefit for the service;

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

service and the health care provider's full fee;

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

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

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

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

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

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

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

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

provider on the basis of a usual, customary, or reasonable fee or charge 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 one y 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) may not include 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 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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) [REPEALED

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) AS 21.03

(2) AS 21.06

(3) AS 21.09, except AS 21.09.090

(4) AS 21.18.010

(5) AS 21.18.030

(6) AS 21.18.040

(7) AS 21.18.120

(8) AS 21.21.321

(9) AS 21.36

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

(11) AS 21.51.120

(12) AS 21.53

(13) AS 21.54.020

(14) AS 21.69.400

(15) AS 21.69.520

(16) AS 21.69.600, 21.69.620, and 21.69.630

(17) AS 21.78

(18) AS 21.89.040

(19) AS 21.89.060 **and 21.89.100 - 21.89.120**

(20) AS 21.90.

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

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

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

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

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

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

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

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

(6) two persons who represent the public.

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

(d) The committee may

(1) establish subcommittees;

(2) conduct hearings;

(3) employ personnel necessary to complete assigned duties;

(4) enter into contracts;

(5) subject to appropriation, expend money.

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

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

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

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

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

(A) a surcharge for coverage of each dependent child or spouse may

be imposed; a surcharge may not exceed 50 percent of the individual premium; it is the intent of the legislature that the premium be set at a rate that does not exceed $100 per month or 14 percent of the individual's monthly gross income, whichever is lower;

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

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

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

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

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

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

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

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

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

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

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

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

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

(4) recommended legislation regarding public health issues;

(5) recommended legislation to simplify health care administration;

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

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

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

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

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

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

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

(1) two persons licensed under AS 08.64;

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

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

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

(c) The committee may

(1) establish subcommittees;

(2) conduct hearings;

(3) employ personnel necessary to complete assigned duties;

(4) enter into contracts;

(5) subject to appropriation, expend money.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

FISCAL NOTE

STATE OF ALASKA
1994 LEGISLATIVE SESSION

BILL NO. SB 367

Revision Date:
Title: Health Care Reform Committees
Sponsor: (S) HES
Requestor: (S) HES

Dept. Affected: Revenue
BRU: Revenue Operations
Component: Income and Excise Audit

COMPONENT SERIAL NO. 113

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY95	FY96	FY97	FY98	FY99	FY00
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL						
REVENUE FUND SOURCE: General	5,397.5	5,397.5	5,397.5	5,397.5	5,397.5	5,397.5

FUNDING: (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1006 GF/MHTIA						
Other						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

Estimate of current year (FY94) impact: $ 0.0

ANALYSIS: (Attach a separate page if necessary.)

(See Attached)

Prepared by: Larry E. Meyers
Division: Director
Approved by Commissioner: Darrel J. Rexwinkel
Agency: Department of Revenue

Phone: 465-2320
Date: March 25, 1994
Date: March 25, 1994

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Bill Analysis

This bill relates to health care and insurance for health care.

Section 12 of this bill pertains to Department of Revenue in that it increases the current cigarette tax rate by 5 mills from 14.5 to 19.5 mills. Note that the total mill rate includes 2.5 mills assessed for the School Fund under AS 43.50.090.

	Current Tax Rate	*SB 367 Tax Rate*	*% Increase*
Cigarettes	14.5 mills* (29¢/pack)	19.5 mills* (39.0¢/pack)	35%

* Includes 2.5 mills assessed under AS 43.50.090.

The tax increase becomes effective July 1, 1994 under this bill.

Operating Costs

This bill will not affect the Department's operating costs because amendments made under this bill increase the cigarette tax rate only. Department of Revenue will revise its forms to reflect the increased tax rate.

Revenue

In determining the amount of additional revenue generated from this bill, Department of Revenue used consumption data available from FY 93. Amounts below do not reflect impacts on consumption, if any, due to increased tax rates and other factors. Additional revenue generated from this bill is estimated to be $5,397,500 calculated as follows.

FY93 Consumption	*FY 93 Revenue*	*SB 367 Revenue*	*Additional Revenue*
1,079,500,000	$15,652,800	$21,050,300	$5,397,500

FISCAL NOTE

STATE OF ALASKA
1994 LEGISLATIVE SESSION

BILL NO. CSSB 367 (HESS)

Revision Date:
Title: "An Act relating to Health Care..."
Sponsor: Senate HESS
Requestor:

Department Affected: Office of the Governor
BRU: Commissions and Special Offices
Component: Health Care Plan/Medical Practice
Advisory Committees
COMPONENT SERIAL NO.

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 95	FY 96	FY 97	FY 98	FY 99	FY 00
PERSONAL SERVICES	246.6	344.4				
TRAVEL	95.5	100.9				
CONTRACTUAL	209.0	245.9				
SUPPLIES	4.5	6.0				
EQUIPMENT	72.6	1.0				
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOT OPERATING	628.2	698.2				
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )						
FUND SOURCE						
1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts	628.2	698.2				
1006 GF/MHTIA						
OTHER						
TOTAL	628.2	698.2				
POSITIONS						
FULL-TIME	6	6				
PART-TIME						
TEMPORARY						

Estimate of any current year (FY94) cost: 0

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

Prepared by: Michael A. Nizich, Director
Division: Division of Administrative Services
Phone: 465-3616
Date: 4/13/94

Approved by Commissioner: Patrick P. Ryan, Chief of Staff
Agency: Office of the Governor
Date: 4/13/94

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Fiscal note reflects costs related to the Health Care Plan Advisory and Medical Practices Advisory Committees to June 30, 1996, repeal date of the enabling legislation per Sec. 31 of the bill. Fiscal note further assumes staff will serve both committees.

	FY95	FY96
Personal Services:	246.6	344.4

Personal services costs reflect 9 months in FY95, 12 months with merit increases in FY96.

1 Executive Director, Rg 23
3 Research Analysts, Rg 18
1 Administrative Assistant, Rg 12
1 Clerk, Rg 10

Travel:	95.5	100.9

Health Care Plan Advisory Committee:
(7 members)
assumes 4 meetings FY95, 5 meetings FY96

	FY95	FY96
airfare/per diem	11,200	14,000

Medical Practices Advisory Committee:
(4 members)
assumes 4 meetings FY95, 3 meetings FY96

	FY95	FY96
airfare/per diem	8,400	6,300

Medical Practices Advisory subcommittees:
assumes 8 subcommittee meetings each fiscal year

	FY95	FY96
airfare/per diem	11,200	11,200

Staff travel:

meetings related travel and 3 out-of-state trips

	FY95	FY96
airfare/per diem	8,700	9,400

Travel - continued

Honorarium:

committee members receive $400/day honorarium

Health Care Plan Advisory Committee:

	FY95	FY96
assumes 2 day meetings	22,400	28,000
8 teleconferences	6,400	6,400

Medical Practices Advisory Committee:

	FY95	FY96
assumes 2 day meetings	12,800	9,600
3 teleconferences	1,600	3,200

Medical Practices Advisory subcommittees:

	FY95	FY96
assumes 2 day meetings	12,800	12,800

Contractual: 209.0 245.9

Professional Services:

	FY95	FY96
consulting actuary	10,000	10,000
legal services	70,000	70,000

Contractual costs per position:

	FY95	FY96
toll costs, postage, fax, utilities, etc.	54,500	70,400

Communications:

Health Care Plan Advisory Committee:
statewide teleconferences for public hearings

	FY95	FY96
teleconferences	28,000	28,000

Contractual - continued

Medical Practices Advisory Committee:
statewide teleconferences for public hearings

	FY95	FY96
teleconferences	7,00	14,000

Advertising:

	FY95	FY96
Public notice for meetings and public hearings:	21,000	22,000

Lease Space:

	FY95	FY96
175 sq.ft. per position x $1.80 sq. foot	17,000	26,700
facility rental for meetings	1,500	4,800

Supplies: 4.5 6.0

1.0 per position

Equipment: 72.6 1.0

work stations, phones, computer equipment @ 12.1 per position

STATE OF ALASKA
1994 LEGISLATIVE SESSION

FISCAL NOTE

BILL NO.: CSSB 367(HES)

Revision Date:		Dept. Affected:	Corrections
Title:	Health Care Reform and .08 Level for OMVI	BRU:	All
Sponsor:	S. HESS	Component:	All
Requestor:	S. JUD	Component Serial #:	694-1884

Expenditures/Revenues (Thousands of Dollars)

OPERATING EXP.	FY95	FY96	FY97	FY98	FY99	FY00
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL	81.4	83.8	86.3	88.9	91.6	94.4
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS,CLAIMS						
MISCELLANEOUS	328.5	338.4	348.5	359.0	369.7	380.9
TOTAL OPERATING	409.9	422.2	434.8	447.9	461.3	475.3
CAPITAL EXP	0.0	0.0	0.0	0.0	0.0	0.0
CHANGES IN REVENUES	0.0	0.0	0.0	0.0	0.0	0.0
FUND SOURCE						
1002 Federal Receipts						
1003 GF Match						
1004 GF	147.1	151.4	156.0	160.7	165.5	170.5
1005 GF/Program Receipts	262.8	270.7	278.8	287.2	295.7	304.7
1006 GF/MHTIA						
Other						
TOTAL	409.9	422.2	434.8	447.9	461.3	475.3

Estimate of any current year (FY94) cost $ 0.0

POSITIONS

FULL-TIME	0	0	0	0	0	0
PART-TIME	0	0	0	0	0	0
TEMPORARY	0	0	0	0	0	0

ANALYSIS: Please see the attached explanation.

Prepared by: Diane Schenker, Special Assistant Phone: 465-4643/785-2147
Division: Office of the Commissioner Date: 4/12/94
Approved by: J. Frank Prewitt, Jr., Commissioner (for) Date: 4/12/94
Agency: Department of Corrections

The bill lowers the blood alcohol limit for the crime of DWI, from .10 to .08 percent.

Assumptions

1. According to the National Highway Traffic Safety Administration, a study of five other states indicates an average increase in DWI cases of approximately 3.9% as a result of lowering the limit from .10 to .08. On 12/31/93 there were 130 inmates incarcerated for DWI, statewide. However, the department has been informed by the Anchorage district court that, beginning in May, 1995, offenders will be remanded either immediately or within three months instead of being allowed to wait for available bedspace. Most of the offenders allowed to await bedspace have been DWIs. This policy decision is expected to double the number of DWI offenders incarcerated per day during FY95. Therefore, the average daily population of 130 is doubled to an expected 260.

A 3.9 percent increase in this population would raise the DWI population by 10 inmates, or 3,650 inmate-days per year (10 X 365 = 3,650).

2. The cost per day to incarcerate the average DWI case is $90. The department calculated this cost by using the cost of Community Residential Center (CRC) beds and state correctional beds actually used to incarcerate DWIs last year. Generally, DWI cases are housed in state correctional centers only in unsentenced status or in locations where no CRC is available.

3. A recent change in law requires DWI offenders to pay for some of the costs of incarceration: Regulations require a first-time DWI offender to pay $270, and a second-time offender to pay $1,000. The Department of Law, which is expected to collect the fees, expects to collect approximately 80% of the fees, through voluntary compliance and by taking Permanent Fund Dividends. It is expected that the fees will offset costs only for first and second-time offenders.

4. *The Department of Law has recently informed the department that it will require an RSA for approximately $81.4 to perform the collection function. If this amount is not funded, the department will not have the resources to collect the DWI fees and the full costs of incarceration would have to be funded by general funds instead of program receipts.*

5. The legislation only affects DWIs charged under state statute. DWIs charged under local city ordinances will remain at the .10 level unless the local laws are changed. It is estimated that over half of the DWIs incarcerated in the state correctional system are from Anchorage, charged under city law.

6. Increases in DWI cases may have a "ripple effect" on other crimes, such as Failure to Appear, Failure to Satisfy Judgment, and Driving With License Suspended/Revoked. The department notes that misdemeanants are the fastest-growing incarcerated population. It is assumed that this factor could double the number of additional inmates referenced in Assumption 1. However, it is assumed that Assumption 5 will offset this, since half the DWI population comes from Anchorage on municipal, rather than state, charges.

7. National studies suggest that this type of legislation may reduce the number of traffic fatalities. This could result in some lessening of prisoner-days served for vehicular homicides. This may help offset the costs not reflected in the fiscal note, such as the costs for third-time or higher offenders who cannot pay the costs of incarceration through fees.

8. The costs of incarceration are reflected under "miscellaneous" because some expenses will be incurred in individual institutions, some in CRC contracts, and some in department overhead for administering contracts and providing support services for institutions.

9. A 3% inflation factor is assumed.

Operating Expenses

3,650 inmate-days per year X $90 per day = **$ 328,500 total expense, FY95**

80% (DWI fee collection rate) of $ 166,590 = **$ 262,800 GF/Program Receipts, FY95**

$328,500 - $262,590 = **$ 65,910 GF, FY95**

Plus **$81.4, contractual** (GF), for RSA to Department of Law to collect fees

DIVISION OF LEGAL SERVICES

LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

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FAX (907) 465-2029
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130 Seward Street, Suite 409
Juneau, Alaska 99801-2105

M E M O R A N D U M March 24, 1994

SUBJECT: Sectional Summary of SB 367

TO: Senator Steve Rieger

FROM: Michael F. Ford
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. Technical amendment required by the imposition of mandatory arbitration.

Section 2. Technical amendment required by the imposition of mandatory arbitration.

Section 3. Requires a civil action brought against a health care provider by a person who is less than two years of age be brought by the person's eighth birthday. Provides certain exceptions for the statutory limit imposed by this section.

Section 4. Provides that the rate of interest on judgments and decrees for the payment of money is equal to the 12th Federal Reserve district discount rate as determined under AS 455.45.010(b).

Section 5. Requires that a person who files a civil action for damages against a health care provider resulting from medical malpractice, must also submit the claim for arbitration. Establishes hearing procedures for arbitrating the claim and imposes deadlines for reaching the arbitrator's decision. Allows a party to appeal a decision of an arbitrator. Imposes a penalty for appeal of an arbitrator's decision if the judgment is not more favorable than the arbitrator's decision.

Section 6. Changes the expert advisory panel required in a medical malpractice action to a single expert advisor.

Section 7. Requires a disability insurer to file rate information with the director of the division of insurance.

Section 8.
Sec. 21.58.010. Requires a health care provider to post certain price information.

Sec. 21.58.020. Requires the Department of Commerce and Economic Development to develop a health care data system. Allows the commissioner to require health care providers to submit data necessary to develop the system. Imposes certain confidentiality provisions and exceptions to confidentiality provisions regarding information in the data system.

Sec. 21.58.030. Requires the director of insurance to develop uniform claims forms, standards, and procedures for billing and payment for health care services.

Sec. 21.58.040. Allows the legislature to appropriate a portion of insurance premium tax proceeds for the administrative costs of this chapter.

Sec. 21.58.400. Definitions.

Section 9. Technical amendment to require health maintenance organizations to comply with provisions of AS 21.89.100 and 21.89.120.

Section 10. Technical amendment to require hospital or medical service corporations to comply with provisions of AS 21.89.100 and 21.89.120.

Section 11.
Sec. 21.89.100. Requires that insurance coverage provided under two or more plans be coordinated so that the insured receives the maximum allowable benefit from each policy.

Sec. 21.89.110. Requires that certain insurers must maintain certain statistical information on fees, that methods of calculation be disclosed within 15 days of the request, and that certain information regarding determination of the usual, customary and reasonable fee that the insurer uses to reimburse the insured.

Sec. 21.89.120. Definitions.

Section 12. Increases the excise tax on cigarettes from 12 to 17 mills.

Section 13. Technical amendment.

Section 14. Technical amendment.

Section 15. Applicability section.

Section 16. Establishes a health care advisory committee in the office of the governor. Establishes the membership of the committee, imposes certain duties, and imposes conditions on imposed duties.

Section 17. Establishes a medical practice advisory committee in the office of the governor. Establishes the membership of the committee, establishes powers and imposes certain duties.

Section 18. Repeals a medical malpractice advisory panel established by court rule.

Section 19. Section describing certain court rule changes.

Section 20. Section describing certain court rule changes.

Section 21. Section describing certain court rule changes.

Section 22. Provides that section 18 takes effect only if it is approved by a two-thirds vote of each house.

Section 23. Repeals sections 16 and 17 on June 30, 1996.

Section 24. Effective date.

MFF:lmb
94-103.lmb

8-LS1498\J.15
Ford
3/29/94

AMENDMENT

OFFERED IN THE SENATE BY SENATOR LEMAN

TO: SB 367

Page 19, line 26:

Delete "prematernal"

Insert "prenatal"

Page 19, line 29:

Delete "prematernal"

Insert "prenatal"

Page 19, line 30:

Delete "prematernal"

Insert "prenatal"

8-LS1498\J.16
Ford
3/29/94

AMENDMENT

OFFERED IN THE SENATE BY SENATOR LEMAN

TO: SB 367

Page 19, after line 27:

Insert a new paragraph to read:

"(3) health care services that may not be covered include elective abortions;"

Renumber the following paragraphs accordingly.

Amendment #2: Senate Bill No. 367

Page 19, Lines 23 and 24 -

Delete: (d) (1)

Insert: (1) participation is mandatory by all State residents who do not already have insurance for the coverage specified in this section; a voluntary pool shall be established to provide coverage to those uninsured who wish to acquire insurance through the pool; coverage shall be made available through the pool for uninsured spouses and dependent children.

Amendment #3: Senate Bill No. 367

Page 20, lines 4-13 -

Delete: lines 4-13

Insert: premiums shall be set to allow reasonable variations based on health risk and cost factors such as smoking, age, geographic region, or other factors within the control of the individual up to the individual cap of $150 per month.

Amendment to Senate Bill No. 367

Page 8 -

Delete: Section 7

Insert : SEC. 7. AS 21.51 is amended by adding new sections to read:

Sec. 21.51.350. PREMIUM RATES AND RATING FACTORS. A disability insurer

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

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

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

Testimony of Mr. Steve LeBrun of Aetna Health Plans
Regarding Senate Bill 201
To the Senate Health, Education and Social Services Committee

Senate Bill 201, introduced at the request of dentists and medical service providers, would change existing rules regarding coordination of insurance benefits and reimbursement of medical service fees submitted to insurers.

Section 4(a) would prohibit employers from electing to use one of the two standard means to coordinate benefits when members of a family are covered under two insurance plans. Employers may instruct their insurers to coordinate benefits by allowing 100% of total medical claims to be paid by a combination of applicable policies, or by capping reimbursements at the higher level of payment offered by the most liberal of the applicable insurance policies. In the latter case, reimbursement of a claim may be limited to 80% - 90% rather than 100%, and the employee would be required to pay the balance. Employers pay a higher premium if they elect the 100% option, because total reimbursements to providers will be higher than the alternative method. Employers should be allowed to retain this option.

If SB 201 is adopted, any employer currently using the more conservative option will have increased insurance costs because the more liberal option will become their only option.

Section 4(b) changes existing disclosure requirements for coordination of benefit administration. The current disclosure requirements used by the Division of Insurance are derived from NAIC guidelines. The division reviews and approves insurance contracts to make sure the disclosures are included and consistent with its regulations. We will defer to the Division of Insurance as to whether its existing disclosure requirements need to be changed, which would require us to reprint all booklets and materials dealing with coordination of benefits. The cost of reprinting would be significant, and is paid by the customer.

Section 4(b) also changes the rules for coordination of benefit administration. These changes are also inconsistent with the NAIC guidelines, and the rules generally used in other states. We don't know the reasons for the inconsistencies, and would suggest testimony on this point by the Division of Insurance.

Section 21.88.110 (p. 5) establishes new rules for determination and disclosure of usual, customary and reasonable fees. Aetna's current practices are in compliance with the existing Division of Insurance requirements, and our explanatory materials must be approved by the division. As in section 4(b), the new rules are similar too, but different than the current rules. It is not clear that the additional information that must be published in all booklets, certificates, etc. is worth the cost to the customer of reprinting these materials. We are interested to hear the Division of Insurance's analysis of this trade-off.

March 30, 1994

TO: Senator Steve Rieger

FM: Rodman Wilson, MD

SUBJ: Suggested Changes to SB 367

Per my testimony today, please note the following suggested changes to Senate Bill 367.

Thank you.

Rodman Wilson, M.D.
800 M St #5W, Anchorage 99501
276-6142 Fax 276-6145

March 30, 1994

Suggested Changes to SB 367

p 5, line 20: After "a" add "written". Reason: It is important to have written opinion because the arbitrator's decision is admissible in court.
p 6, lines 15-16: Delete "professions or specialties to be represented by" and substitute "specialty of". Reason: The expert advisor will only have one specialty (as a rule). He or she certainly will not represent other specialties. The plural language is an inappropriate holdover from the 3-person panel.
p 7, lines 10,12,13: Why "must" for "shall"? "Must" and "shall" have essentially the same meaning.
P 8, lines 1-3: Delete the 2 sentences about staying discovery (and also delete p 23, lines 1-3, which should refer to (f) not (g)). Reason: Staying discovery has always been troublesome to parties to a malpractice action. It will make no difference to the expert advisor whether discovery proceeds or not. Unless there is some sacred legal reason or principle for staying discovery, the prohibition should be dropped.
p 8, line 6-7: After "entitled to" add "a stipend of $500 and". After "expenses" delete remainder of sentence. Reason: The expert advisor should be paid. The task is worth at least $500. With abandonment of the 3-person panel, it is not likely that physicians will be willing to do the tough task of the expert advisor essentially without pay. There are 30-40 malpractice actions annually. Paying the expert advisor would add $20,000 to the costs of the mandatory arbitration system.
p 16, lines 12-13: I oppose geographic price differentials. They are not that great and add significantly to administrative complexity.
p 17, line 3: "Health care service" should be given the same definition as previously on p 11, lines 17 foll; namely AS 21.50.400.
P 19, line 3: There is no provision for pay for committee members.

lines 4-7: What is the point about "inpatient" and "outpatient" employment? Most health care providers do both.

line 9: True actuaries (a highly skilled profession) are rare. Are there any in Alaska?

lines 23-24: Words about spouse and dependent children are superfluous; all residents are covered. Or does the language mean a spouse or children living Outside who are not residents?

lines 25-26: Use the words "preventive care including immunizations." Then whenever "preventive" is used again "and immunizations" does not need to be repeated, e.g., lines 30-31.

lines 28-30: Unless I misunderstand the language, a policy covering 100% of the first $3000 of medical expenses will be enormously expensive. Talk about "first dollar coverage"! It will be impossible, I think, to pay for such a plan with a premium of $100-150/mo (p 20). In New York state Mutual of Omaha is offering

coverage only ($250,000 annual/$1 million lifetime limits) to all comers but it costs $1620/yr.

p 20, line 4-5: Surcharge of 50% for each child may be too steep for large families. Isn't the usual family policy premium approximately 2½ times the individual rate, irrespective of the number of children?

line 11: rating lifesyles other than smoking is pretty difficult to do, e.g., eating excessive fats, teenage pregnancy, not using condoms, drinking, speeding, etc.

P 21, lines 9-10: (6) is obscure, at least to me. What does antitrust law have to do with pools?

lines 25-31: Medical Practice Advisory Committee is 4 members, an awkward number, especially on votes. Suggest adding a 5th person - a public member. Also there is no reason to distinguish between doctors of medicine (MDs) and doctors of osteopathy (DOs). They once were slightly different, but now are identical in training and practice, except for a few DOs who may still do spinal manipulation (a largely discredited technique). DOs are in the mainstream of medicine. There are only about 40 in the state. Suggest "two physicians licensed under AS 08.64."

p 22, lines 9-22: Duties of Medical Practice Advisory Committee:

(1) is obscure. Primary care providers know how to refer properly. Does (1) have financial conflict of interest in mind?

(2) a difficult task. It will take 10 years or longer to know, if indeed it is ever known, whether practice parameters reduce malpractice claims. Parameters have not been fully developed yet.

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(4) This is a task for a lawyer, not a medical advisory committee.

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Note: I find the rationale and duties of the Medical Practice Advisory Committee fuzzy. How about deleting it or letting the Health Care Plan Advisory Committee do some of redefined duties under its subcommittees (p 19, line 15)?

TELECOPY COVER SHEET
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FROM: Charles McKee --- PHONE: _____

INSTRUCTIONS: Document supporting testimony on SB 367 at Teleconference.

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P. 02
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Notes of Decisions

Evidence 2
Intent 1

1. Intent

Crime of forging signature of United States officer for purpose of authenticating any document includes element of fraudulent intent. Levinson v. U. S., C.C.A.Mich.1931, 47 F.2d 470.

2. Evidence

Where, upon a petition for a writ of habeas corpus, the transcript of the record of conviction which accompanied the petition showed that the petitioner was indicted for forging the signature of C. Douglass Gray, register in bankruptcy, to the following receipt: "Harrisonburg, July 30, 1872. Received of J. D. Martin, by R. S. Parks, his attorney, the application, with necessary papers, for adjudication in bankruptcy of said Martin; also, $30, amount of required deposit. C. Douglass Gray, Register" but the petitioner contended that the forging of this receipt was not a crime by any Act of Congress, as the paper whose forgery was charged was not a document which could be used in evidence in any proceeding by reason of its being authenticated by the official signature of the register, in dismissing the writ for the reason that the question could not be raised by means of the writ, but should have been taken by writ of error to some superior court, the court incidentally said that the receipt could be used in evidence, if genuine, for the purpose of showing the fact stated therein as against the signer in his official as well as private capacity. Ex parte Parks, Va.1876, 93 U.S. 18, 23 L.Ed. 787. See, also, In re Parks, D.C. Mich.1874, 18 Fed.Cas.No.10,760.

§ 506. Seals of departments or agencies

Whoever falsely makes, forges, counterfeits, mutilates, or alters the seal of any department or agency of the United States; or

Whoever knowingly uses, affixes, or impresses any such fraudulently made, forged, counterfeited, mutilated, or altered seal to or upon any certificate, instrument, commission, document, or paper, of any description; or

Whoever, with fraudulent intent, possesses any such seal, knowing the same to have been so falsely made, forged, counterfeited, mutilated, or altered—

Shall be fined not more than $5,000 or imprisoned not more than five years, or both.

June 25, 1948, c. 645, 62 Stat. 714.

Historical and Revision Notes

Revisor's Note. Based on Title 18, U. S.C., 1940 ed., § 131 (June 25, 1917, c. 30, Title X, § 2, 40 Stat. 228).

Reference to persons causing, procuring, aiding or assisting was omitted as unnecessary as such persons are made principals by section 2 of this title.

In view of definitions of department and agency in section 6 of this title, words "department or agency" in first paragraph were substituted for "executive department, or any bureau, commission, or office".

Provision for 10 years' imprisonment was reduced to 5 years to conform to punishment provision in section 505 of this title, covering an offense of like gravity.

Minor changes in phraseology were also made.

Canal Zone. Applicability of section to Canal Zone, see section 14 of this title.

3/29/94 Vicki Contratt

Cross References

Government seals wrongfully used and instruments wrongfully sealed, see section 1017 of this title.
Jurisdiction of offenses, see section 3241 of this title.
Letters, writings, etc., in violation of this section as nonmailable, see section 1717 of this title.

Library References

Costs ⇐2 et seq.
Forgery ⇐7(1) et seq.
C.J.S. Costs § 1.
C.J.S. Forgery § 17 et seq.

§ 507. Ship's papers

Whoever falsely makes, forges, counterfeits, or alters any instrument in imitation of or purporting to be, an abstract or official copy or certificate of the recording, registry, or enrollment of any vessel, in the office of any collector of the customs, or a license to any vessel for carrying on the coasting trade or fisheries of the United States, or a certificate of ownership, pass, or clearance, granted for any vessel, under the authority of the United States, or a permit, debenture, or other official document granted by any collector or other officer of the customs by virtue of his office; or

Whoever utters, publishes, or passes, or attempts to utter, publish, or pass, as true, any such false, forged, counterfeited, or falsely altered instrument, abstract, official copy, certificate, license, pass, clearance, permit, debenture, or other official document herein specified, knowing the same to be false, forged, counterfeited, or falsely altered, with an intent to defraud—

Shall be fined not more than $1,000 or imprisoned not more than three years, or both.

June 25, 1948, c. 645, 62 Stat. 714.

Historical and Revision Notes

Revisor's Note. Based on Title 18, U. S.C., 1940 ed., § 129 (Mar. 4, 1909, c. 321, § 72, 35 Stat. 1101).

The words "passport" and "sea letter" were omitted as obsolete, in view of the Presidential proclamation of April 10, 1918, discontinuing the use of such passports and sea letters.

Mandatory punishment provisions were rephrased in the alternative.

Minor changes of phraseology were made.

Canal Zone. Applicability of section to Canal Zone, see section 14 of this title.

Cross References

Certificate, license or document issued to vessels, officers or seamen, counterfeiting or forging, see section 2197 of this title.
Provisions relating to recording, registry or enrollment of vessels, see chapter 46, Shipping.

Library References

Costs ⇐2 et seq.
Forgery ⇐7(1) et seq.
C.J.S. Costs § 1.
C.J.S. Forgery § 17 et seq.

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TO: Senate HESS Cmte

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FROM: Anch LIO PHONE: _____

INSTRUCTIONS: Testimony on Bill from Dr. Rod Wilson. SB 367

SENT: Date 3/30 Time 1:40

DISPOSAL OF ORIGINAL: Discard _____ Hold for Pickup _____

NUMBER OF PAGES: 3 (counting cover sheet)

TRANSMITTED BY: Jan

Rodman Wilson, M.D.
800 M St #5W, Anchorage, AK 99501
276-6142 Fax 276-6145

March 30, 1994

Suggested Changes to SB 367

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lines 25-26: Use the words "preventive care including immunizations." Then whenever "preventive" is used again "and immunizations" does not need to be repeated, e.g., lines 30-31.
line 30: Language is not clear. It sounds as if the first $3000 is a covered expense, whereas the intent, I think, is $3000 deductible. Is this per individual or per family? Even so, $100/mo ($1200/yr) probably would not buy coverage. In New York state, Mutual of Omaha is offering $5000 deductible catastrophic

coverage only ($250,000 annual/$1 million lifetime limits) to all comers but it costs $1620/yr.

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8-LS1498\J.17 ✓
Ford
4/1/94

AMENDMENT

OFFERED IN THE SENATE BY SENATOR RIEGER

TO: SB 367

Page 19, lines 1 - 2:

Delete "Office of the Governor"

Insert "Department of Commerce and Economic Development"

Page 21, line 24:

Delete "Office of the Governor"

Insert "Department of Commerce and Economic Development"

AMENDMENT

OFFERED IN THE SENATE

TO: SB 367

Page 5, line 11, after "shall":

Insert "determine if the parties can agree on an arbitrator to review the claim. If the parties agree on an arbitrator, the court shall appoint that person to review the claim. If within 30 days after the filing of an answer to the complaint the parties have not agreed on an arbitrator, the court shall"

AMENDMENT

OFFERED IN THE SENATE

TO: SB 367

Page 6, lines 10 - 11:

Delete "[WHEN THE PARTIES HAVE NOT AGREED TO ARBITRATION OF THE CLAIM UNDER AS 09.55.535,]"

Insert "**after** [WHEN] the parties have **completed** [AGREED TO] arbitration of the claim under AS 09.55.535,"

Page 6, lines 12 - 13:

Delete "within 20 days after filing of answer to a summons and complaint **an expert medical advisor** [A THREE-PERSON EXPERT ADVISORY PANEL]"

Insert "**an expert medical advisor** within 20 days after **completion of arbitration** [FILING OF ANSWER TO A SUMMONS AND COMPLAINT A THREE-PERSON EXPERT ADVISORY PANEL]"

AMENDMENT

OFFERED IN THE SENATE

TO: SB 367

Page 8, line 21, through page 9, line 3:

Delete all material and insert:

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

(1) shall file with the director rates or rating factors for disability insurance at least 90 days before the intended effective date of the rate or rating factor; and

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

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

Page 11, after line 29:

Insert new bill sections to read:

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

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

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

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

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

before the intended effective date of the filing; and

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

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

Renumber the following bill sections accordingly.

Page 12, after line 5:

Insert a new bill section to read:

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

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

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

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

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

Renumber the following bill sections accordingly.

Page 18, line 22:

Delete "Sections 9, 10, and 11"

Insert "Sections 11, 13, and 14"

Page 22, after line 24:

Insert a new bill section to read:

"* **Sec. 22.** AS 21.86.070(e) and 21.86.070(f) are repealed."

Renumber the following bill sections accordingly.

Page 23, line 7:

Delete "Section 18"

Insert "Section 21"

Page 23, line 10:

Delete "Sections 16 and 17"

Insert "Sections 19 and 20"

8-LS1498\J.21
Ford
4/5/94

AMENDMENT

OFFERED IN THE SENATE

TO: SB 367

Page 19, after line 13:

Insert a new subsection to read:

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

Reletter the following subsections accordingly.

Page 20, line 20:

Delete "(d)(1) - (5)"

Insert "(e)(1) - (5)"

Page 21, after line 31:

Insert a new subsection o read:

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

Reletter the following subsections accordingly.

FISCAL NOTE

DRAFT

STATE OF ALASKA
1994 LEGISLATIVE SESSION

BILL NO. SB 367

Revision Date: 4/5/94
Title: An Act relating to health care and insurance for health care; review of insurance rates...
Sponsor: Senate HESS Committee
Requestor: Senate HESS Committee

Department: Commerce and Economic Dev.
BRU: Occupational Licensing
Component: Operations
COMPONENT SERIAL NO. 1844

Expenditures/Revenues (Thousands of Dollars)

OPERATING EXPENDITURES	FY 95	FY 96	FY 97	FY 98	FY 99	FY 00
PERSONAL SERVICES	142.2	142.2				
TRAVEL	243.3	112.0				
CONTRACTUAL	707.0	363.8				
SUPPLIES	3.0	3.0				
EQUIPMENT	24.0	0.0				
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	1,119.5	621.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES	1,740.5	0.0	0.0	0.0	0.0	0.0

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 G/F Match						
1004 General Fund						
1005 GF/Program Receipts						
1006 GF/MHTIA						
Other (Inter-Agency Receipts)	1,119.5	621.0				
TOTAL	1,119.5	621.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY 94) cost: $ None

POSITIONS

FULL-TIME	0.0	0.0	0.0	0.0	0.0	0.0
PART-TIME	0.0	0.0	0.0	0.0	0.0	0.0
TEMPORARY	0.0	0.0	0.0	0.0	0.0	0.0

ANALYSIS: (Attach a separate page if necessary)

SB 367 requires the formation of a Medical Practice Advisory Committee. The committee is responsible for making recommendations to the legislature for necessary health care reform legislation. In order to form the recommendations, the committee will hold meetings and hearings and receive recommendations from subcommittees representing health care providers. This fiscal note is based on the state licensing boards for health care occupations in the state forming 13 subcommittees plus three additional subcommittees for health care occupations that are licensed without a board. (Cont'd on attached page.)

Prepared by: JoAnne Cummings, Regulations Specialist
Phone: 465-2537
Division: Occupational Licensing
Date: 4/5/94
Approved by Commissioner: Paul Fuhs
Date:
Agency: Commerce and Economic Development

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CONTINUATION of FISCAL NOTE ANALYSIS FOR BILL/RESOLUTION NO. SB 367

The attached organizational chart shows the relationships of the committees and agencies involved.

The division estimates that the Medical Practice Advisory Committee (MPAC) and the 16 subcommittees will meet frequently during FY 95. An honorarium of $400 per day is included for MPAC and subcommittee members during the special meetings.

The meeting and travel expenses are based on the assumption that all meetings will be held in Anchorage and not all members will be required to travel. Travel costs are calculated for the subcommittees using the present composition of the licensing boards when applicable.

Costs for FY 96 are expected to decrease due to fewer anticipated meetings of the MPAC and subcommittees. Four meetings of the MPAC and three meetings of each subcommittee are anticipated in FY 96. The section of SB 367 that establishes the MPAC is repealed June 30, 1996; therefore, no costs are shown beyond FY 96.

Costs for FY 95 are determined as follows:

PERSONAL SERVICES **$142.2**

1 - Program Coordinator position, Range 20, PFT, located in Juneau ($65.8)

This position will work directly with the MPAC, the staff of the 16 subcommittees, the division, the office of the attorney general, and the legislature.

1 - Regulations Specialist I position, Range 13, PFT, located in Juneau ($42.7)

This position will be responsible for the technical requirements in drafting, publicizing, and finalizing the recommendations of the MPAC. This position will also be responsible for any related regulations changes required in the Alaska Administrative Code for health care occupations.

1 - Clerk III position, Range 8, PFT, located in Juneau ($33.7)

This position will provide clerical assistance for the two positions listed above and the staff of the 16 subcommittees.

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TRAVEL $243.3

It is anticipated that the MPAC will hold 10 meetings or hearings in FY95. It is anticipated that all meetings will be two-day meetings held in Anchorage and that two of the committee members will be required to travel. The travel costs are estimated at .7 per member per meeting. The cost may increase or decrease depending on the home city of the member.

MPAC travel to meetings
2 members @ .7 ea = $1.4 per meeting
10 meetings @ $1.4 = $14.0

It is also anticipated that each subcommittee will meet seven times in FY 95 and that each subcommittee meeting will be a two-day meeting held in Anchorage. Travel costs are based on members from various parts of the state traveling to Anchorage using the present composition of the licensing boards when applicable.

Subcommittee travel to meetings:

Acupuncture - three members, one member traveling
7 meetings @ .714 5.0

Audiology - three members, one member traveling
7 meetings @ .714 5.0

Chiropractic - five members, two members traveling
7 meetings @ 1.545 10.8

Dental - nine members, five members traveling
7 meetings @ 2.457 17.2

Medical - seven members, three members traveling
7 meetings @ 1.633 11.4

Naturopathy - three members, one member traveling
7 meetings @ .714 ea 5.0

Nursing - seven members, two members traveling
7 meetings @ 1.663 11.6

Nursing Home Admin. - three members, two traveling
7 meetings @ 1.077 7.5

Dispensing Opticians - five members, three members traveling
7 meetings @ 1.23 8.6

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Optometry - five members, three members traveling 7 meetings @ 1.404	9.8
Pharmacy - seven members, one member traveling 7 meetings @ .969	6.8
Physical/Occupational Therapy - seven members, three traveling 7 meetings @ 1.838	12.9
Psychology - five members, two members traveling 7 meetings @ 1.276	8.9
Clinical Social Workers - five members, two members traveling 7 meetings @ .636	4.5
Marital and Family Therapy - five members, one member traveling 7 meetings @ .562	3.9
Direct-Entry Midwives - five members, four members traveling 7 meetings @ .886	6.2
Total Subcommittee Travel	$ 135.1

Staff travel is estimated as follows:

One staff member to each subcommittee meeting - 112 meetings (16 subcommittees x 7 meetings) @ .714	80.0
Program Coordinator to each MPAC meeting 10 meetings @ .714	7.1
Regulations Specialist to each MPAC meeting 10 meetings @ .714	7.1
Total Staff Travel	$ 94.2

CONTRACTUAL $707.0

Honorariums for MPAC and subcommittee members are calculated at $.4 per day. All MPAC and subcommittee meetings are scheduled for two days.

Honorarium for MPAC
4 members @ .4 per day = 1.6 per meeting day

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10 meetings x 2 days = 20 meeting days
20 meeting days @ 1.6 = 32.0

Honorarium for subcommittee members
87 total members @ .4 per day = 34.8 per meeting day
7 subcommittee meetings x 2 days = 14 meeting days
14 meeting days @ 34.8 = 487.2

Public Notices

MPAC meetings
10 meetings @ 1.0 10.0

Subcommittee meetings
24 notices (two per month) @ 1.0 24.0

Postage, communications, printing 6.8

Office space 3.8

Facilities rental
MPAC meetings
20 meeting days @ .3 6.0

Subcommittee meetings
224 meeting days @ .3 67.2

Legal services
It is estimated that one additional assistant attorney general and secretary will be required to accomplish the purposes of SB 367. This fiscal note shows one-half of the costs of these legal services. The fiscal note provided by the division of insurance shows the other half of the costs of legal services. 70.0

SUPPLIES 3.0

The cost of supplies is calculated at 1.0 for each of the three new positions requested under personal services.

EQUIPMENT (one-time costs) 24.0

This is a one-time cost of equipment and office set-up for the three new positions requested

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under personal services. The costs are calculated at 8.0 for each position.

TOTAL:	**$ 1,119.5**

Fund Source: The division anticipates funding to be provided via RSA (inter-agency receipts) from the division of insurance. Unlike the general fund program receipts funding from licensing fees, the requirements in this bill do not relate to regulation of the profession. Therefore, it is not acceptable to increase licensing fees to fund activities under SB 367.

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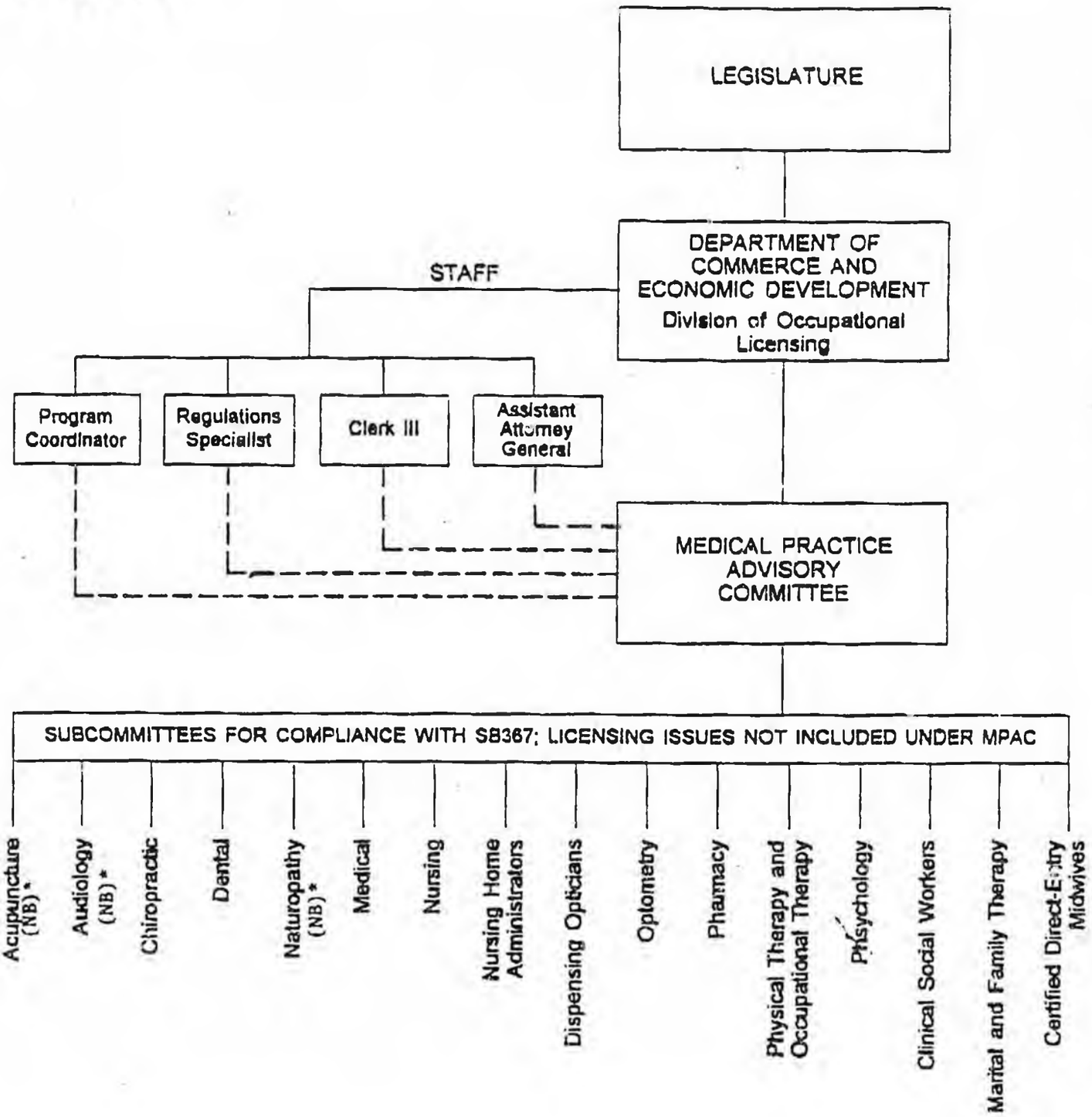
SB367 - ORGANIZATIONAL CHART



* NB = professions licensed by the department without a board

FISCAL NOTE

STATE OF ALASKA
1994 LEGISLATIVE SESSION

BILL NO. CSSB 367 (HES)

Revision Date: 4/5/94
Title: Health Care Reform Committee
Sponsor: Senate HESS Committee
Requestor:

Department Affected: Commerce and Economic Development
BRU: Insurance
Component: Operations
COMPONENT SERIAL NO. 0354

Expenditures/Revenues:

OPERATING EXPENDITURES	FY 95	FY 96	FY 97	FY 98	FY 99	FY 00
PERSONAL SERVICES	585.8	1,353.2	1,143.8	1,143.8		
TRAVEL	225.0	141.8	3.6	3.6		
CONTRACTUAL	384.8	521.2	343.8	343.8		
SUPPLIES	11.0	27.0	23.0	23.0		
EQUIPMENT	133.1	204.6	23.0	23.0		
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	1,339.7	2,247.8	1,537.2	1,537.2		
CAPITAL EXPENDITURES	500.0	500.0	500.0	500.0		
CHANGE IN REVENUES ( )						

FUND SOURCE

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts	1,839.7	2,747.8	2,037.2	2,037.2		
1006 GF/MHTIA						
Other						
TOTAL	1,839.7	2,747.8	2,037.2	2,037.2		

Estimate of current year (FY 94) cost: $

POSITIONS

FULL-TIME	11.0	27.0	23.0	23.0		
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary.)

Please see attached.

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Prepared by: David J. Walsh, Director
Division: Insurance
Phone: 465-2515
Date: 4/5/94

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

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						FY 95	FY 96	FY 97	FY 98
SB 367 Fiscal Note for the Dept of Commerce and Economic Development									
Division of Insurance									
Data Collection/Analysis and Claims:									
1	Chief R-22 @ $74.5					74.5	74.5	74.5	74.5
1	Analyst/Programmer IV R-19 @$61.9					61.9	61.9	61.9	61.9
1	Analyst/Programmer III R-17 @$54.5					54.5	54.5	54.5	54.5
1	Secretary R-10 @$36.9					36.9	36.9	36.9	36.9
1	Economist II R-20 @ $65.8						65.8	65.8	65.8
4	Statistical Tech I R-12 @ $41.0						164.0	164.0	164.0
3	Statistical Tech II R-14 @ $45.2						135.6	135.6	135.6
2	Statistical Clerk R-10 @ $36.9						73.8	73.8	73.8
3	Research Analyst II R-16 @ $51.2						153.6	153.6	153.6
3	Research Analyst III R-18 @ $58.2						174.6	174.6	174.6
20					Total:	227.8	995.2	995.2	995.2
	Contractual- $10.6 per position					42.4	212.0	212.0	212.0
	Office space per position-								
	12 mths/$1.80/sq ft/175 sq ft = $3.8								
	Miscellaneous contractual- $6.8								
	Supplies: $1.0/position					4.0	20.0	20.0	20.0
	Equipment: 12.1/position 1st yr, 1.0/pos. after					48.4	197.6	20.0	20.0
	Capital Expenditure:								
	Contractual Claims Handling/Data Collection costs:					500.0	500.0	500.0	500.0
Rate Approval									
1	Insurance Analyst III R-18@$58.2					58.2	58.2	58.2	58.2
2	Consumer Complaint Specialists R-14 @$45.2					90.4	90.4	90.4	90.4
3	Total:					148.6	148.6	148.6	148.6
	Travel: Instate					3.6	3.6	3.6	3.6
	Contractual: 3 position X $10.6					31.8	31.8	31.8	31.8
	Office space per position-								
	12 mths/$1.80/sq ft/175 sq ft = $3.8								
	Miscellaneous contractual- $6.8								
	Supplies: $1.0/position					3.0	3.0	3.0	3.0
	Equipment: $12.1/position 1st yr, $1.0 after					36.3	3.0	3.0	3.0

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		FY 95	FY 96	FY 97	FY 98
Federal Waivers					
	Contract w/Dept. of Law for representation in Washington D.C.	100.0	100.0	100.0	100.0
	NOTE: These figures are estimates. The actual number could be significantly higher.				
Advisory Committee:					
	Committee member honorarium for meetings:	134.4	86.4	0.0	0.0
	Assume: 2 meetings per month, 2 days each				
	First 18 months all people attend meetings, last 6 months only 2 people attend meetings.				
	$400 per day per member				
	Travel costs for attending meetings:				
	Assume: 4/7 of members have to travel to meetings, average cost for a two day meeting is $700	67.2	43.2	0.0	0.0
	Public notice of meetings at $1000 each	24.0	24.0	0.0	0.0
	Facilities rental for meetings at $300 per day	14.4	14.4	0.0	0.0
	Consulting Actuary to price benefit packages: 100 hours at $200 per hour split between 1994 and 1995	10.0	10.0	0.0	0.0
Advisory Committee: Staff					
1	Secretary R-10	36.9	36.9	0.0	0.0
1	Administrative Asst III R-16	51.2	51.2	0.0	0.0
1	Publication Specialist II R-16	51.2	51.2	0.0	0.0
1	Health & Soc Ser Planner III R-21	70.1	70.1	0.0	0.0
4	Total:	209.4	209.4	0.0	0.0
	Travel: Instate	3.0	3.0	0.0	0.0
	Contractual: 4 position X $10.6	42.4	42.4	0.0	0.0
	Office space per position- 12 mths/$1.80/sq ft/175 sq ft = $3.8				
	Miscellaneous contractual- $6.8				
	Supplies: $1.0/position	4.0	4.0	0.0	0.0
	Equipment: $12.1/position 1st yr, $1.0 after	48.4	4.0	0.0	0.0

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		FY 95	FY 96	FY 97	FY 98
	Contract with Department of Law for legal	70.0	70.0	0.0	0.0
	services 1/2 of (1 AAG and a secretary). The				
	other 1/2 is in the fiscal note for the Division of				
	Occ. Licensing for the medical practice				
	committee.				
Hearings on benefit packages, etc:					
	Assume 4 days of hearings fall 1994, 2 days in				
	spring 1995, and 2 days in fall 1995, with full LIO				
	set-up at $7000 per day				
	Committee member honorarium @$400 per	16.8	5.6	0.0	0.0
	member per day				
	Facilities rental @300 per day	1.8	0.6	0.0	0.0
	Public notice @1000 per day	6.0	2.0	0.0	0.0
	LIO setup @$7000 per day	42.0	14.0	0.0	0.0
	Total Costs:	1,839.7	2,747.8	2,037.2	2,037.2

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NFIB Alaska

National Federation of
Independent Business

Post-it™ brand fax transmittal memo 7671	# of pages ▸ 4
To Bettye Hargrave	From Rosa Jemel
Co. Senator Pfeiffer	Co. NFIB/AK
Dept.	Phone # 789-4278
Fax # 465-2069	Fax # 789-3433

POSITION PAPER

OF

NATIONAL FEDERATION OF INDEPENDENT BUSINESS
(NFIB/ALASKA)

SB 367 HEALTH CARE REFORM COMMITTEES AND

RAISING THE TAXES ON CIGARETTES.

9159 Skywood Lane
Juneau, AK 99801

The Guardian of
Small Business

CHAIRMAN, MEMBERS OF THE COMMITTEE, MY NAME IS RESA JERREL, AND I AM THE STATE DIRECTOR FOR NATIONAL FEDERATION OF INDEPENDENT BUSINESS - NFIB/ALASKA. I APPRECIATED THE OPPORTUNITY TO SHARE OUR VIEWS WITH YOU ON SB 367.

NFIB/ALASKA IS COMPRISED OF 4,400 SMALL AND INDEPENDENT BUSINESS OWNERS. THE LEGISLATIVE AGENDA OF NFIB/ALASKA IS DETERMINED BY OUR BALLOT. THE BALLOT IS OUR ANNUAL POLL OF OUR MEMBERS ON A SERIES OF ISSUES DEEMED CRITICAL TO SMALL BUSINESS. A MAJORITY VOTE, OF THE MEMBERS IN RESPONSE TO THE POLL, SETS OUR POLICY AND POSITION ON LEGISLATIVE ISSUES. WE THEN SHARE THE RESULTS OF OUR POLL WITH THE LEGISLATURE AND ADMINISTRATION. THERE IS NOT ENOUGH SPACE ON THE ANNUAL POLL TO PLACE EVERY POSSIBLE ISSUE BEFORE OUR MEMBERS. THEREFORE, WE ALSO USE THE PREVIOUS YEARS BALLOT RESULTS AS GUIDANCE ON ISSUES. OVER THE PAST FEW YEARS WE HAVE ASKED OUR MEMBERS NUMEROUS QUESTIONS ABOUT HEALTH INSURANCE.

> 72 PERCENT SUPPORT CREATING A VOLUNTARY HEALTH INSURANCE PLAN WHICH WOULD BE ADMINISTERED BY PRIVATE INSURANCE COMPANIES AND WOULD POOL SMALL BUSINESSES TOGETHER SO THEY COULD PURCHASE EMPLOYEE HEALTH INSURANCE AT GROUP RATES.
>
> 87 PERCENT OPPOSE REQUIRING EMPLOYERS TO PROVIDE BASIC HEALTH CARE INSURANCE COVERAGE FOR THEIR EMPLOYEES.
>
> 76 PERCENT SUPPORT REQUIRING DOCTORS AND HOSPITALS TO POST THEIR FEES FOR THE SERVICES AND PROCEDURES THEY PROVIDE.
>
> 79 PERCENT SUPPORT CHANGING MEDICAL MALPRACTICE LAWS SO DOCTORS WILL NOT FEEL COMPELLED TO PERFORM VARIOUS MEDICAL SERVICES SIMPLY TO AVOID POTENTIAL LAWSUITS.

I HAVE A CONCERN WITH THE LANGUAGE "MANDATORY HEALTH CARE PLAN" ON PAGE 18, LINE 27, "MANDATORY COVERAGE" ON PAGE 18, LINE 29 AND "PARTICIPATION IS MANDATORY BY ALL STATE RESIDENTS" ON PAGE 19, LINE 23.

OUR MEMBERS BELIEVE IN THE FREEDOM OF CHOICE IN HEALTH INSURANCE. THIS MEANS, BEING ABLE TO BUY A HEALTH INSURANCE POLICY

TAILORED TO THE INDIVIDUAL, FAMILY AND/OR EMPLOYEE NEEDS. WE WOULD SUGGEST THE WORD "MANDATORY" BE DELETED. INSTEAD, DIRECT THE ADVISORY COMMITTEE TO PRESENT A RANGE OF OPTIONAL COVERAGE. WITH THE ABILITY TO PICK AND CHOOSE A PERSON COULD PURCHASE A POLICY THAT BEST MEETS THEIR PERSONAL CIRCUMSTANCES AND FINANCES.

WE ARE OPPOSED TO THE LANGUAGE ON PAGE 17, LINES 14 - 16 WHICH PROPOSES RAISING THE CIGARETTE TAX. THE 1993 SURVEY OF NFIB/ALASKA MEMBERS FOUND OVERWHELMING SUPPORT - 92 PERCENT - TO REDUCE STATE GOVERNMENT SPENDING BEFORE INCREASING TAXES.

I AM HAPPY TO SEE THAT THE HEALTH CARE PLAN ADVISORY COMMITTEE IS TO REPORT TO THE LEGISLATURE BY DECEMBER 15, 1994 ON THE SCOPE OF COVERAGE AND THE COST. A COUPLE OF YEARS AGO WE ASKED OUR MEMBERS IN ALAGKA TO RANK ELEVEN PROBLEM AREAS - THE MOST COSTLY OR BURDENSOME PROBLEM THEY FACED AND, THE TOP TWO WERE: #1 WORKERS COMPENSATION COST AND, #2 HEALTH INSURANCE FOR EMPLOYEES. WHEN ASKED WHY THEY DID NOT PROVIDE HEALTH INSURANCE FOR THEIR EMPLOYEES, RANKING NUMBER ONE WAS: PREMIUMS ARE TOO HIGH OR THE FIRM CANNOT AFFORD TO PAY FOR BENEFITS.

COST OF ANY HEALTH INSURANCE PLAN IS OF GREAT CONCERN TO OUR MEMBERS. ONCE THE COST IS DETERMINED WE ALL CAN MAKE AN INFORMED DECISION ON THIS VERY IMPORTANT ISSUE.

I DO NOTE A POTENTIAL COST SAVING IN THE BILL - UNIFORM CLAIMS FORMS. PAPERWORK CONNECTED WITH HEALTH INSURANCE IS CHOKING OUR DOCTORS AND HOSPITALS NOT TO MENTION SMALL EMPLOYERS AND INDIVIDUALS. SMALL FIRMS ARE PARTICULARLY HARD HIT BY THESE COSTS: 30-40 PERCENT OF THEIR PREMIUMS GO TO ADMINISTRATIVE CHARGES. SMALL FIRMS, TOO, LACK EMPLOYEE BENEFITS DEPARTMENTS TO HANDLE THE PAPERWORK. REDUCING PAPERWORK THROUGH UNIFORM CLAIMS AND SOME

DAY ELECTRONIC FILING WILL MARKEDLY CUT THE COST OF ADMINISTERING INSURANCE.

THANK YOU FOR THE OPPORTUNITY TO COMMENT ON THIS IMPORTANT LEGISLATION. NFIB/ALASKA HAS AND WILL CONTINUE TO SUPPORT LEGISLATION THAT WILL HELP MAKE VOLUNTARY, PRIVATELY ADMINISTERED HEALTH INSURANCE MORE ACCESSIBLE, RENEWABLE, PREDICTABLE AND STABLE FOR SMALL BUSINESS OWNERS.

WALTER J. HICKEL, GOVERNOR

DEPARTMENT OF COMMERCE AND
ECONOMIC DEVELOPMENT

DIVISION OF INSURANCE

P.O. BOX 110805
JUNEAU, ALASKA 99811-0805
PHONE (907) 465-2515

RECEIVED APR 0 5

April 5, 1994

Senator Steve Rieger
State Capitol, Room 516
Juneau, AK 99801

RE: SB 367-Coordination of Benefits Section 21.89.100 and Usual, Customary and Reasonable Fees Section 21.89.110

Dear Senator Rieger:

Outlined below is the requested information on coordination of benefits and usual, customary and reasonable fees as they relate to current Alaska insurance code.

1. Section 21.89.100 REQUIRED PROVISIONS REGARDING COORDINATION OF BENEFITS.

Currently, there is no statute or regulation in Alaska relating to coordination of benefits. However, in 1980 and 1985, bulletins were issued that urged insurers follow the NAIC's Model Group Coordination of Benefits(COB) Model Regulation, in order to give insurers some guidance.

The Division of Insurance currently reviews policy forms for inclusion of these NAIC COB provisions, if the policy forms do contain the provision or contain a provision which differs from the NAIC model, the insurer is requested to modify their policy forms (and practice).

A copy of the NAIC model regulation on COB is attached. This model is a more uniform standard for the industry and is quite different from the proposed COB language. As you can see it applies only to group contracts.

2. Section 21.89.110 DETERMINATION AND DISCLOSURE OF USUAL, CUSTOMARY, AND REASONABLE FEES(UCR fees).

Alaska insurance code addresses this issue with regulation 3 AAC 26.110 and the definitions in 3 AAC 26.300. 3 AAC 26.110 is very similar to proposed language in SB 367. The differences are as follows:

SB 367 does not contain a definition of UCR fees, whereas the regulation does. However, it may be acceptable even though it does not exactly meet this definition, if the language used to define the UCR fees in the policy is clear and reasonable.

3 AAC 26.110 requires that a complete explanation of the basis of payments, including the reason for any difference between the provider's charge and the allowable benefit, be disclosed to the insured. Also, AS 21.54.010 requires the essential features of the insurance coverage be disclosed to the insured.

Neither of these require this disclosure to be made in the policy form, certificate, employee benefit description, etc as SB 367 does. However, the Division has requested inclusion by the insurers in their policy forms of the percentile of UCR that will be reimbursed on a claim.

Please feel free to contact me with any questions on this.

Sincerely yours,

David J. Walsh
Director
Division of Insurance

Bulletin 80-8

COORDINATION OF BENEFITS

December 1, 1980

Recently, the Division of Insurance has been receiving an increasing number of inquiries concerning coordination of benefits from both consumers and industry. Most inquiries have involved problems surrounding the order of benefit determination.

This Bulletin is for the purpose of reiterating the division's intent of urging all writers of health insurance to follow the guidelines for coordination of benefits as set forth in the NAIC Model COB provisions. Recently, the Health Insurance Association of America recommended an amendment to Section (4), Rule (b) of the NAIC model. The proposed amendment addresses the order of benefit determination in the case of divorce or separation. Among the inquiries received were problems concerning the order of benefit determination in the circumstances treated in the proposed amendment offered by HIAA. The division recommends that all writers of disability insurance follow the guidelines as set forth in the HIAA amendment. The following is Section (4) of the NAIC Model with the HIAA proposed amendment to Rule (b) underlined.[1]

(4) For the purposes of item (3) of this Section C, the rules establishing the order of benefit determination are:

(a) The benefits of a Plan which covers the person on whose expenses claim is based other than as a dependent shall be determined before the benefits of a Plan which covers such person as a dependent;

(b) the benefits of a Plan which covers the person on whose expenses claim is based as a dependent of a male person shall be determined before the benefits of a Plan which covers such person as a dependent of a female person; *except that in the case of a person for whom claim is made as a dependent child,*

(i) when the parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a Plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a Plan which covers the child as a dependent of the parent without custody;

(ii) when the parents are divorced and the parent with the custody of the child has remarried, the benefits of a Plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a Plan which covers that child as a dependent of the stepparent, and the benefits of a Plan which covers that child as a dependent of the stepparent will be determined before the benefits of a Plan which covers that child as dependent of the parent without custody.

Notwithstanding (i) and (ii) above, if there is a court decree which would otherwise establish financial responsibility for the medical, dental or other health care expenses with respect to the child, the benefits of a Plan which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other Plan which covers the child as a dependent child.

(c) When rules (a) and (b) do not establish an order of benefit determination, the benefits of a Plan which has covered the person on whose expenses claim is based for the longer period of time shall be determined before the benefits of a Plan which has covered such person the shorter period of time.

Kenneth C. Moore
DIRECTOR OF INSURANCE

[1] Italicized herein.

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Bulletin 85-3

COORDINATION OF HEALTH INSURANCE BENEFITS

May 16, 1985

This bulletin is for the purpose of expressing the division's intent that all writers of health insurance adhere to the guidelines for coordination of benefits set forth in the National Association of Insurance Commissioners' Model Group Coordination of Benefits Provisions (COB). This same message was contained in Bulletin 80-8 which was issued December 1, 1980. Since that date, the National Association of Insurance Commissioners (NAIC) has adopted a number of amendments to the COB. Very important and noteworthy changes were adopted in June 1984 at the NAIC Summer Annual Meeting. It is this group of amendments to which the division urges you to adhere.

In substance, the June 1984 changes include:

1. a change from the "gender" based rule to a "birth date" rule for determining the order of benefit payment;

2. changes in the operative section of COB that provide for a plan to use one of two alternative provisions for the reduction of benefits paid below 100% of covered expenses to preserve the intended effect of copayments;

3. changes to avoid "stand-off" situations when two plans contain inconsistent provisions that could leave both plans in either a primary or secondary position; and

4. provisions that establish "right of entry" into a group plan under group health insurance contracts that reduce benefits below 100% of covered expenses.

The division urges the adoption of June 1984 amended version of the NAIC Model COB to avoid any undue delay in claim payments, to alleviate the possibility of potential sexual discrimination allegations, and to participate in cost containment. Additionally, the division supports the NAIC Model COB's deferred effective date of July 1, 1985 to accommodate an orderly and universal implementation.

John George
DIRECTOR OF INSURANCE

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3 AAC 26.100 Additional standards for prompt, fair, and equitable settlements of workers' compensation claims

Any person transacting a business of insurance who participates in the investigation, adjustment, negotiation, or settlement of a worker's compensation claim:

(1) may not require a claimant to travel unreasonably for medical care, rehabilitation services, or any other purpose;

(2) shall provide necessary claim forms, written instructions, and assistance that is reasonable so that any claimant not represented by an attorney is able to comply with the law and reasonable claims handling requirements;

(3) shall promptly make all payments or denials of payment as required by statute or regulation.

History. – Eff. 5/6/89, Register 110.

Authority. – AS 21.06.090, AS 21.36.125, AS 21.36.350.

3 AAC 26.110 Additional standards for prompt, fair, and equitable settlements of disability claims

(a) If a disability insurance policy or a subscriber contract provides for payment of a claim on the basis of services provided by a medical care provider using a usual, customary and reasonable, or prevailing charge basis, a person transacting a business of insurance who participates in the investigation, adjustment, negotiation, or settlement of a claim must:

(1) maintain or use a statistically credible profile of medical care providers' charges on which to base payment of claims, which is updated at least every six months and contains charges for services performed not more than one year before the date of the most recent profile; the profile must contain charges for each geographical area in which a claimant might receive treatment; if the profile does not contain a statistically credible data base for a particular medical care service in a certain geographic area, the insurer may include in the profile a sufficient number of charges for that service from another geographic area so that a reliable basis is established; however, the final basis for payment shall be adjusted to reflect the general cost

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differences between the geographical area where the service was performed and the other geographical areas used in establishing the statistically credible profile; the adjustment may be based on the Consumer Price Index, the medical care component of the Consumer Price Index, or another reasonable basis stated in writing; the written explanation provided to a claimant must include a complete explanation of these adjustments;

(2) provide to the claimant, in writing, a complete explanation of the basis of payments and document the explanation in the claim file; if the basis for payment is less than the actual charge made by the medical care provider, the explanation to the claimant must state with specificity the reason for the amount not paid.

(b) This section does not apply to workers' compensation claims.

History. – Eff. 6/6/89, Register 110.

Authority. – AS 21.06.090, AS 21.36.125, AS 21.36.350.

3 AAC 26.300 Definitions

In this chapter,

(1) "claim" means notice that an event, act or omission has occurred which may result in injury or damage for which an insured may be legally obligated to pay;

(2) "claimant" means a first-party claimant, a third-party claimant, or both, and includes the claimant's legal representative and includes a member of the claimant's immediate family if authorized by the claimant;

(3) "Consumer Price Index" means the data published annually in the Detailed Report by the United States Department of Labor, Bureau of Labor Statistics;

(4) "destination or delivery charges" means the charges for shipping a motor vehicle to a primary residence of the claimant or to where the motor vehicle is primarily operated;

(5) "first-party claimant" means a person asserting a right to payment under his or her own coverage;

(6) "frequency as to indicate a general business practice" means violation of any one standard committed on one or more percent of

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claims handled within a 12-month period, or the repeated violation of a single standard without reasonable explanation;

(7) "local market area" means the geographical area, in the closest proximity to the claimant's residence, in which two or more qualified dealers are located;

(8) "outside attorney" means an attorney who is in private practice and not an employee of a person transacting a business of insurance under AS 21;

(9) "person" means an individual, corporation, association, partnership, or other legal entity;

(10) "third-party claimant" means any person asserting a claim against any other person;

(11) "usual, customary, and reasonable, or prevailing charge basis" means that payment basis for a disability insurance claim where the reasonable and prevailing charge for a medical care procedure, service, or supply item is determined by the lowest of the following amounts:

(A) the billed amount of the medical care provider's actual charges;

(B) the charge usually made by that provider for performing that procedure; or

(C) the customary charge based on a profile of charges made for the same medical procedure, service, or supply item in the same geographical area by other providers that have performed the same procedure or service or have provided the same supply item;

(12) "working days" means all calendar days except Saturdays, Sundays, all official federal holidays, and all official Alaska holidays.

History. – Eff. 5/6/89, Register 110.

Authority. – AS 21.06.090, AS 21.36.125, AS 21.36.350.

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Chapter 54

GROUP AND BLANKET DISABILITY INSURANCE

§ 21.54.010 Required provisions

Each group disability insurance policy must contain in substance the following provisions:

(1) a provision that, in the absence of fraud, all statements made by applicants or the policyholder or by an insured person shall be considered representations and not warranties, and that a statement made for the purpose of effecting insurance may not void the insurance or reduce benefits unless contained in a written instrument signed by the policyholder or the insured person, a copy of which has been furnished to the policyholder or to the person or the beneficiary of the insured person;

(2) a provision that the insurer will furnish to the policyholder for delivery to each employee or member of the insured group, a statement in summary form of the essential features of the insurance coverage of the employee or member and to whom benefits are payable; if dependents are included in the coverage, only one certificate need be issued for each family unit;

(3) a provision that to the group originally insured may be added from time to time eligible new employees or members or dependents, as the case may be, in accordance with the terms of the policy.

History.—§ 1, ch. 120, SLA 1966.

§ 21.54.020 Direct payment to health care provider

(a) An insurer may, and upon written request of the covered person shall, within 30 working days after receiving a proof of loss statement, pay indemnities under a group disability policy directly to the provider of the hospital, nursing, medical, dental, or surgical services. The policy

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GROUP COORDINATION OF BENEFITS MODEL REGULATION

Table of Contents

Section 1. Authority

This regulation is adopted and promulgated by [title of supervisory authority] pursuant to Section ... of the Insurance Code. It replaces the regulation of similar purpose which took effect on _____.

Section 2. Purpose and Applicability

The purpose of this regulation is to:

A. Permit, but not require, plans to include a coordination of benefits (COB) provision;

B. Establish an order in which plans pay their claims;

C. Provide the authority for the orderly transfer of information needed to pay claims promptly;

D. Reduce duplication of benefits by permitting a reduction of the benefits paid by a plan when the plan, pursuant to rules established by this regulation, does not have to pay its benefits first;

E. Reduce claims payment delays; and

F. Make all contracts that contain a COB provision consistent with this regulation.

Section 3. Definitions

The following words and terms, when used in this regulation, shall have the following meanings unless the context clearly indicates otherwise:

A. Allowable Expenses

(1) "Allowable Expense" means the necessary, reasonable and customary item of expense for health care when the item of expense is covered at least in part under any of the plans involved, except where a statute requires a different definition.

(2) Notwithstanding the above definition, items of expense under coverages such as dental care, vision care, prescription drug or hearing aid programs may be excluded from the definition of Allowable Expense. A plan which provides benefits only for any such items of expense may limit its definition of Allowable Expenses to like items of expense.

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(3) When a plan provides benefits in the form of service, the reasonable cash value of each service will be considered as both an Allowable Expense and a benefit paid.

(4) The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an Allowable Expense under the above definition unless the patient's stay in a private hospital room is medically necessary in terms of generally accepted medical practice.

(5) When COB is restricted in its use to specific coverage in a contract (for example, major medical or dental), the definition of "Allowable Expense" must include the corresponding expenses or services to which COB applies.

(6) When benefits are reduced under a Primary Plan because a covered person does not comply with the plan provisions, the amount of such reduction will not be considered an Allowable Expense. Examples of such provisions are those related to second surgical opinions, precertification of admissions or services, and preferred provider arrangements.

(a) Only benefit reductions based upon provisions similar in purpose to those described above and which are contained in the Primary Plan may be excluded from Allowable Expenses.

(b) This provision shall not be used by a Secondary Plan to refuse to pay benefits because an HMO member has elected to have health care services provided by a non-HMO provider and the HMO, pursuant to its contract, is not obligated to pay for providing those services.

NOTE: This Paragraph (6) is not intended to allow a Secondary Plan to exclude expenses that are applied towards the satisfaction of the deductible, copayments or coinsurance amounts required by the Primary Plan, except for the benefit reductions expressly described in this paragraph.

B. Claim

A request that benefits of a plan be provided or paid is a claim. The benefits claimed may be in the form of:

(1) Services (including supplies);

(2) Payment for all or a portion of the expenses incurred;

(3) A combination of (1) and (2) above; or

(4) An indemnification.

C. Claim Determination Period

This is the period of time, which must not be less than twelve consecutive months, over which Allowable Expenses are compared with total benefits payable in the absence of COB, to determine whether overinsurance exists and how much each plan will pay or provide.

(1) The Claim Determination Period is usually a calendar year, but a plan may use some other period of time that fits the coverage of the group contract. A person may be covered by a plan during a portion of a Claim Determination Period if that person's coverage starts or ends during the Claim Determination Period.

(2) As each claim is submitted, each plan is to determine its liability and pay or provide benefits based upon Allowable Expenses incurred to that point in the Claim Determination Period. That determination is subject to adjustment as later Allowable Expenses are incurred in the same Claim Determination Period.

D. Coordination of Benefits

This is a provision establishing an order in which plans pay their claims.

E. Hospital Indemnity Benefits

These are benefits not related to expenses incurred. The term does not include reimbursement-type benefits even if they are designed or administered to give the insured the right to elect indemnity-type benefits at the time of claim.

F. Plan

Plan means a form of coverage with which coordination is allowed. The definition of Plan in the group contract must state the types of coverage which will be considered in applying the COB provision of that contract. The right to include a type of coverage is limited by the rest of this definition.

(1) The definition shown in the Model COB Provision, attached to this rule as Appendix A, is an example of what may be used. Any definition that satisfies this subsection may be used.

(2) This subchapter uses the term "plan." However, a group contract may, instead, use "program" or some other term.

(3) Plan may include:

(a) Group insurance and group subscriber contracts;

(b) Uninsured arrangements of group or group-type coverage;

(c) Group or group-type coverage through HMOs and other prepayment, group practice and individual practice plans;

(d) Group-type contracts. Group-type contracts are contracts which are not available to the general public and can be obtained and maintained only because of membership in or connection with a particular organization or group. Group-type contracts answering this description may be included in the definition of plan, at the option of the insurer or the service provider and the contract client, whether or not uninsured arrangements or individual contract forms are used and regardless of how the group-type coverage is designated (for example, "franchise" or "blanket"). Individually underwritten and issued guaranteed renewable policies would not be considered "group-type" even though purchased through payroll deduction at a premium savings to the insured since the insured would have the right to maintain or renew the policy independently of continued employment with the employer.

Note: The purpose and intent of this provision is to identify certain plans of coverage which may utilize the [illegible] group contract but are administered on a basis more characteristic of group insurance. These "group-type contracts" are distinguished by two factors: (1) they are not available to the general public, but may be obtained only through membership in, or connection with, the particular organization or group through which they are marketed (for example, through an employer payroll withholding system), and (2) they can be obtained only through such affiliation (for example, the contracts might provide that they cannot be renewed if the insured leaves the particular employment or

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organization in which case they would meet the "group-type" definition). On the other hand, if such contracts are guaranteed renewable, thereby allowing the insured the right to renewal regardless of continued employment or affiliation with the organization, they would not be considered "group-type".

(e) The amount by which group or group-type hospital indemnity benefits exceed $100 per day;

(f) The medical benefits coverage in group, group-type and individual automobile "no fault" and traditional automobile "fault" type contracts; and

(g) Medicare or other governmental benefits, except as provided in (4)(g) below. That part of the definition of plan may be limited to the hospital, medical and surgical benefits of the governmental program.

(4) Plan shall not include:

(a) Individual or family insurance contracts;

(b) Individual or family subscriber contracts;

(c) Individual or family coverage through Health Maintenance Organizations (HMOs);

(d) Individual or family coverage under other prepayment, group practice and individual practice plans;

(e) Group or group-type hospital indemnity benefits of $100 per day or less;

(f) School accident-type coverages. These contracts cover grammar, high school and college students for accidents only, including athletic injuries, either on a twenty-four-hour basis or on a "to and from school" basis; and

(g) A State plan under Medicaid, and shall not include a law or plan when, by law, its benefits are in excess of those of any private insurance plan or other non-governmental plan.

G. Primary Plan

A Primary Plan is a plan whose benefits for a person's health care coverage must be determined without taking the existence of any other plan into consideration. A plan is a Primary Plan if either of the following conditions is true:

(1) The plan either has no order of benefit determination rules, or it has rules which differ from those permitted by this subchapter. There may be more than one Primary Plan; or

(2) All plans which cover the person use the order of benefit determination rules required by this regulation, and under those rules the plan determines its benefits first.

H. Secondary Plan

A Secondary Plan is a plan which is not a Primary Plan. If a person is covered by more than one Secondary Plan, the order of benefit determination rules of this regulation decide the order in which their benefits are determined in relation to each other. The benefits of each Secondary Plan may take into consideration the benefits of the Primary Plan or plans and the benefits of any other plan which, under the rules of this regulation, has its benefits determined before those of that Secondary Plan.

L. This Plan

In a COB provision, this term refers to the part of the group contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the group contract providing health care benefits is separate from This Plan. A group contract may apply one COB provision to certain of its benefits (such as dental benefits), coordinating only with like benefits, and may apply other separate COB provisions to coordinate other benefits.

Section 4. Model COB Contract Provision

A. General

Appendix A contains a model COB provision for use in group contracts. That use is subject to the provisions of B and C below and to the provisions of Section 5.

B. Flexibility

A group contract's COB provision does not have to use the words and format shown at Appendix A. Changes may be made to fit the language and style of the rest of the group contract or to reflect the difference among plans which provide services, which pay benefits for expenses incurred, and which indemnify. No other substantive changes are allowed.

C. Prohibited Coordination and Benefit Design

(1) A group contract may not reduce benefits on the basis that:

(a) Another plan exists;

(b) A person is or could have been covered under another plan, except with respect to Part B of Medicare; or

(c) A person has elected an option under another plan providing a lower level of benefits than another option which could have been elected.

(2) No contract may contain a provision that its benefits are "excess" or "always secondary" to any plan as defined in this regulation, except in accord with the rules permitted by this regulation.

Section 5. Rules for Coordination of Benefits

Order of Benefits

A. General

The general order of benefits is as follows:

(1) The Primary Plan must pay or provide its benefits as if the Secondary Plan or Plans did not exist. A Plan that does not include a coordination of benefits provision may not take the benefits of another Plan as defined in Section 3 into account when it determines its benefits. There is one exception: a contract holder's coverage that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder

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(2) A Secondary Plan may take the benefits of another plan into account only when, under these rules, it is Secondary to that other plan.

B. Order of Benefit Determination

Use the first of the following rules which applies:

(1) Non-Dependent/Dependent

The benefits of the plan which covers the person as an employee, member or subscriber (that is, other than as a dependent) are determined before those of the plan which covers the person as a dependent; except that: if the person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is

(a) Secondary to the plan covering the person as a dependent and

(b) Primary to the plan covering the person as other than a dependent (e.g. a retired employee),

then the benefits of the plan covering the person as a dependent are determined before those of the plan covering that person as other than a dependent.

(2) Dependent Child/Parents Not Separated or Divorced

The rules for the order of benefits for a dependent child when the parents are not separated or divorced are as follows:

(a) The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year;

(b) If both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time;

(c) The word "birthday" refers only to month and day in a calendar year, not the year in which the person was born;

(d) A group contract which includes COB and which is issued or renewed, or which has an anniversary date on or after sixty days after the effective date of this subchapter shall include the substance of the provision in (2)(a), (b) and (c) above. Until that provision becomes effective, the group contract may instead contain wording such as:

"Except as stated in (3) below, the benefits of a plan which covers a person as a dependent of a male are determined before those of a plan which covers the person as a dependent of a female."

(e) If the other plan does not have the rule described in (2)(a), (b) and (c) above, but instead has a rule based upon the gender of the parent; and if, as a result, the plans do not agree on the order of benefits, the rule based upon the gender of the parent will determine the order of benefits.

(3) Dependent Child/Separated or Divorced Parents

If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

(a) First, the plan of the parent with custody of the child;

(b) Then, the plan of the spouse of the parent with the custody of the child; and

(c) Finally, the plan of the parent not having custody of the child.

(d) If the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent shall be the Secondary Plan. This paragraph does not apply with respect to any Claim Determination Period or Plan Year during which any benefits are actually paid or provided before the entity has that actual knowledge.

(e) If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined in Section 5B(2), Dependent Child/Parents Not Separated or Divorced.

(4) Active/Inactive Employee

The benefits of a plan which covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a plan which covers that person as a laid off or retired employee (or as that employee's dependent). If the other plan does not have this rule; and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

Drafting Note: This paragraph does not supersede Subsection B(1). Coverage provided an individual as a retired worker and as a dependent of that individual's spouse as an active worker will be determined under Subsection B(1). This rule covers the situation where one individual is covered under one policy as an active worker and under another policy as a retired worker. It would also apply to an individual covered as a dependent under both of those policies.

(5) Continuation Coverage

If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the following shall be the order of benefit determination:

(a) First, the benefits of a plan covering the person as an employee, member or subscriber (or as that person's dependent);

(b) Second, the benefits under the continuation coverage.

If the other plan does not have the rule described above, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

Drafting Note: The Consolidated Omnibus Budget Reconciliation Act of 1987 (COBRA) originally provided that coverage under a new group health plan caused the COBRA coverage to end. An amendment passed as part of H.R. 3299 (1989) allows the COBRA coverage to continue if the other group plan contains any preexisting condition limitation. In this instance two policies will cover an individual, and the rule above will be used to determine which of them assumes the primary position. In addition, some states have continuation provisions comparable to the federal law.

(6) Longer/Shorter Length of Coverage

If none of the above rules determines the order of benefits, the benefits of the plan which covered an employee, member or subscriber longer are determined before those of the plan which covered that person for the shorter term.

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(a) To determine the length of time a person has been covered under a plan, two plans shall be treated as one if the claimant was eligible under the second within twenty-four hours after the first ended.

(b) The start of a new plan does not include:

(i) A change in the amount of scope of a plan's benefits;

(ii) A change in the entity which pays, provides or administers the plan's benefits; or

(iii) A change from one type of plan to another (such as, from a single employer plan to that of a multiple employer plan).

(c) The claimant's length of time covered under a plan is measured from the claimant's first date of coverage under that plan. If that date is not readily available, the date the claimant first became a member of the group shall be used as the date from which to determine the length of time the claimant's coverage under the present plan has been in force.

Section 6. Procedure to be Followed by Secondary Plan

Total Allowable Expenses

A. When it is determined, pursuant to Section 5, that this Plan is a Secondary Plan, it may reduce its benefits so that the total benefits paid or provided by all plans during a Claim Determination Period are not more than total Allowable Expenses. The amount by which the Secondary Plan's benefits have been reduced shall be used by the Secondary Plan to pay Allowable Expenses, not otherwise paid, which were incurred during the Claim Determination Period by the person for whom the claim is made. As each claim is submitted, the Secondary Plan determines its obligation to pay for Allowable Expenses based on all claims which were submitted up to that point in time during the Claim Determination Period.

B. The benefits of the Secondary Plan will be reduced when the sum of the benefits that would be payable for the Allowable Expenses under the Secondary Plan in the absence of this COB provision and the benefits that would be payable for the Allowable Expenses under the other Plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made, exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of the Secondary Plan will be reduced so that they and the benefits payable under the other plans do not total more than those Allowable Expenses.

(1) When the benefits of this Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Plan.

(2) Paragraph B(1) above may be omitted if the plan provides only one benefit, or may be altered to suit the coverage provided.

Section 7. Miscellaneous Provisions

A. Reasonable Cash Values of Services

A Secondary Plan which provides benefits in the form of services may recover the reasonable cash value of providing the services from the Primary Plan, to the extent that benefits for the services are covered by the Primary Plan and have not already been paid or provided by the Primary Plan. Nothing in this provision shall be interpreted to require a plan to reimburse a covered person in cash for the value of services provided by a plan which provides benefits in the form of services.

B. Excess and Other Nonconforming Provisions

(1) Some plans have order of benefit determination rules not consistent with this regulation which declare that the plan's coverage is "excess" to all others, or "always secondary." This occurs because certain plans may not be subject to insurance regulation, or because some group contracts have not yet been conformed with this regulation pursuant to Section 2.

(2) A plan with order of benefit determination rules which comply with this regulation (Complying Plan) may coordinate its benefits with a plan which is "excess" or "always secondary" or which uses order of benefit determination rules which are inconsistent with those contained in this regulation (Noncomplying Plan) on the following basis:

(a) If the Complying Plan is the Primary Plan, it shall pay or provide its benefits on a primary basis;

(b) If the Complying Plan is the Secondary Plan, it shall, nevertheless, pay or provide its benefits first, but the amount of the benefits payable shall be determined as if the Complying Plan were the Secondary Plan. In such a situation, such payment shall be the limit of the Complying Plan's liability; and

(c) If the Noncomplying Plan does not provide the information needed by the Complying Plan to determine its benefits within a reasonable time after it is requested to do so, the Complying Plan shall assume that the benefits of the Noncomplying Plan are identical to its own, and shall pay its benefits accordingly. However, the Complying Plan must adjust any payments it makes based on such assumption whenever information becomes available as to the actual benefits of the Noncomplying Plan.

(3) If the Noncomplying Plan reduces its benefits so that the employee, subscriber, or member receives less in benefits than he or she would have received had the Complying Plan paid or provided its benefits as the Secondary Plan and the Noncomplying Plan paid or provided its benefits as the Primary Plan, and governing State law allows the right of subrogation set forth below, then the Complying Plan shall advance to or on behalf of the employee, subscriber or member an amount equal to such difference.

However, in no event shall the Complying Plan advance more than the Complying Plan would have paid had it been the Primary Plan less any amount it previously paid. In consideration of such advance, the Complying Plan shall be subrogated to all rights of the employee, subscriber or member against the Noncomplying Plan. Such advance by the Complying Plan shall also be without prejudice to any claim it may have against the Noncomplying Plan in the absence of such subrogation.

C. Allowable Expense

A term such as "usual and customary," "usual and prevailing," or "reasonable and customary," may be substituted for the term "necessary, reasonable and customary." Terms such as "medical care" or "dental care" may be substituted for "health care" to describe the coverages to which the COB provisions apply.

D. Subrogation

The COB concept clearly differs from that of subrogation. Provisions for one may be included in health care benefits contracts without compelling the inclusion or exclusion of the other

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Section 8. Effective Date; Existing Contracts

A. This subchapter is applicable to every group contract which provides health care benefits and which is issued on or after the effective date of this regulation, which is [insert date].

B. A group contract which provides health care benefits and was issued before the effective date of this regulation shall be brought into compliance with this regulation by the later of:

(1) The next anniversary date or renewal date of the group contract; or

(2) The expiration of any applicable collectively bargained contract pursuant to which it was written.

APPENDIX A. MODEL COB PROVISIONS

COORDINATION OF THE GROUP CONTRACT'S BENEFITS WITH OTHER BENEFITS

I. APPLICABILITY

A. This Coordination of Benefits ("COB") provision applies to This Plan when an employee or the employee's covered dependent has health care coverage under more than one Plan. "Plan" and "This Plan" are defined below.

B. If this COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of This Plan are determined before or after those of another plan. The benefits of This Plan:

(1) Shall not be reduced when, under the order of benefit determination rules, This Plan determines its benefits before another plan; but

(2) May be reduced when, under the order of benefits determination rules, another plan determines its benefits first. The above reduction is described in Section IV "Effect on the Benefits of This Plan."

II. DEFINITIONS

A. "Plan" is any of these which provides benefits or services for, or because of, medical or dental care or treatment:

(1) Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.

(2) Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time).

Each contract or other arrangement for coverage under (1) or (2) is a separate plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan.

B. "This Plan" is the part of the group contract that provides benefits for health care expenses.

C. "Primary Plan/Secondary Plan:" The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan as to another plan covering the person.

When This Plan is a Primary Plan, its benefits are determined before those of the other plan and without considering the other plan's benefits.

When This Plan is a Secondary Plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits.

When there are more than two plans covering the person, This Plan may be a Primary Plan as to one or more other plans, and may be a Secondary Plan as to a different plan or plans.

D. "Allowable Expense" means a necessary, reasonable and customary item of expense for health care; when the item of expense is covered at least in part by one or more plans covering the person for whom the claim is made.

The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an Allowable Expense under the above definition unless the patient's stay in a private hospital room is medically necessary either in terms of generally accepted medical practice, or as specifically defined in the plan.

When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

When benefits are reduced under a Primary Plan because a covered person does not comply with the plan provisions, the amount of such reduction will not be considered an Allowable Expense. Examples of such provisions are those related to second surgical opinions, precertification of admissions or services, and preferred provider arrangements.

E. "Claim Determination Period" means a calendar year. However, it does not include any part of a year during which a person has no coverage under This Plan, or any part of a year before the date this COB provision or a similar provision takes effect.

III. ORDER OF BENEFIT DETERMINATION RULES

A. General. When there is a basis for a claim under This Plan and another plan, This Plan is a Secondary Plan which has its benefits determined after those of the other plan, unless:

(1) The other plan has rules coordinating its benefits with those of This Plan; and

(2) Both those rules and This Plan's rules, in Subsection B below, require that This Plan's benefits be determined before those of the other plan.

B. Rules. This Plan determines its order of benefits using the first of the following rules which applies:

(1) Non-Dependent/Dependent. The benefits of the plan which covers the person as an employee, member or subscriber (that is, other than as a dependent) are determined before those of the plan which covers the person as a dependent; except that: if the person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is

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(a) Secondary to the plan covering the person as a dependent and

(b) Primary to the plan covering the person as other than a dependent (e.g. a retired employee)

then the benefits of the plan covering the person as a dependent are determined before those of the plan covering that person as other than a dependent.

(2) Dependent Child Parents not Separated or Divorced. Except as stated in Paragraph B(3) below, when This Plan and another plan cover the same child as a dependent of different persons, called "parents:"

(a) The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but

(b) If both parents have the same birthday, the benefits of the plan which covered one parent longer are determined before those of the plan which covered the other parent for a shorter period of time.

However, if the other plan does not have the rule described in (a) immediately above, but instead has a rule based upon the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

(3) Dependent Child/Separated or Divorced. If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

(a) First, the plan of the parent with custody of the child;

(b) Then, the plan of the spouse of the parent with the custody of the child; and

(c) Finally, the plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expense of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent shall be the Secondary Plan. This paragraph does not apply with respect to any Claim Determination Period or Plan Year during which any benefits are actually paid or provided before the entity has that actual knowledge.

(4) Joint Custody. If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined in Paragraph B(2).

(5) Active/Inactive Employee. The benefits of a plan which covers a person as an employee who is neither laid off nor retired are determined before those of a plan which covers that person as a laid off or retired employee. The same would hold true if a person is a dependent of a person covered as a retiree and an employee. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this Rule (5) is ignored.

(6) Continuation coverage. If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the following shall be the order of benefit determination:

(a) First, the benefits of a plan covering the person as an employee, member or subscriber (or as that person's dependent);

(b) Second, the benefits under the continuation coverage.

If the other plan does not have the rule described above, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

(7) Longer Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the plan which covered an employee, member or subscriber longer are determined before those of the Plan which covered that person for the shorter term.

IV. EFFECT ON THE BENEFITS OF THIS PLAN

A. When This Section Applies. This Section IV applies when, in accordance with Section III "Order of Benefit Determination Rules," This Plan is a Secondary Plan as to one or more other plans. In that event the benefits of This Plan may be reduced under this section. Such other plan or plans are referred to as "the other plans" in B immediately below.

B. Reduction in this Plan's Benefits. The benefits of This Plan will be reduced when the sum of:

(1) The benefits that would be payable for the Allowable Expense under This Plan in the absence of this COB provision; and

(2) The benefits that would be payable for the Allowable Expenses under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made; exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the other plans do not total more than those Allowable Expenses.

When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

V. RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts are needed to apply these COB rules. [Insurer] has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. [Insurer] need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give [insurer] any facts it needs to pay the claim.

VI. FACILITY OF PAYMENT

A payment made under another plan may include an amount which should have been paid under This Plan. If it does, [insurer] may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under This Plan. [Insurer] will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services

VII. RIGHT OF RECOVERY

If the amount of the payments made by [insurer] is more than it should have paid under this COB provision, it may recover the excess from one or more of:

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A. The persons it has paid or for whom it has paid;

B. Insurance companies; or

C. Other organizations.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Legislative history; all references are to the Proceedings of the NAIC.

1971 Proc. I 54, 58, 209, 225, 226-230 (adopted).
1980 Proc. II 22, 26, 588, 592-593 (added section on divorced parents).
1983 Proc. I 6, 35, 644, 693, 699 (added section on laid-off and retired employees).
1984 Proc. II, 9, 20, 536, 616, 625-636 (revised and added birthdate rule and reprinted).
1985 Proc. II 11, 23, 609, 615, 627-638 (adopted easy-to-read version).
1986 Proc. I 9-10, 23, 665, 673 (footnote added).
1988 Proc. I 9, 20-21, 630, 713, 715-728 (amended and reprinted).
1989 Proc. I 9, 24-25, 703-704, 539, 543-546 (amended).
1990 Proc. II 7, 16, 600, 676-677, 679-683 (amended).
1991 Proc. I 9, 17-18, 609, 648-652 (amended).

ALASKA NURSES ASSOCIATION

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

April 6, 1994

Senator Steve Rieger
Room 516-C
Capitol Building
Juneau, Alaska 99801-1182

Dear Senator Rieger:

On behalf of the Alaska Nurses Association I would like to take this opportunity to comment on SB 367. The Alaska Nurses Association recognizes your effort to address the health care reform issue. However, we believe this bill does not include many of the essential components for health care reform that we believe are critical to the achievement of any true reform. Those components include:

- **Universal Coverage**
- **Single Payer Option**
- **Strong Consumer Involvement**
- **Review and Approval of Rates and Rating Factors**
- **Strong Public Health Infrastructure**
- **Cost-Control Mechanism**

The Alaska Nurses Association strongly supports universal coverage for all Alaskans. We believe this is the single most important aspect of health care reform. In order to achieve this health insurance needs to be made available to all Alaskans.

The Association, knowing the value of guaranteed coverage to primary care services also supports a single payer approach to ensuring a basic set of benefits for every citizen of this state. Following the study of a number of groups it has been determined that the single payer option promised to be the best approach to meet the unique needs of a small state such as Alaska.

The Association is committed to the belief that the consumer must play an integral part in a reformed health care system. We urge you to increase the consumer presence on the Health Care Plan Advisory Committee. Although SB 367 now includes two consumers on the committee, it does not go far enough to adequately address the concerns of those directly impacted by the system. It also does not include any plan for ongoing required public involvement in the process.

We strongly support Sec. 7. AS.21.51 Sec. 21.51.350. Review and approval of rates and rating factors. However, it is our understanding that an amendment has been offered to only require the insurance companies to comply with a "file and use" mechanism which would significantly dilute the intent of this section. We are strongly opposed to any efforts to amend this section as we are convinced this will offer immediate consumer protection.

The Alaska Nurses Association is disturbed that there is no identified portion of the bill which recognizes the need for a strong public health care system. As an organization that has long advocated the principles of disease prevention and health promotion, we believe that wellness and prevention should be recognized as appropriate strategies to achieve the goals of cost containment and improved health outcomes.

In fact, we do not find that this bill as written addresses one of the primary goals of health care reform, that of cost-control mechanisms to address the problems of spiraling health care costs. There is no mention made of any kind of health care expenditure target within this piece of legislation. With health care costs increasing at three times the rate of inflation, steps must be taken to control costs.

This bill as written does not provide for community rating and may continue to allow for client exclusion as well as ongoing cost-shifting by the insurance companies by not demanding that health insurance be guaranteed to all Alaskans.

Overall, we remain committed to SB 284 and recommend that you incorporate the provisions of that bill into SB 367. We cannot support SB 367 as it is presently written.
We urge you to act now. Or it could well be 1996 before any significant changes are made in the system.

Thank you for the opportunity to comment on SB 367.

Sincerely yours,

Jackie Pflaum/6h

Jackie Pflaum
Legislative Chair

April 6, 1994

To: Health, Education and Social Service Committee, Alaska Legislature

From: Jan Craddick, President, Sitka League of Women Voters

Re: Senate Bill 367

The Sitka League wishes to express its opposition to Senator Lehman's proposed amendment to SB 367 barring elective abortions. This amendment would directly conflict with the League's positions on Reproductive Choice and Universal Health Care. Additionally, such an amendment would quite likely increase rather than decrease the problems of insurers and health care providers. We ask that you vote against such an amendment.

Sincerely,

Jan Craddick

Jan Craddick

cc Senator Robin Taylor
Rep. Ben Grussendorf

Alaska State Legislature

Please enter into the record my testimony to the Senate HESS Committee
committee name

committee on SB 367 Health Care Reform , dated Wed., April 6th 1:30pm .
bill/subject

To the HESS Committee
Alaska Senate
Juneau, Alaska

Gentlemen:

Please do not pass Senator Leman's amendment to SB 367 which says we can not have abortions covered by our health care. Women need full coverage for all reproductive care.

Thank you.

Sonia K. Birkeland

Sonia K. Birkeland
Sitka, Alaska 99835

Signed: Sonia K. Birkeland
Testifier

Representing (Optional)

Box 2966 , Sitka, AK 99835
Address

747-4829
Phone No.

9/86 Legislative Information Office

Alaska State Legislature

Please enter into the record my testimony to the Senate HESS Committee
committee name

committee on SB 367 Health Care Reform , dated Wed., April 6, 1994 1:30pm
bill/subject

1501 Edgecumbe Drive
Sitka, Alaska 99835
6 April, 1994

Chairman, Senate HSS Committee
Alaska Legislature
Juneau, Alaska

Dear Sir:

It is my understanding that you will be having hearings on SB 367 today. It is my further understanding that Senator Loren Leman has offered an amendment to this bill denying any elective abortions. I wish to register a strong objection to this amendment or any other amendment that limits women's reproductive choices. Any health reform bill that limits elective abortions will be unacceptable to the vast majority of women in Alaska.

Sincerely,

Lois M. Jund

Lois M. Jund

Signed: Lois M. Jund
Testifier

Representing (Optional)

1501 Edgecumbe Dr.. Sitka, AK 99835
Address

907-747-3103
Phone No.

Diana J. Woods
P.O. Box 468
Girdwood, Alaska 99587

brand fax transmittal memo 7671	# of pages ▸
To Sen. Reiger	From D. Woods
Co.	Co.
Dept.	Phone # 783-2461
Fax # 465-2069	Fax #

Senator Steve Reiger
Alaska State Legislature

April 6, 1994

Dear Senator Reiger,

I just received word Senator Leman added an amendment to SB367 excluding elective abortion from Alaska health care reform. Please reject this amendment. It discriminates against poor women. Safe, legal abortions must be available to all our women, not just the rich. To discriminate against poor women is wrong.

No one likes abortion. But as long as contraceptives fail and rape continues, we must ensure the availability of safe, legal abortion. Everyone agrees pregnancy prevention is the only way to stop abortion. Government has an obligation to help people prevent unwanted pregnancies. I suggest health care reform include making contraceptives available to all who wish to use them.

Until every person is able to completely control his or her reproductive system, safe, accessible abortion must remain a part of any responsible health care program. Our health care program ought to be for everyone, not just the rich or the "righteous."

Thank you for rejecting Senator Leman's amendment to SB367. Let's keep safe abortion accessible for everyone.

Sincerely,

Diana Woods

Diana Woods

Alaska State Legislature

Please enter into the record my testimony to the SENATE RESS
committee name

committee on SB 367 , dated 6 April 1994 .
bill/subject

Please See Attached
testimony

Signed: Natasha Calvin and Robert J. Ellis
Testifier

Sitkans for Choice self
Representing (Optional)

Box 2966 - Sitka
Address

907 747-8950
Phone No.

9/86 Legislative Information Office

1 of 3

April 5,. 1994

Senate HESS Committee
Alaska State Legislature
Juneau, Alaska

Re: SB367

Sitkans for Choice opposes the proposed amendment to SB 367 which would disallow payment for elective abortions. We oppose any interference with the right to reproductive choice.

Sitkans for Choice supports full health care coverage for everyone without restrictions to impose the religious beliefs of some. Please allow no restrictions on repoductive freedom in this or any other health care bill.

Thank you for the opportunity to comment.

Sincerely,

Natasha I. Calvin

Natasha I. Calvin for
Sitkans for Choice
P.O. Box 2966
Sitka, Alaska 99835

6 April, 1994

To: Senate HESS Committee
Alaska State Legislature
Juneau, Alaska ~~99835~~

Re: SB 367
Leman amendment

I absolutely oppose this proposed amendment to allow "no elective abortions". I have just heard of this outrage. I expect that there is a well orchestrated anti-choice campaign in favor of this amendment.

Robert J. Ellis
P.O. Box 2966
Sitka, Alaska 99835