

ALASKA LEGISLATURE SPECIAL COMMITTEE/SUBJECT FILE 8672
2193 SCOMM 86: HEALTH RESOURCES & ACCESS TASK FORCE, 1991-93

21

1 required under this paragraph shall be in operation by December 31, 1993;

2 (2) create and begin a phased implementation of geographic specific health care
3 provider reimbursement systems and utilization standards within the boundaries of communities
4 that have a population of less than 20,000 as reflected by the 1990 United States census; the
5 health care provider reimbursement systems and utilization standards required under this
6 paragraph shall be in operation by July 1, 1995;

7 (3) establish the reimbursement systems and utilization standards prospectively
8 utilizing the most accurate information available to the authority regarding defined reliable
9 components of the reimbursement systems and utilization standards; components for the
10 reimbursement systems must include but are not limited to

11 (A) effort and time by provider;

12 (B) technological advances resulting in new equipment, staff, or training;

13 (C) facilities and practice expense;

14 (D) training as a specialist that expands or improves service;

15 (E) professional liability insurance;

16 (F) resolution of rate disputes and associated expenses;

17 (G) geographic modifier;

18 (H) uncollectible debt expenses;

19 (I) availability of services modifier;

20 (J) charity caseload modifier;

21 (K) uncompensated care net cost;

22 (L) long-term elder care expenses;

23 (M) employee expenses resulting from competition with state employee

24 salaries;

25 (N) specialist recruitment expenses;

26 (O) capital costs;

27 (P) Medicaid rates;

28 (Q) actual provider charges as of January 1, 1991;

29 (4) assign relative weight to each component specified in (3) of this subsection
30 and may further define each component;

31 (5) publish, not later than July 1, 1992, a guide for health care providers, insurers,

1 and participants that describes and explains how to use the reimbursement systems and utilization
2 standards;

3 (6) establish health care information and data reporting procedures; the procedures
4 shall be established in cooperation with health care providers and insurers.

5 (c) A health care provider and a person paying a claim shall use the health care provider
6 reimbursement systems and utilization standards established by the authority when billing for
7 services provided to a public employer or a public employee. Other employers may elect to use
8 the reimbursement systems and utilization standards, if the use is approved by the authority.

9 (d) Upon application by an employer or an eligible state program, the authority may,
10 beginning July 1, 1992, allow the employer or the eligible state program to participate in a group
11 health insurance pool established by the authority.

12 (e) Not later than July 1, 1992, the authority shall design and procure or provide a basic
13 health insurance program for employers who elect to participate and who have

14 (1) 50 or fewer full-time employees;

15 (2) been refused coverage by two or more health insurance carriers in the last 12
16 months; or

17 (3) not provided health insurance coverage to their employees in the last 12
18 months.

19 (f) A plan required under (e) of this section

20 (1) must emphasize preventative and protective health services;

21 (2) must include provisions to streamline marketing and payment of claims to
22 providers and participants;

23 (3) must include the reimbursement systems and utilization standards described
24 in (b) of this section;

25 (4) may utilize insurance agents or brokers licensed in this state to assist in the
26 marketing and servicing of the plan.

27 (g) The authority shall submit recommendations to the legislature for providing financial
28 incentives for employers to provide health protection for their employees and dependents.

29 (h) At least 60 days before implementing a phase of the reimbursement systems and
30 utilization standards, the authority shall provide public notice and accept public comments on that
31 phase of the reimbursement systems and utilization standards.

1 Sec. 44.87.015. REQUIRED COOPERATION BY STATE AGENCIES. An agency of
2 the state that provides health care or that provides funds to purchase health care shall, to the
3 maximum extent possible, cooperate in the development of the use of the health care provider
4 reimbursement systems and utilization standards established by the authority, including sharing
5 relevant information.

6 Sec. 44.87.020. BOARD OF DIRECTORS; ORGANIZATION. (a) The authority shall
7 be managed by a board of directors composed of nine members appointed by the governor. The
8 governor shall appoint at least one but not more than two members as representatives from each
9 of the following:

- 10 (1) the executive branch;
- 11 (2) labor organizations;
- 12 (3) school districts;
- 13 (4) municipalities;
- 14 (5) private sector employers;
- 15 (6) health care providers.

16 (b) Members of the board serve staggered terms of four years. The board shall elect
17 from its membership a president, vice-president, and secretary. Members of the board serve
18 without compensation but are entitled to receive per diem and travel expenses authorized for
19 boards and commissions under AS 39.20.180. Members of the board are subject to AS 39.50.

20 Sec. 44.87.030. GENERAL POWERS. The authority may

21 (1) beginning July 1, 1992, exercise the powers granted to insurers under the laws
22 of the state; if the authority acts as an insurer, the authority shall comply with the requirements
23 applicable to insurers under AS 21;

- 24 (2) sue or be sued;
- 25 (3) enter into contracts or agreements;
- 26 (4) establish administrative or accounting procedures;
- 27 (5) collect, invest, and disburse funds;
- 28 (6) charge fees for providing administrative services;
- 29 (7) establish appropriate levels of reserves to cover the expenses of the authority;
- 30 (8) adopt necessary regulations and procedures for implementation of this chapter.

31 Sec. 44.87.040. DUTIES OF BOARD; ANNUAL REPORT. The board shall

1 (1) in providing group health insurance required under this chapter, provide
2 comprehensive coverage at the lowest possible cost per eligible employee;

3 (2) provide to the governor and to the legislature an annual report covering the
4 previous fiscal year's activities of the authority;

5 (3) review each application for a certificate of need under AS 18.07.041 and
6 within 60 days after receiving a copy of the application determine the effect of issuing the
7 certificate on the cost of the group health insurance required under this chapter; a copy of the
8 determination shall be provided to the office of planning and research in the Department of
9 Health and Social Services;

10 (4) establish a grievance procedure to resolve disputes between the authority and
11 participants;

12 (5) every third fiscal year, include in the annual report a cost and benefit analysis
13 of the activities of the authority;

14 (6) analyze the health care needs of the state population that is uninsured or
15 underinsured;

16 (7) provide recommendations to the legislature not later than February 15, 1992,
17 for a systematic approach or plan with alternatives including liabilities and financing alternatives
18 that may be considered to assure access to affordable quality health insurance for all state
19 residents; the recommendations must be updated each year;

20 (8) provide recommendations to the legislature not later than February 15, 1993,
21 for the design of a program with alternatives including liability and financing alternatives to
22 provide health care insurance to state residents who

23 (A) are not covered by health insurance;

24 (B) have been refused health insurance coverage by two or more health
25 insurance carriers in the last 12 months;

26 (C) have been considered uninsurable for health coverage; or

27 (D) are unable to pay for basic health care protection and do not qualify
28 for any other health care protection program or plan;

29 (9) beginning January 1, 1994, periodically review and update the reimbursement
30 systems and utilization standards established by the authority, and evaluate the need for
31 reimbursement systems and utilization standards in other areas of the state.

1 Sec. 44.87.050. STAFF AND PROFESSIONAL SERVICES CONTRACTS. The
2 authority shall employ an executive director who serves at the pleasure of the authority as its
3 chief administrative officer. The executive director may, with the approval of the authority,
4 select and employ additional staff as necessary. Employees of the authority are in the exempt
5 service under AS 39.25.110. In addition to its staff of regular employees, the authority may
6 contract for the services of consultants and professional, technical, and financial advisors the
7 authority considers necessary for the purpose of developing information, conducting hearings,
8 studies, investigations, or other proceedings, or otherwise exercising its powers.

9 Sec. 44.87.060. PROCUREMENT OF INSURANCE. (a) The authority may, after
10 July 1, 1992, begin to procure a policy or policies of comprehensive group health insurance
11 covering an individual or an employer that the authority determines does not have health
12 insurance or for whom health insurance could be more cost effective if procured by the authority.
13 The authority may procure or, if procurement of insurance is not economically feasible, provide
14 group health insurance to employers who elect to participate. Group health insurance may
15 include coverage for eligible employees and dependents. The authority shall procure the
16 insurance from an insurer authorized to transact business in the state under AS 21.09, or the
17 authority may elect to act as a self-insurer if the authority determines that self-insurance can
18 provide the desired insurance coverage and benefits at a lower cost per eligible employee and the
19 authority complies with (c) of this section.

20 (b) The authority, no earlier than July 1, 1992, may establish a group health insurance
21 pool or pools of eligible employers that elect to participate in the group health insurance obtained
22 by the authority. Coverage provided under this subsection must include eligible employees and
23 dependents. Employers that elect to participate shall use the reimbursement systems and
24 utilization standards established by the authority.

25 (c) Except when acting as a self-insurer, the authority shall procure or provide group
26 health insurance in compliance with the provisions of AS 36.30 and shall make available bid
27 specifications for desired group health insurance benefits to all insurance carriers licensed in the
28 state and qualified to provide the desired benefits. The specifications shall be made available at
29 least once every five years.

30 (d) Before the authority elects to act as a self-insurer, the authority shall solicit proposals
31 for the required coverage from insurers licensed in this state to offer health insurance. If after

1 the proposal process has been completed, the authority determines that the desired coverage or
2 benefits are not available from insurers licensed in this state or the authority can provide the
3 desired coverage and benefits at a lower cost per eligible person, the authority may submit a plan
4 of the intended self-insurance coverage and benefits to the legislature. The authority may not
5 begin acting as a self-insurer until the legislature has approved the self-insurance plan submitted
6 by the authority.

7 (e) The authority, when procuring or providing insurance, may create pools or subpools
8 of participants to accurately track premium, experience, and exposure by category. The authority
9 may employ risk sharing mechanisms to limit the total exposure and premium claim volatility
10 of the authority or a participant.

11 Sec. 44.87.070. ALASKA STATE HEALTH RESOURCES FUND. The Alaska state
12 health resources fund is created in the general fund. The fund consists of money appropriated
13 by the legislature. The fund shall be managed and invested by the board. The board may expend
14 money from the fund to carry out the provisions of this chapter.

15 Sec. 44.87.080. INSURANCE PREMIUMS. The authority shall provide that sufficient
16 funds are collected to provide authorized benefits, reserves, and to pay the expenses of the
17 authority. Reserves remaining at the termination of an insurance contract shall be invested by
18 the authority in the same manner as retirement funds are invested under AS 14.25.180.

19 Sec. 44.87.090. PARTICIPATION; WAIVER. (a) The state, a municipality, a district,
20 or other employer in the state may participate in the group insurance coverage provided by the
21 authority. If the state, municipality, district, or other employer elects to participate, the state,
22 municipality, district, or other employer shall continue to participate unless a waiver is granted
23 by the board.

24 (b) In determining whether a waiver should be granted, the board shall establish
25 minimum benefit and financial standards for the desired group health insurance coverage. The
26 minimum benefit and financial standards and the proposed time schedule for responsive offers
27 shall be sent to all participants at the time the request for proposal for the desired group health
28 insurance coverage is issued. A participant seeking a waiver of coverage shall match the
29 minimum benefit and financial standards set out in the request for proposal for the desired group
30 health insurance coverage. Participants shall submit documentation of their insurance coverage
31 matching the board's minimum benefit and financial requirements before the deadline established

1 by the board. The board may approve or disapprove a waiver of participation based on the
2 documentation submitted by the participant regarding the benefit and financial standards
3 established by the board.

4 (c) A participant may separately provide for health insurance coverage additional to that
5 offered by the authority.

6 Sec. 44.87.900. DEFINITIONS. In this chapter,

7 (1) "authority" means the Alaska State Health Resources Authority;

8 (2) "board" means the board of directors of the Alaska State Health Resources
9 Authority;

10 (3) "district" has the meaning given in AS 14.17.250;

11 (4) "eligible employee" means an employee of a participant who qualifies for
12 group health benefits as determined by the participant;

13 (5) "eligible state program" means a program in which an agency of the state
14 provides health care or provides funds to purchase health care for persons who are not employees
15 of the state;

16 (6) "employer" means the state, a municipality, a district, a collective bargaining
17 unit, the board of a public corporation of the state created within a principal executive
18 department, a self-employed person, or a person employing one or more persons in a business
19 or industry;

20 (7) "full-time employee" means a person who works 30 or more hours in a week;

21 (8) "fund" means the Alaska state health resources fund;

22 (9) "group health insurance" means coverage that may include medical care and
23 treatment, dental care, eye care, and other group health coverage as determined by the authority;

24 (10) "health care provider" has the meaning given in AS 21.88.900;

25 (11) "municipality" includes a public corporation established by a municipality;

26 (12) "participant" means a person who participates in the group health insurance
27 procured or provided by the authority;

28 (13) "reimbursement systems" means systems or methods that streamline or result
29 in cost efficient payments to health care providers, and includes schedules of maximum allowable
30 reimbursement for health care related services based on geographic regions, actual provider costs,
31 and availability of services;

1 (14) "state" means the executive, legislative, and judicial branches of state
2 government, and includes the University of Alaska and a public corporation of the state created
3 within a principal executive department;

4 (15) "utilization standards" means a system to monitor, track, and verify patterns
5 of treatment by health care providers that assures that cost efficient and cost effective care is
6 provided within accepted medical standards without reducing the quality of care.

- 7 * Sec. 9. REPORT. The Alaska State Health Resources Authority shall report to the Alaska State
8 Legislature by March 1, 1992, on the progress made by the authority in establishing a health care
9 provider reimbursement systems and utilization standards.
- 10 * Sec. 10. This Act takes effect immediately under AS 01.10.070(c).

HOUSE BILL NO. 71
IN THE LEGISLATURE OF THE STATE OF ALASKA
SEVENTEENTH LEGISLATURE - FIRST SESSION

BY REPRESENTATIVES BOYER, Navarre

Introduced: 1/24/91

Referred: Labor and Commerce, Health, Education and Social Services, Finance

A BILL
FOR AN ACT ENTITLED

1 "An Act relating to the Alaska State Health Resources Authority; relating to the delivery,
2 quality, and financing of health care for residents of the state, and to the issuance of
3 certificates of need; and providing for an effective date."

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

5 * **Section 1. PURPOSE.** The purpose of this Act is to

6 (1) by July 1, 1992, create and begin implementation of a statewide health care provider
7 reimbursement system and utilization standards;

8 (2) after July 1, 1992, provide comprehensive group health insurance for the state,
9 municipalities, school districts, other employers in the state who elect to participate, and all eligible
10 employees of the state, a municipality, a school district, or other employer in the state who elect to
11 participate in the group insurance offered by the Alaska State Health Resources Authority;

12 (3) expand the pool of subscribers and maximize the opportunities for health care cost
13 management and economies of scale when purchasing group health insurance;

14 (4) maintain an efficient provider reimbursement system to reduce the administrative cost

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1 to providers who are serving employees of participants;

2 (5) maintain a statewide health care data base and utilization standards to control
3 inappropriate or improper utilization practices and to reduce the rate of inflation in the cost of health care
4 in the state;

5 (6) create the most comprehensive, cost-effective, and efficient method of providing a
6 variety of types of health care insurance necessary to meet the coverage requirements of a participant
7 resulting from negotiated employee contracts;

8 (7) realize the potential savings that will result if approximately 135,000 active and
9 retired state, municipal, and school district employees and their dependents participate in the group health
10 insurance program offered by the authority;

11 (8) evaluate the need for mandatory participation in the group health insurance offered
12 by the authority; and

13 (9) evaluate the need for group health insurance for residents of the state who are
14 uninsured or underinsured.

15 * Sec. 2. AS 18.07.035 is amended to read:

16 Sec. 18.07.035. APPLICATION AND FEES. Application for a certificate of need shall
17 be made to the department upon a form provided by the department and must contain the
18 information the department requires to reach a decision under AS 18.07.041 - 18.07.111. Each
19 application for a certificate of need must be accompanied by an application fee established by
20 the department by regulation. A copy of each application for a certificate of need, except an
21 application for a temporary or emergency certificate issued under AS 18.07.071, shall be
22 provided to the Alaska State Health Resources Authority.

23 * Sec. 3. AS 18.07.041 is amended to read:

24 Sec. 18.07.041. STANDARD OF REVIEW FOR APPLICATIONS FOR CERTIFICATES
25 OF NEED. The office shall grant a sponsor a certificate of need or modify a certificate of need
26 if the availability and quality of existing health care resources or the accessibility to those
27 resources is less than the current or projected requirement for health services required to maintain
28 the good health of Alaska citizens. A certificate of need may not be issued, except for a
29 temporary or emergency certificate under AS 18.07.071, unless the office has received a
30 determination from the Alaska State Health Resources Authority regarding the effect of the
31 certificate of need on the cost of group health insurance.

1 * Sec. 4. AS 21 is amended by adding a new chapter to read:

2 CHAPTER 77. STATE INSURANCE.

3 Sec. 21.77.010. AUTHORITY CREATED; REQUIRED REIMBURSEMENT SYSTEM
4 AND UTILIZATION STANDARDS. (a) There is established within the Department of
5 Administration a nonprofit incorporated legal entity known as the Alaska State Health Resources
6 Authority.

7 (b) The authority shall, by July 1, 1992, establish and begin implementaion of a health
8 care provider reimbursement system and utilization standards. The state, a municipality, or a
9 school district shall use the health care provider reimbursement system and utilization standards
10 established by the authority for eligible employees of the state, a municipality, or a school
11 district. With the approval of the authority, other employers in the state may use the health care
12 provider reimbursement system and utilization standards established by the authority.

13 (c) The authority shall, no earlier than July 1, 1992, establish a group health insurance
14 pool or pools of eligible employees of the state, a municipality, or a school district if the
15 employer has elected to participate in the group health insurance obtained by the authority and
16 may provide group health insurance to employees of other groups that elect to participate in the
17 group health insurance pool provided by the authority. Employees of other groups that elect to
18 participate shall use the reimbursement system and utilization standards established by the
19 authority.

20 (d) Upon application by an eligible state program, the authority may, beginning July 1,
21 1992, allow the eligible state program to participate in the group health insurance pool provided
22 by the authority.

23 Sec. 21.77.015. REQUIRED COOPERATION BY STATE AGENCIES. An agency of
24 the state that provides health care or that provides funds to purchase health care shall, to the
25 maximum extent possible, cooperate in the development of the use of the health care provider
26 reimbursement system and utilization standards established by the authority, including sharing
27 relevant information.

28 Sec. 21.77.020. BOARD OF DIRECTORS; ORGANIZATION. (a) The authority shall
29 be managed by a board of directors composed of nine members appointed by the governor. The
30 governor shall appoint at least one but not more than two members as representatives from each
31 of the following:

- (1) the executive branch;
- (2) labor organizations;
- (3) school districts;
- (4) municipalities;
- (5) private sector employers;
- (6) health care providers.

(b) Members of the board serve staggered terms of four years. The board shall elect from its membership a president, vice-president, and secretary. Members of the board serve without compensation but are entitled to receive per diem and travel expenses authorized for boards and commissions under AS 39.20.180. Members of the board are subject to AS 39.50.

Sec. 21.77.030. GENERAL POWERS. The authority may

(1) beginning July 1, 1992, exercise the powers granted to insurers under the laws of the state; if the authority acts as an insurer, the authority shall comply with the requirements applicable to insurers under this title;

- (2) sue or be sued;
- (3) enter into contracts or agreements;
- (4) establish administrative or accounting procedures;
- (5) collect, invest, and disburse funds;
- (6) charge fees for providing administrative services;
- (7) establish appropriate levels of reserves to cover the expenses of the authority;
- (8) adopt necessary regulations and procedures for implementation of this chapter.

Sec. 21.77.040. DUTIES OF BOARD; ANNUAL REPORT. The board shall

(1) in providing group health insurance required under this chapter, provide comprehensive coverage at the lowest possible cost per eligible employee;

(2) provide to the governor and to the legislature an annual report covering the previous fiscal year's activities of the authority;

(3) review each application for a certificate of need under AS 18.07.041 and within 60 days after receiving a copy of the application determine the effect of issuing the certificate on the cost of the group health insurance required under this chapter; a copy of the determination shall be provided to the office of planning and research in the Department of Health and Social Services;

1 (4) every third fiscal year, include in the annual report a cost and benefit analysis
2 of the activities of the authority.

3 Sec. 21.77.050. STAFF AND PROFESSIONAL SERVICES CONTRACTS. The
4 authority shall employ an executive director who serves at the pleasure of the authority as its
5 chief administrative officer. The executive director may, with the approval of the authority,
6 select and employ additional staff as necessary. Employees of the authority are in the exempt
7 service under AS 39.25.110. In addition to its staff of regular employees, the authority may
8 contract for the services of consultants and professional, technical, and financial advisors the
9 authority considers necessary for the purpose of developing information, conducting hearings,
10 studies, investigations, or other proceedings, or otherwise exercising its powers.

11 Sec. 21.77.060. PROCUREMENT OF INSURANCE. (a) The authority shall, after
12 July 1, 1992, obtain a policy or policies of group health insurance covering eligible employees
13 of an employer that has elected to participate, from an insurer authorized to transact business in
14 the state under AS 21.09, or act as a self-insurer if the authority determines that self-insurance
15 can provide the desired insurance coverage and benefits at a lower cost per eligible employee.

16 (b) Except when acting as a self-insurer, the authority shall obtain group health insurance
17 in compliance with the provisions of AS 36.30 and shall make available bid specifications for
18 desired group health insurance benefits to all insurance carriers licensed in the state and qualified
19 to provide the desired benefits. The specifications shall be made available at least once every five
20 years.

21 Sec. 21.77.070. ALASKA STATE HEALTH RESOURCES FUND. The Alaska state
22 health resources fund is created in the general fund. The fund consists of money appropriated
23 by the legislature. The fund shall be managed and invested by the board. The board may expend
24 money from the fund to carry out the provisions of this chapter.

25 Sec. 21.77.080. INSURANCE PREMIUMS. The authority shall provide that sufficient
26 funds are collected to provide authorized benefits, reserves, and to pay the expenses of the
27 authority. Reserves remaining at the termination of an insurance contract shall be invested by
28 the authority in the same manner as retirement funds are invested under AS 14.25.180.

29 Sec. 21.77.090. PARTICIPATION; WAIVER. (a) The state, a municipality, a district,
30 or other employer in the state may participate in the group insurance coverage provided by the
31 authority. If the state, municipality, district, or other employer elects to participate, the state,

1 municipality, district, or other employer shall continue to participate unless a waiver is granted
2 by the board.

3 (b) In determining whether a waiver should be granted, the board shall establish
4 minimum benefit and financial standards for the desired group health insurance coverage. The
5 minimum benefit and financial standards and the proposed time schedule for responsive offers
6 shall be sent to all participants at the time the request for proposal for the desired group health
7 insurance coverage is issued. A participant seeking a waiver of coverage shall match the
8 minimum benefit and financial standards set out in the request for proposal for the desired group
9 health insurance coverage. Participants shall submit documentation of their insurance coverage
10 matching the board's minimum benefit and financial requirements before the deadline established
11 by the board. The board may approve or disapprove a waiver of participation based on the
12 documentation submitted by the participant regarding the benefit and financial standards
13 established by the board.

14 (c) A participant may separately provide for health insurance coverage additional to that
15 offered by the authority.

16 Sec. 21.77.100. DEFINITIONS. In this chapter,

17 (1) "authority" means the Alaska State Health Resources Authority;

18 (2) "board" means the board of directors of the Alaska State Health Resources
19 Authority;

20 (3) "district" has the meaning given in AS 14.17.250;

21 (4) "eligible employee" means an employee of a participant who qualifies for
22 group health benefits as determined by the participant;

23 (5) "eligible state program" means a program in which an agency of the state
24 provides health care or provides funds to purchase health care for persons who are not employees
25 of the state;

26 (6) "employer" means the state, a municipality, a district, a collective bargaining
27 unit, the board of a public corporation of the state created within a principal executive
28 department, a self-employed person, or a person employing one or more persons in a business
29 or industry;

30 (7) "fund" means the Alaska state health resources fund;

31 (8) "group health insurance" means coverage that may include life insurance.

1 accidental death and dismemberment, medical care and treatment, dental care, eye care, and other
2 group health coverage as determined by the authority;

3 (9) "municipality" includes a public corporation established by a municipality;

4 (10) "participant" means the state, a municipality, a district, or other employer in
5 the state;

6 (11) "reimbursement system" means a system or method that streamlines or results
7 in cost efficient payments to health care providers, and includes schedules of maximum allowable
8 reimbursement for health care related services based on geographic regions, actual provider costs,
9 and availability of services;

10 (12) "state" means the executive, legislative, and judicial branches of state
11 government, and includes the University of Alaska and a public corporation of the state created
12 within a principal executive department;

13 (13) "utilization standards" means a system to monitor, track, and verify patterns
14 of treatment by health care providers that assures that cost efficient and cost effective care is
15 provided within accepted medical standards without reducing the quality of care.

16 * Sec. 5. AS 37.07.030 is amended to read:

17 Sec. 37.07.030. RESPONSIBILITIES OF THE LEGISLATURE. The legislature shall

18 (1) provide for a budget review function;

19 (2) analyze the comprehensive operating and capital improvements programs and
20 financial plans recommended by the governor;

21 (3) adopt legislation to authorize implementation of the governor's comprehensive
22 operating and capital improvements programs and financial plans or appropriate alternatives to
23 those plans;

24 (4) provide for a post-audit function to cover financial transactions, program
25 accomplishment, and compliance with legislative intent;

26 (5) adopt or revise the estimate of receipts required to balance the succeeding
27 fiscal year's budget in order that proposed expenditures do not exceed estimated receipts for that
28 fiscal year;

29 (6) adopt, revise, or initiate revenue measures in order to balance the succeeding
30 fiscal year's budget and the capital improvements section of the budget for the succeeding six
31 years;

- 1 (7) appropriate funds for the operation of the Alaska State Health Resources
2 Authority.
3 * Sec. 6. AS 39.25.110 is amended by adding a new paragraph to read:
4 (30) employees of the Alaska State Health Resources Authority.
5 * Sec. 7. AS 39.50.200(b) is amended by adding a new paragraph to read:
6 (52) Alaska State Health Resources Authority (AS 21.77).
7 * Sec. 8. REPORT. The Alaska State Health Resources Authority shall report to the Alaska State
8 Legislature by March 1, 1992, on the progress made by the authority in establishing a health care
9 provider reimbursement system and utilization standards.
10 * Sec. 9. This Act takes effect immediately under AS 01.10.070(c).

SENATE BILL NO. 84

IN THE LEGISLATURE OF THE STATE OF ALASKA

SEVENTEENTH LEGISLATURE - FIRST SESSION

BY SENATOR DUNCAN

Introduced: 1/23/91

Referred: HESS and Finance

A BILL

FOR AN ACT ENTITLED

1 "An Act relating to state coordination of health planning and development; abolishing the
2 Statewide Health Coordinating Council; and providing for an effective date."

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

4 * Section 1. AS 18.07 is amended by adding a new section to read:

5 Sec. 18.07.005. LEGISLATIVE PURPOSE. It is the purpose of this chapter to create
6 a rational framework for the planning and development of all health care services in the state to
7 ensure promotion and protection of public health, provide equitable access to health services, and
8 avoid unnecessary increases in health care costs.

9 * Sec. 2. AS 18.07.021 is amended to read:

10 Sec. 18.07.021. STATE HEALTH PLANNING AND DEVELOPMENT [AGENCY].
11 The [OFFICE OF PLANNING AND RESEARCH IN THE] department is responsible for [THE]
12 state health planning and development, [AGENCY DESIGNATED UNDER 42 U.S.C.
13 300m(b)(3). THE OFFICE] shall [PERFORM THE FUNCTIONS ENUMERATED UNDER 42
14 U.S.C. 300m-2,] administer the certificate of need program outlined in AS 18.07.031 - 18.07.111

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1 [AS 18.07.041 - 18.07.111], and shall perform other functions prescribed in this chapter.

2 * Sec. 3. AS 18.07.031 is repealed and reenacted to read:

3 Sec. 18.07.031. CERTIFICATE OF NEED REQUIRED. (a) Unless authorized under
4 the terms of a certificate of need issued by the department, a person may not

5 (1) make a capital expenditure of \$1,000,000 or more for construction of a health
6 care facility;

7 (2) convert a building, in whole or in part, for use as a health care facility if the
8 fair market value of the converted part of the building is greater than \$500,000 and the sum of
9 the fair market value plus additional capital expenditures made to facilitate the conversion equals
10 or exceeds \$1,000,000;

11 (3) alter or redistribute the bed capacity of a health care facility by more than 10
12 beds or 10 percent of the number of beds in the facility, whichever is fewer;

13 (4) add or eliminate a category of health services to or from those provided by
14 the health care facility; or

15 (5) acquire a health care facility at a cost of \$1,000,000 or more.

16 (b) The dollar thresholds in (a) of this section apply to total anticipated costs. Costs of
17 constructing or acquiring a health care facility may not be artificially divided, fragmented, or
18 structured to circumvent the requirements of this section.

19 * Sec. 4. AS 18.07.035 is amended to read:

20 Sec. 18.07.035. APPLICATION AND FEES. Application for a certificate of need shall
21 be made to the department upon a form provided by the department and must contain the
22 information the department requires to reach a decision under AS 18.07.031 - 18.07.111
23 [AS 18.07.041 - 18.07.111]. Each application for a certificate of need must be accompanied by
24 an application fee established by the department by regulation.

25 * Sec. 5. AS 18.07.051 is amended by adding a new subsection to read:

26 (b) A certificate of need is valid only for the defined scope, physical location, and person
27 stated in the certificate.

28 * Sec. 6. AS 18.07.061 is amended to read:

29 Sec. 18.07.061. MODIFICATION AND TERMINATION OF ACTIVITIES. The
30 certificate holder shall apply to the department [OFFICE] for a modification of the certificate
31 [BEFORE TERMINATING PART OF THE ACTIVITIES AUTHORIZED BY THE TERMS OF

1 ISSUANCE, BUT THE CERTIFICATE HOLDER IS NOT REQUIRED TO OBTAIN THE
2 ACQUIESCENCE OF THE OFFICE] before transferring the certificate or modifying or
3 terminating all or part of the activities authorized by the certificate. If a certificate holder
4 intends to terminate [TERMINATES] all of the activities authorized by a certificate, the
5 certificate holder is required to apply to [NOTIFY] the department [OFFICE] 60 days before
6 termination and to surrender the certificate to the department [OFFICE] within 30 days after
7 [OF] termination.

8 * Sec. 7. AS 18.07.061 is amended by adding new subsections to read:

9 (b) An application for transfer of a certificate shall be made on forms provided by the
10 department and must contain

11 (1) evidence, of the type the department may require by regulation, that the
12 transferee is able to assume ownership or operation of the health care facility and to provide the
13 appropriate health services;

14 (2) evidence that the transferee is acquiring the health care facility at no more
15 than its current fair market value; and

16 (3) other information that the department may require.

17 (c) Transfer of a certificate is subject to conditions the department considers necessary.

18 * Sec. 8. AS 18.07.071 is repealed and reenacted to read:

19 Sec. 18.07.071. EMERGENCY CERTIFICATES. (a) The department shall expedite
20 review of an application for a certificate of need under AS 18.07.031(a)(1) that is required to

21 (1) eliminate or prevent imminent safety hazards as defined by a federal, state,
22 or local fire, building, or life safety code or regulation;

23 (2) comply with state licensure standards; or

24 (3) comply with accreditation standards, compliance with which is required to
25 receive federal reimbursement.

26 (b) An application approved under (a) of this section may be approved only to the extent
27 that the capital expenditure is required to eliminate or prevent the hazards or to comply with the
28 standards described in (a) of this section.

29 * Sec. 9. AS 18.07 is amended by adding a new section to read:

30 Sec. 18.07.079. FINAL DECISION. (a) Within 150 days after it determines that it has
31 received a complete application, the department shall take one or more of the following actions:

1 (1) approve part or all of the application and issue a certificate of need that
2 includes conditions that the department considers appropriate; the conditions must be directly
3 related to the activities for which the application was made;

4 (2) deny a certificate of need;

5 (3) recommend modifications to the application; if the applicant agrees to modify
6 the application, the department may defer a final decision on the application for 30 days after
7 receiving the modified application and all additional information to support the modifications;
8 deferral for more than 30 days under this paragraph may be made by the department only after
9 written findings that there is good cause for deferring the decision and that deferral is in the
10 public interest.

11 (b) The department shall send the final written findings and decision to the applicant and
12 to other persons who request a copy of the findings and decision. If the final decision is to
13 approve an application, the department shall issue a certificate of need to the applicant.

14 * Sec. 10. AS 18.07.081(a) is amended to read:

15 (a) The department [OFFICE], a member of the public who is substantially affected by
16 activities authorized by the certificate, [OR] another applicant for a certificate of need, or a
17 health care facility that either provides services similar to the proposed activity or has
18 indicated to the department in writing within the year preceding the decision to grant the
19 certificate an intention to provide similar services to a health service population that
20 includes all or part of the health service population served under the certificate of need may
21 request [INITIATE] a hearing to obtain modification, suspension or revocation of an existing
22 certificate of need by filing an accusation with the department [COMMISSIONER] as prescribed
23 under AS 44.62.360. A revocation, modification, or suspension of an outstanding certificate may
24 not be undertaken unless it is in accordance with AS 44.62.330 - 44.62.630.

25 * Sec. 11. AS 18.07.081(c) is amended to read:

26 (c) A certificate of need shall be suspended if an accusation is filed before the
27 commencement of activities authorized under AS 18.07.079 [AS 18.07.041] that charges that
28 factors upon which the certificate of need was issued have changed [,] or new factors have been
29 discovered that significantly alter the need for the activity authorized. [A SUSPENSION OF A
30 CERTIFICATE MAY NOT EXCEED 60 DAYS. AT THE END OF THIS PERIOD OR
31 SOONER, THE OFFICE SHALL REVOKE OR REINSTATE THE CERTIFICATE].

1 * Sec. 12. AS 18.07.081(d) is amended to read:

2 (d) A certificate of need may be revoked if

3 (1) the certificate holder [SPONSOR] has not shown continuing progress toward
4 commencement of the activities authorized under AS 18.07.079 within one year after
5 [AS 18.07.041 AFTER SIX MONTHS OF] issuance;

6 (2) the certificate holder [APPLICANT] fails, without good cause, to complete
7 activities authorized by the certificate;

8 (3) the certificate holder [SPONSOR] fails to comply with the provisions of this
9 chapter or regulations adopted under this chapter;

10 (4) the certificate holder [SPONSOR] knowingly misrepresents a material fact
11 in obtaining the certificate;

12 (5) the facts charged in an accusation filed under (c) of this section are
13 established; or

14 (6) the certificate holder [SPONSOR] fails to provide services authorized by the
15 terms of the certificate.

16 * Sec. 13. AS 18.07.081(e) is amended to read:

17 (e) A person who files [MAY NOT FILE] an accusation seeking suspension or
18 revocation of a certificate of need under this section, knowing that the charges stated in the
19 accusation are untrue or that the charges do not constitute grounds for revocation or suspension
20 under this chapter, is guilty of a class B misdemeanor.

21 * Sec. 14. AS 18.07.091 is repealed and reenacted to read:

22 Sec. 18.07.091. REPORTING REQUIREMENTS, PENALTIES, AND INJUNCTION.

23 (a) The department shall require all health care facilities operating in the state to periodically
24 file reports required by the department by regulation.

25 (b) The department shall require a certificate holder to file with the department.
26 periodically during the development stage and annually after that until completion of the activity
27 authorized under AS 18.07.031, a report demonstrating that the activity is in compliance with all
28 provisions of the certificate of need.

29 (c) If the department finds that a person has substantially failed or refused to comply
30 with AS 18.07.031 - 18.07.111 or a regulation adopted under those sections, the department may
31 take one or more of the following actions:

- (1) issue an order directing the person to stop the questioned activity;
- (2) deny, suspend, revoke, or modify a construction license required under AS 18.20.020 as related to the questioned activity;
- (3) suspend a payment to be made by the department to the person for capital and operating expenses relating to the questioned activity;
- (4) deny, suspend, revoke, or modify a certificate of need; or
- (5) issue an order against a person who violates a provision of AS 18.07.031 - 18.07.111 or a regulation adopted under those sections imposing a civil penalty of not more than \$20,000.

(d) Before imposing a sanction listed in (c) of this section, the department shall give reasonable notice of and an opportunity for a hearing.

(e) Notwithstanding AS 44.62.330 - 44.62.630, if the department finds that there will be a significant and adverse effect upon the public interest caused by substantial failure or refusal of a person to comply with AS 18.07.031 - 18.07.111 or a regulation adopted under those sections, the department may issue an order that does one or more of the following:

- (1) directs the person to stop the questioned activity;
- (2) suspends a construction license required under AS 18.20.020 as related to the questioned activity; or
- (3) suspends a payment to be made by the department to the person for capital and operating expenses relating to the questioned activity.

(f) Notwithstanding AS 44.62.330 - 44.62.630, an order under (e) of this section takes effect immediately upon service by the department and remains in effect pending the decision after any hearing that may have been requested unless the person served can demonstrate to the department's satisfaction that the questioned activity is not subject to the application and review requirements of AS 18.07.031 - 18.07.111, or that the person would likely prevail on the merits and that allowing the activity to continue is in the public interest.

(g) Injunctive relief against a violation of AS 18.07.031 - 18.07.111 or a regulation adopted under those sections may be obtained from a court of competent jurisdiction by the department, a certificate holder who is adversely affected by the violation, or a member of the public substantially and adversely affected by the violation.

* Sec. 15. AS 18.07.101 is amended to read:

1 Sec. 18.07.101. REGULATIONS. The department [COMMISSIONER] shall adopt, in
2 accordance with the Administrative Procedure Act (AS 44.62), regulations that establish
3 procedures under which a person [SPONSORS] may apply [MAKE APPLICATION] for a
4 certificate [CERTIFICATES] of need required by this chapter, establish the amount of
5 variation that may occur in an activity authorized by a certificate of need without requiring
6 a modification of the certificate, [AND THAT] govern the review of those applications by the
7 department [OFFICE], establish requirements for a uniform statewide system of reporting
8 financial and other operating data, establish reasonable fees for applications and other
9 services, and otherwise carry out the purposes of this chapter.

10 * Sec. 16. AS 18.07.111 is repealed and reenacted to read:

11 Sec. 18.07.111. DEFINITIONS. In this chapter

12 (1) "category of health services" means a service that is recognized as a distinct
13 service for the purposes of health care facility licensure and certification under regulations
14 adopted under AS 18.20.010 - 18.20.130, except that "service" does not include the lawful
15 practice of a profession or vocation conducted independently of a health care facility and in
16 accordance with applicable licensing laws of the state;

17 (2) "certificate" means a certificate of need;

18 (3) "certificate of need" means a written order of the department that sets out the
19 affirmative findings that a proposed activity sufficiently satisfies the plans and criteria prescribed
20 for such an activity by this chapter and by department regulations and that permits the certificate
21 holder to proceed with the activity;

22 (4) "commencement of activities" means, with the intent to continue until it is
23 completed,

24 (A) the visible commencement of actual operations, on the ground, which
25 is readily recognizable as such, for the construction of a building, the alteration of the bed
26 capacity of a health care facility, or the provision for or deletion of an existing category
27 of health services to consumers; or

28 (B) a significant step toward acquisition of a health care facility;

29 (5) "complete activities" means the substantial performance of the work required
30 to comply with the terms of issuance of the certificate of need that all parties participating in
31 those activities have obligated themselves to perform;

1 (6) "construction" means excavation, erection, alteration, modification,
2 reconstruction, modernization, improvement, extension, or other development by or on behalf of
3 a health care facility and includes the lease or purchase of equipment;

4 (7) "department" means the Department of Health and Social Services;

5 (8) "health care facility" means an institutional health service provider licensed
6 in whole or in part by the state under AS 18.20.010 - 18.20.130, whether public or private,
7 whether a partnership or corporation, whether organized for profit or not, and includes a hospital,
8 psychiatric hospital, substance abuse hospital, tuberculosis hospital, skilled nursing facility,
9 kidney disease treatment center (including freestanding hemodialysis units), intermediate care
10 facility, ambulatory surgical facility, freestanding emergency care facility, osteopathic facility,
11 independent diagnostic laboratory, and central service facility; "health care facility" does not
12 include

13 (A) an Alaska Pioneers' Home administered by the Department of
14 Administration under AS 44.21.020(10) and AS 47.55;

15 (B) the offices of private physicians or dentists, whether in individual or
16 group practice, occupied on a regular basis to perform the range of diagnostic and
17 treatment services usually performed by physicians and dentists on an outpatient basis;

18 (C) office buildings built or leased by or on behalf of a health care facility
19 for the exclusive use of physicians, dentists, and other practitioners of the healing arts,
20 or other investments made by or on behalf of a health care facility, unless capital
21 expenditures or operating expenses will be charged or reimbursed in the future as costs
22 for providing patient services offered by the health care facility; and

23 (9) "person" means an individual, corporation, company, partnership, firm,
24 association, organization, business trust, estate, or government entity, and includes a health care
25 facility.

26 * Sec. 17. AS 18.20.050 is amended to read:

27 Sec. 18.20.050. DENIAL, SUSPENSION, OR REVOCATION OF LICENSE. The
28 department may deny, suspend, or revoke a license in a case in which it finds that there has been
29 a substantial failure to comply with the requirements established under AS 08.64.336,
30 AS 18.07.031 - 18.07.111, or AS 18.20.060 - 18.20.080. The license of a nursing facility, as
31 defined in AS 18.20.390, also may be suspended or revoked by the department under

1 AS 18.20.310(a)(5).

2 * Sec. 18. AS 44.29.100 is amended to read:

3 Sec. 44.29.100. ADVISORY BOARD ON ALCOHOLISM AND DRUG ABUSE. There
4 is established in the Department of Health and Social Services an advisory board on alcoholism
5 and drug abuse. [THE BOARD SHALL FUNCTION AS A STANDING COMMITTEE OF THE
6 STATEWIDE HEALTH COORDINATING COUNCIL ESTABLISHED UNDER AS 18.07.011.]

7 * Sec. 19. AS 47.30.475(b) is amended to read:

8 (b) Money available under this section shall be awarded by the department to applicants
9 on the basis of community need, but only if the award is consistent with the annual
10 implementation plan developed under 42 U.S.C. 300l-2(b)(2) (National Health Resources
11 Planning and Development Act of 1974) by the health systems agency for the health system area
12 in which the applicant is located [AND THE STATE HEALTH PLAN DEVELOPED BY THE
13 STATEWIDE HEALTH COORDINATING COUNCIL UNDER 42 U.S.C. 300m-3(c)(2)(A),] and
14 only after consideration of comment and advice of the Advisory Board on Alcoholism and Drug
15 Abuse. In awarding grants, the department shall further consider the amount of money that is
16 available for all applications and whether an application would contribute to the wise
17 development of a comprehensive program of alcoholic and drug abuse rehabilitation and
18 prevention.

19 * Sec. 20. AS 18.07.011, 18.07.041, 18.07.081(b); AS 18.08.020(2), 18.08.090(11); and
20 AS 18.26.030(a)(4)(B) are repealed.

21 * Sec. 21. This Act takes effect immediately under AS 01.10.070(c).

J-78

HOUSE BILL NO. 69
IN THE LEGISLATURE OF THE STATE OF ALASKA
SEVENTEENTH LEGISLATURE - FIRST SESSION

BY REPRESENTATIVES BOYER, Navarre

Introduced: 1/23/91

Referred: Health, Education and Social Services, Judiciary, Finance

A BILL

FOR AN ACT ENTITLED

1 "An Act relating to state coordination of health planning and development; abolishing the
 2 Statewide Health Coordinating Council; and providing for an effective date."

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

4 * **Section 1.** AS 18.07 is amended by adding a new section to read:

5 Sec. 18.07.005. **LEGISLATIVE PURPOSE.** It is the purpose of this chapter to create
 6 a rational framework for the planning and development of all health care services in the state to
 7 ensure promotion and protection of public health, provide equitable access to health services, and
 8 avoid unnecessary increases in health care costs.

9 * **Sec. 2.** AS 18.07.021 is amended to read:

10 Sec. 18.07.021. **STATE HEALTH PLANNING AND DEVELOPMENT [AGENCY].**
 11 The [OFFICE OF PLANNING AND RESEARCH IN THE] department is responsible for [THE]
 12 state health planning and development, [AGENCY DESIGNATED UNDER 42 U.S.C.
 13 300m(b)(3). THE OFFICE] shall [PERFORM THE FUNCTIONS ENUMERATED UNDER 42
 14 U.S.C. 300m-2,] administer the certificate of need program outlined in AS 18.07.031 - 18.07.111

1 [AS 18.07.041 - 18.07.111], and shall perform other functions prescribed in this chapter.

2 * Sec. 3. AS 18.07.031 is repealed and reenacted to read:

3 Sec. 18.07.031. CERTIFICATE OF NEED REQUIRED. (a) Unless authorized under
4 the terms of a certificate of need issued by the department, a person may not

5 (1) make a capital expenditure of \$1,000,000 or more for construction of a health
6 care facility;

7 (2) convert a building, in whole or in part, for use as a health care facility if the
8 fair market value of the converted part of the building is greater than \$500,000 and the sum of
9 the fair market value plus additional capital expenditures made to facilitate the conversion equals
10 or exceeds \$1,000,000;

11 (3) alter or redistribute the bed capacity of a health care facility by more than 10
12 beds or 10 percent of the number of beds in the facility, whichever is fewer;

13 (4) add or eliminate a category of health services to or from those provided by
14 the health care facility; or

15 (5) acquire a health care facility at a cost of \$1,000,000 or more.

16 (b) The dollar thresholds in (a) of this section apply to total anticipated costs. Costs of
17 constructing or acquiring a health care facility may not be artificially divided, fragmented, or
18 structured to circumvent the requirements of this section.

19 * Sec. 4. AS 18.07.035 is amended to read:

20 Sec. 18.07.035. APPLICATION AND FEES. Application for a certificate of need shall
21 be made to the department upon a form provided by the department and must contain the
22 information the department requires to reach a decision under AS 18.07.031 - 18.07.111
23 [AS 18.07.041 - 18.07.111]. Each application for a certificate of need must be accompanied by
24 an application fee established by the department by regulation.

25 * Sec. 5. AS 18.07.051 is amended by adding a new subsection to read:

26 (b) A certificate of need is valid only for the defined scope, physical location, and person
27 stated in the certificate.

28 * Sec. 6. AS 18.07.061 is amended to read:

29 Sec. 18.07.061. MODIFICATION AND TERMINATION OF ACTIVITIES. The
30 certificate holder shall apply to the department [OFFICE] for a modification of the certificate
31 [BEFORE TERMINATING PART OF THE ACTIVITIES AUTHORIZED BY THE TERMS OF

1 ISSUANCE, BUT THE CERTIFICATE HOLDER IS NOT REQUIRED TO OBTAIN THE
2 ACQUIESCENCE OF THE OFFICE] before transferring the certificate or modifying or
3 terminating all or part of the activities authorized by the certificate. If a certificate holder
4 intends to terminate [TERMINATES] all of the activities authorized by a certificate, the
5 certificate holder is required to apply to [NOTIFY] the department [OFFICE] 60 days before
6 termination and to surrender the certificate to the department [OFFICE] within 30 days after
7 [OF] termination.

8 * Sec. 7. AS 18.07.061 is amended by adding new subsections to read:

9 (b) An application for transfer of a certificate shall be made on forms provided by the
10 department and must contain

11 (1) evidence, of the type the department may require by regulation, that the
12 transferee is able to assume ownership or operation of the health care facility and to provide the
13 appropriate health services;

14 (2) evidence that the transferee is acquiring the health care facility at no more
15 than its current fair market value; and

16 (3) other information that the department may require.

17 (c) Transfer of a certificate is subject to conditions the department considers necessary.

18 * Sec. 8. AS 18.07.071 is repealed and reenacted to read:

19 Sec. 18.07.071. EMERGENCY CERTIFICATES. (a) The department shall expedite
20 review of an application for a certificate of need under AS 18.07.031(a)(1) that is required to

21 (1) eliminate or prevent imminent safety hazards as defined by a federal, state,
22 or local fire, building, or life safety code or regulation;

23 (2) comply with state licensure standards; or

24 (3) comply with accreditation standards, compliance with which is required to
25 receive federal reimbursement.

26 (b) An application approved under (a) of this section may be approved only to the extent
27 that the capital expenditure is required to eliminate or prevent the hazards or to comply with the
28 standards described in (a) of this section.

29 * Sec. 9. AS 18.07 is amended by adding a new section to read:

30 Sec. 18.07.079. FINAL DECISION. (a) Within 150 days after it determines that it has
31 received a complete application, the department shall take one or more of the following actions:

1 (1) approve part or all of the application and issue a certificate of need that
2 includes conditions that the department considers appropriate; the conditions must be directly
3 related to the activities for which the application was made;

4 (2) deny a certificate of need;

5 (3) recommend modifications to the application; if the applicant agrees to modify
6 the application, the department may defer a final decision on the application for 30 days after
7 receiving the modified application and all additional information to support the modifications;
8 deferral for more than 30 days under this paragraph may be made by the department only after
9 written findings that there is good cause for deferring the decision and that deferral is in the
10 public interest.

11 (b) The department shall send the final written findings and decision to the applicant and
12 to other persons who request a copy of the findings and decision. If the final decision is to
13 approve an application, the department shall issue a certificate of need to the applicant.

14 * Sec. 10. AS 18.07.081(a) is amended to read:

15 (a) The department [OFFICE], a member of the public who is substantially affected by
16 activities authorized by the certificate, [OR] another applicant for a certificate of need, or a
17 health care facility that either provides services similar to the proposed activity or has
18 indicated to the department in writing within the year preceding the decision to grant the
19 certificate an intention to provide similar services to a health service population that
20 includes all or part of the health service population served under the certificate of need may
21 request [INITIATE] a hearing to obtain modification, suspension or revocation of an existing
22 certificate of need by filing an accusation with the department [COMMISSIONER] as prescribed
23 under AS 44.62.360. A revocation, modification, or suspension of an outstanding certificate may
24 not be undertaken unless it is in accordance with AS 44.62.330 - 44.62.630.

25 * Sec. 11. AS 18.07.081(c) is amended to read:

26 (c) A certificate of need shall be suspended if an accusation is filed before the
27 commencement of activities authorized under AS 18.07.079 [AS 18.07.041] that charges that
28 factors upon which the certificate of need was issued have changed [,] or new factors have been
29 discovered that significantly alter the need for the activity authorized. [A SUSPENSION OF A
30 CERTIFICATE MAY NOT EXCEED 60 DAYS. AT THE END OF THIS PERIOD OR
31 SOONER, THE OFFICE SHALL REVOKE OR REINSTATE THE CERTIFICATE].

1 * Sec. 12. AS 18.07.081(d) is amended to read:

2 (d) A certificate of need may be revoked if

3 (1) the certificate holder [SPONSOR] has not shown continuing progress toward
4 commencement of the activities authorized under AS 18.07.079 within one year after
5 [AS 18.07.041 AFTER SIX MONTHS OF] issuance;

6 (2) the certificate holder [APPLICANT] fails, without good cause, to complete
7 activities authorized by the certificate;

8 (3) the certificate holder [SPONSOR] fails to comply with the provisions of this
9 chapter or regulations adopted under this chapter;

10 (4) the certificate holder [SPONSOR] knowingly misrepresents a material fact
11 in obtaining the certificate;

12 (5) the facts charged in an accusation filed under (c) of this section are
13 established; or

14 (6) the certificate holder [SPONSOR] fails to provide services authorized by the
15 terms of the certificate.

16 * Sec. 13. AS 18.07.081(e) is amended to read:

17 (e) A person who files [MAY NOT FILE] an accusation seeking suspension or
18 revocation of a certificate of need under this section, knowing that the charges stated in the
19 accusation are untrue or that the charges do not constitute grounds for revocation or suspension
20 under this chapter, is guilty of a class B misdemeanor.

21 * Sec. 14. AS 18.07.091 is repealed and reenacted to read:

22 Sec. 18.07.091. REPORTING REQUIREMENTS, PENALTIES, AND INJUNCTION.

23 (a) The department shall require all health care facilities operating in the state to periodically
24 file reports required by the department by regulation.

25 (b) The department shall require a certificate holder to file with the department,
26 periodically during the development stage and annually after that until completion of the activity
27 authorized under AS 18.07.031, a report demonstrating that the activity is in compliance with all
28 provisions of the certificate of need.

29 (c) If the department finds that a person has substantially failed or refused to comply
30 with AS 18.07.031 - 18.07.111 or a regulation adopted under those sections, the department may
31 take one or more of the following actions:

- 1 (1) issue an order directing the person to stop the questioned activity;
2 (2) deny, suspend, revoke, or modify a construction license required under
3 AS 18.20.020 as related to the questioned activity;
4 (3) suspend a payment to be made by the department to the person for capital and
5 operating expenses relating to the questioned activity;
6 (4) deny, suspend, revoke, or modify a certificate of need; or
7 (5) issue an order against a person who violates a provision of AS 18.07.031 -
8 18.07.111 or a regulation adopted under those sections imposing a civil penalty of not more than
9 \$20,000.

10 (d) Before imposing a sanction listed in (c) of this section, the department shall give
11 reasonable notice of and an opportunity for a hearing.

12 (e) Notwithstanding AS 44.62.330 - 44.62.630, if the department finds that there will be
13 a significant and adverse effect upon the public interest caused by substantial failure or refusal
14 of a person to comply with AS 18.07.031 - 18.07.111 or a regulation adopted under those
15 sections, the department may issue an order that does one or more of the following:

- 16 (1) directs the person to stop the questioned activity;
17 (2) suspends a construction license required under AS 18.20.020 as related to the
18 questioned activity; or
19 (3) suspends a payment to be made by the department to the person for capital
20 and operating expenses relating to the questioned activity.

21 (f) Notwithstanding AS 44.62.330 - 44.62.630, an order under (e) of this section takes
22 effect immediately upon service by the department and remains in effect pending the decision
23 after any hearing that may have been requested unless the person served can demonstrate to the
24 department's satisfaction that the questioned activity is not subject to the application and review
25 requirements of AS 18.07.031 - 18.07.111, or that the person would likely prevail on the merits
26 and that ~~allowing~~ the activity to continue is in the public interest.

27 (g) Injunctive relief against a violation of AS 18.07.031 - 18.07.111 or regulation
28 adopted under those sections may be obtained from a court of competent jurisdiction by the
29 department, a certificate holder who is adversely affected by the violation, or a member of the
30 public substantially and adversely affected by the violation.

31 * Sec. 15. AS 18.07.101 is amended to read:

1 Sec. 18.07.101. REGULATIONS. The department [COMMISSIONER] shall adopt, in
2 accordance with the Administrative Procedure Act (AS 44.62), regulations that establish
3 procedures under which a person [SPONSORS] may apply [MAKE APPLICATION] for a
4 certificate [CERTIFICATES] of need required by this chapter, establish the amount of
5 variation that may occur in an activity authorized by a certificate of need without requiring
6 a modification of the certificate, [AND THAT] govern the review of those applications by the
7 department [OFFICE], establish requirements for a uniform statewide system of reporting
8 financial and other operating data, establish reasonable fees for applications and other
9 services, and otherwise carry out the purposes of this chapter.

10 * Sec. 16. AS 18.07.111 is repealed and reenacted to read:

11 Sec. 18.07.111. DEFINITIONS. In this chapter

12 (1) "category of health services" means a service that is recognized as a distinct
13 service for the purposes of health care facility licensure and certification under regulations
14 adopted under AS 18.20.010 - 18.20.130, except that "service" does not include the lawful
15 practice of a profession or vocation conducted independently of a health care facility and in
16 accordance with applicable licensing laws of the state;

17 (2) "certificate" means a certificate of need;

18 (3) "certificate of need" means a written order of the department that sets out the
19 affirmative findings that a proposed activity sufficiently satisfies the plans and criteria prescribed
20 for such an activity by this chapter and by department regulations and that permits the certificate
21 holder to proceed with the activity;

22 (4) "commencement of activities" means, with the intent to continue until it is
23 completed,

24 (A) the visible commencement of actual operations, on the ground, which
25 is readily recognizable as such, for the construction of a building, the alteration of the bed
26 capacity of a health care facility, or the provision for or deletion of an existing category
27 of health services to consumers; or

28 (B) a significant step toward acquisition of a health care facility;

29 (5) "complete activities" means the substantial performance of the work required
30 to comply with the terms of issuance of the certificate of need that all parties participating in
31 those activities have obligated themselves to perform;

1 (6) "construction" means excavation, erection, alteration, modification,
2 reconstruction, modernization, improvement, extension, or other development by or on behalf of
3 a health care facility and includes the lease or purchase of equipment;

4 (7) "department" means the Department of Health and Social Services;

5 (8) "health care facility" means an institutional health service provider licensed
6 in whole or in part by the state under AS 18.20.010 - 18.20.130, whether public or private,
7 whether a partnership or corporation, whether organized for profit or not, and includes a hospital,
8 psychiatric hospital, substance abuse hospital, tuberculosis hospital, skilled nursing facility,
9 kidney disease treatment center (including freestanding hemodialysis units), intermediate care
10 facility, ambulatory surgical facility, freestanding emergency care facility, osteopathic facility,
11 independent diagnostic laboratory, and central service facility; "health care facility" does not
12 include

13 (A) an Alaska Pioneers' Home administered by the Department of
14 Administration under AS 44.21.020(10) and AS 47.55;

15 (B) the offices of private physicians or dentists, whether in individual or
16 group practice, occupied on a regular basis to perform the range of diagnostic and
17 treatment services usually performed by physicians and dentists on an outpatient basis;

18 (C) office buildings built or leased by or on behalf of a health care facility
19 for the exclusive use of physicians, dentists, and other practitioners of the healing arts,
20 or other investments made by or on behalf of a health care facility, unless capital
21 expenditures or operating expenses will be charged or reimbursed in the future as costs
22 for providing patient services offered by the health care facility; and

23 (9) "person" means an individual, corporation, company, partnership, firm,
24 association, organization, business trust, estate, or government entity, and includes a health care
25 facility.

26 * Sec. 17. AS 18.20.050 is amended to read:

27 Sec. 18.20.050. DENIAL, SUSPENSION, OR REVOCATION OF LICENSE. The
28 department may deny, suspend, or revoke a license in a case in which it finds that there has been
29 a substantial failure to comply with the requirements established under AS 08.64.336,
30 AS 18.07.031 - 18.07.111, or AS 18.20.060 - 18.20.080. The license of a nursing facility, as
31 defined in AS 18.20.390, also may be suspended or revoked by the department under

1 AS 18.20.310(a)(5).

2 * Sec. 18. AS 44.29.100 is amended to read:

3 Sec. 44.29.100. ADVISORY BOARD ON ALCOHOLISM AND DRUG ABUSE. There
4 is established in the Department of Health and Social Services an advisory board on alcoholism
5 and drug abuse. [THE BOARD SHALL FUNCTION AS A STANDING COMMITTEE OF THE
6 STATEWIDE HEALTH COORDINATING COUNCIL ESTABLISHED UNDER AS 18.07.011.]

7 * Sec. 19. AS 47.30.475(b) is amended to read:

8 (b) Money available under this section shall be awarded by the department to applicants
9 on the basis of community need, but only if the award is consistent with the annual
10 implementation plan developed under 42 U.S.C. 3001-2(b)(2) (National Health Resources
11 Planning and Development Act of 1974) by the health systems agency for the health system area
12 in which the applicant is located [AND THE STATE HEALTH PLAN DEVELOPED BY THE
13 STATEWIDE HEALTH COORDINATING COUNCIL UNDER 42 U.S.C. 300m-3(c)(2)(A),] and
14 only after consideration of comment and advice of the Advisory Board on Alcoholism and Drug
15 Abuse. In awarding grants, the department shall further consider the amount of money that is
16 available for all applications and whether an application would contribute to the wise
17 development of a comprehensive program of alcoholic and drug abuse rehabilitation and
18 prevention.

19 * Sec. 20. AS 18.07.011, 18.07.041, 18.07.081(b); AS 18.08.020(2), 18.08.090(11); and
20 AS 18.26.030(a)(4)(B) are repealed.

21 * Sec. 21. This Act takes effect immediately under AS 01.10.070(c).

SENATE BILL NO. 138

IN THE LEGISLATURE OF THE STATE OF ALASKA

SEVENTEENTH LEGISLATURE - FIRST SESSION

BY SENATOR ZHAROFF

Introduced: 2/22/91

Referred: HES and Finance

Funding Information: General Fund \$3,000,000

Other Funds -0-

\$3,000,000

A BILL

FOR AN ACT ENTITLED

1 "An Act making an appropriation for a grant to the City of Unalaska for the Unalaska
 2 Health Care Clinic facility; and providing for an effective date."

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

4 * Section 1. The sum of \$3,000,000 is appropriated from the general fund to the Department of
 5 Administration for payment as a grant under AS 37.05.315 to the City of Unalaska for planning, design,
 6 and construction of the Unalaska Health Care Clinic facility.

7 * Sec. 2. This Act takes effect immediately under AS 01.10.070(c).

HOUSE BILL NO. 173
IN THE LEGISLATURE OF THE STATE OF ALASKA
SEVENTEENTH LEGISLATURE - FIRST SESSION

BY REPRESENTATIVES JACKO, C.Davis

Introduced: 2/27/91

Referred: Health, Education and Social Services, Finance

Funding Information:	General Fund	\$3,000,000
	Other Funds	<u>-0-</u>
		\$3,000,000

A BILL

FOR AN ACT ENTITLED

1 "An Act making an appropriation for a grant to the City of Unalaska for the Unalaska
2 Health Care Clinic facility; and providing for an effective date."

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

4 * Section 1. The sum of \$3,000,000 is appropriated from the general fund to the Department of
5 Administration for payment as a grant under AS 37.05.315 to the City of Unalaska for planning, design,
6 and construction of the Unalaska Health Care Clinic facility.

7 * Sec. 2. This Act takes effect immediately under AS 01.10.070(c).

SENATE BILL NO. 210

IN THE LEGISLATURE OF THE STATE OF ALASKA

SEVENTEENTH LEGISLATURE - FIRST SESSION

BY SENATORS FRANK, Fahrenkamp

Introduced: 3/15/91

Referred: HES and Finance

Funding Information:	General Fund	\$11,000,000
	Other Funds	<u>-0-</u>
		\$11,000,000

A BILL

FOR AN ACT ENTITLED

1 "An Act making an appropriation for a long-term health care facility in Fairbanks; and
2 providing for an effective date."

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

4 * Section 1. The sum of \$11,000,000 is appropriated from the general fund to the Department of
5 Health and Social Services for payment as a grant under AS 37.05.316 to the Greater Fairbanks
6 Community Hospital Foundation, Inc., for the planning, design, engineering, and construction of a
7 regional long-term health care facility in Fairbanks.

8 * Sec. 2. The appropriation made by this Act is for a capital project and is subject to AS 37.25.020.

9 * Sec. 3. This Act takes effect July 1, 1991.

HOUSE BILL NO. 6
IN THE LEGISLATURE OF THE STATE OF ALASKA
SEVENTEENTH LEGISLATURE - FIRST SESSION

BY REPRESENTATIVES BOYER, Koponen, Sharp, Moyer

Introduced: 1/21/91

Referred: Health, Education and Social Services, Finance

Funding Information:	General Fund	\$11,000,000
	Other Funds	<u>-0-</u>
		\$11,000,000

A BILL
FOR AN ACT ENTITLED

1 "An Act making an appropriation for a long-term health care facility in Fairbanks; and
2 providing for an effective date."

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

4 * Section 1. The sum of \$11,000,000 is appropriated from the general fund to the Department of
5 Administration for payment as a grant under AS 37.05.315 to the Fairbanks North Star Borough for a
6 grant to the Greater Fairbanks Community Hospital Foundation for the planning, design, engineering,
7 and construction of a regional long-term health care facility in Fairbanks.

8 * Sec. 2. For the purposes of AS 37.05.315(b), the appropriation made by sec. 1 of this Act is for
9 a grant to a municipality for construction of a public facility.

10 * Sec. 3. This Act takes effect July 1, 1991.

SENATE BILL NO. 239**IN THE LEGISLATURE OF THE STATE OF ALASKA****SEVENTEENTH LEGISLATURE - FIRST SESSION****BY THE SENATE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE**

Introduced: 4/5/91

Referred: HES, L&C, Finance

A BILL**FOR AN ACT ENTITLED**

1 "An Act providing for the licensing and regulation of private health care review agents;
2 and providing for an effective date."

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

4 * Section 1. AS 08.01.010 is amended by adding a new paragraph to read:

5 (33) regulation of private review agents under AS 08.85.

6 * Sec. 2. AS 08 is amended by adding a new chapter to read:

7 **CHAPTER 85. PRIVATE REVIEW AGENTS.**

8 **Sec. 08.85.010. PURPOSE.** The purpose of this chapter is to

9 (1) promote the delivery of quality health care in a cost-effective and efficient
10 manner;

11 (2) foster greater coordination between those paying for health care services and
12 health care providers in the conduct of utilization review activities;

13 (3) assure protection for patients, state employers, and health care providers by
14 ensuring that private health care review agents are qualified to perform utilization review

1 activities and to make informed decisions on the appropriateness of medical care; and

2 (4) ensure that private review agents maintain the confidentiality of medical
3 records in accordance with applicable state and federal laws.

4 Sec. 08.85.020. LICENSE REQUIRED. (a) A person who is affiliated with, under
5 contract to, or acting on behalf of a health care insurer or a person doing business in the state,
6 whether or not for profit, may not perform a utilization review in this state unless a private
7 review agent license is held by the person, the person's employer, or another for whom the
8 person is providing those services under contract. This section does not apply to a person
9 affiliated with a hospital.

10 (b) The department shall issue a license to an applicant that meets the requirements of
11 this chapter and regulations adopted under this chapter.

12 (c) A license issued under this chapter is not transferable and expires biennially on a date
13 determined by the department.

14 Sec. 08.85.030. APPLICATION FOR LICENSE. (a) An applicant for a private review
15 agent license shall submit an application to the department and pay an application fee set by
16 regulation. The application must be on a form approved by the department.

17 (b) An applicant is entitled to a license if the applicant submits and the department
18 approves a utilization review plan that will be provided to patients and providers that includes

19 (1) the specific review standards, criteria, and procedures to be used in evaluating
20 hospital or outpatient care that has been proposed or is being or has been delivered;

21 (2) those circumstances under which utilization review may be delegated to a
22 hospital utilization review program;

23 (3) the provisions by which patients or providers may seek prompt reconsideration
24 or appeal of adverse decisions by the private review agent and the time period in which the
25 private review agent must respond to the request for reconsideration or appeal;

26 (4) the number, type, and qualifications of the personnel employed by or under
27 contract with the private review agent to perform the utilization review including

28 (A) the requirement that a private review agent have available the services
29 of sufficient numbers of registered nurses with masters degrees, or similarly qualified
30 persons, supported and supervised by physicians trained in the appropriate specialty area,
31 to carry out its utilization review activities, or to have appropriate numbers of physicians

1 trained in the appropriate specialties for which utilization review is being conducted; and
2 (B) a requirement that only a physician trained in a relevant specialty or
3 subspecialty and licensed in the state be permitted to make a final determination that care
4 rendered, being rendered, or to be rendered in that specialty or subspecialty is medically
5 inappropriate;

6 (5) the procedures and policies to ensure that a representative of the private
7 review agent is reasonably accessible to patients and providers at least five days a week during
8 normal business hours and that payment will not be denied for treatment rendered

9 (A) during a period when a private review agent is not accessible; or

10 (B) when the appeal of an adverse decision is pending;

11 (6) the requirement that, except in exceptional circumstances, a determination that
12 care rendered, being rendered, or to be rendered is medically inappropriate may not be made until
13 an appropriately qualified review physician has conferred with the patient's attending physician
14 and reviewed all pertinent information concerning the medical care delivered or proposed;

15 (7) the requirement that a determination that care rendered, being rendered, or to
16 be rendered is medically inappropriate must include the written evaluation and findings of the
17 reviewing physician;

18 (8) the procedures and policies to ensure that all applicable state and federal laws
19 to protect the confidentiality of individual medical records are followed;

20 (9) prohibitions against a private review agent entering a hospital to interview a
21 patient unless the attending physician is advised of the interview with reasonable advance notice,
22 and the attending physician or the physician's designee is allowed to attend the interview;

23 (10) a prohibition against an incentive payment provision or plan contained in a
24 private review agent's contract with an entity paying for health care services under which the
25 agent's compensation is based on controlling the amount charged for services, duration of
26 services, or setting in which services are rendered and a prohibition against the agent receiving
27 the incentive payment;

28 (11) a copy of the written material intended to be sent to patients and providers
29 to inform them of the requirements of the utilization review plan;

30 (12) a list of the health care insurers for which the private review agent is
31 performing utilization review in the state and a brief description of the services it is providing

1 for each client, including an affirmation that a payment incentive provision or plan designed to
2 control the amount, duration, or setting in which services are rendered does not exist with respect
3 to each client;

4 (13) evidence of liability insurance carried by the private review agent to cover
5 potential liability from its activities under this chapter in an amount, type, nature, and carrier
6 satisfactory to the department;

7 (14) provisions that, in the absence of fraud, prohibit retrospective denial of
8 payment for treatment after it has been initially approved by the private review agent;

9 (15) other information the department determines to be appropriate.

10 Sec. 08.85.040. RENEWAL OF LICENSE. (a) The department shall renew the license
11 of a private review agent holding a license under AS 08.85.020 if, before the license expires, the
12 agent

13 (1) files an application for renewal, including the information required under
14 AS 08.85.030(b), and submits the appropriate renewal fee; and

15 (2) meets the qualifications for issuance of a license under AS 08.85.020(b).

16 (b) An application for renewal of a private review agent license must include a list of
17 all complaints made to the agent by patients or providers and a brief description of how the
18 complaints were resolved, including the nature of the complaint, the review process, and the time
19 between the filing of the complaint and its resolution.

20 Sec. 08.85.050. DENIAL OF LICENSE OR RENEWAL APPLICATION. (a) Before
21 denying an application for a private review agent license or for renewal of a license, the
22 department shall provide the applicant with reasonable time to supply additional documentation
23 establishing that the applicant is entitled to a license or to renewal of a license.

24 (b) An applicant who is denied a license or renewal of a license shall be afforded the
25 opportunity for a hearing. The hearing shall be conducted by the department. The hearing shall
26 be held in accordance with AS 44.62.330 - 44.62.630.

27 Sec. 08.85.060. REVOCATION OF LICENSE. (a) The department may revoke a
28 license if the holder fails to comply with a utilization review plan filed by the holder under
29 AS 08.85.030(b) or otherwise violates a provision of this chapter or a regulation adopted under
30 this chapter.

31 (b) Before revoking a license under this section, the department shall provide the license

1 holder with reasonable time to supply additional information demonstrating the holder's
2 compliance with the requirements of this chapter.

3 (c) A license holder whose license is proposed for revocation by the department shall be
4 afforded the opportunity for a hearing. The hearing shall be held in accordance with
5 AS 44.62.330 - 44.62.630.

6 Sec. 08.85.070. COMPLAINTS AGAINST LICENSE HOLDER. (a) A patient or
7 provider may file a complaint with the department alleging that a private review agent is not in
8 compliance with this chapter or the regulations adopted under this chapter or with other
9 applicable federal or state law. The complaint may request that the department revoke the license
10 of the agent or require that the agent demonstrate to the department proof of compliance.

11 (b) Proceedings under this section shall be conducted in accordance with AS 44.62.330 -
12 44.62.630.

13 (c) If the department fails to render a decision on a complaint brought by a patient or
14 provider within 90 days, the patient or provider shall have the right to bring suit in the superior
15 court to compel the department to take an action specified in (a) of this section.

16 (d) This section may not be construed to deprive a patient, a provider, a private review
17 agent, or a health care insurer of a right available under other provisions of law.

18 Sec. 08.85.080. REGULATIONS. The department shall adopt regulations to implement
19 the provisions of this chapter, including regulations

20 (1) establishing license application and renewal fees in an amount sufficient to
21 pay for the costs to the department of administering this chapter;

22 (2) establishing rules of procedure consistent with AS 44.62.330 - 44.62.630.

23 Sec. 08.85.090. EXEMPTION. A private review agent that operates solely under contract
24 with the federal government or an agency of the federal government for utilization review of
25 patients eligible for health related services under 42 U.S.C. 1395 - 1395ccc (Subchapter XVIII
26 of the Social Security Act), 42 U.S.C. 1396 - 1396s (Subchapter XIX of the Social Security Act),
27 and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) is exempt
28 from the licensing requirements of this chapter.

29 Sec. 08.85.100. LIST OF PRIVATE REVIEW AGENTS. The department shall
30 periodically provide a list of licensed private review agents and the expiration date for their
31 licenses to all hospital utilization review programs and to other individuals or organizations

1 requesting the list. The department may charge a reasonable fee for providing the list.

2 Sec. 08.85.110. PATIENT CONFIDENTIALITY AND RECORDS. (a) A private review
3 agent may not disclose or publish individual medical records or other confidential information
4 obtained in the performance of activities as a private review agent, except that an agent may
5 provide patient information to a third party to which the agent is under contract or with which
6 it is affiliated.

7 (b) A person seeking payment of a reimbursement for hospital or medical services may
8 not invoke the privilege of confidentiality arising from a physician-patient relationship to
9 withhold pertinent information from review of those services by a private review agent.

10 (c) Notwithstanding the provisions of this chapter or another law, a patient is entitled to
11 inspect and copy records developed or maintained by a private review agent pertaining to the
12 health care rendered, being rendered, or proposed to be rendered to the patient.

13 (d) This chapter may not be construed to allow a private review agent to take actions that
14 violate a state or federal statute or regulation concerning confidentiality of patient records.

15 Sec. 08.85.150. DEFINITIONS. In this chapter,

16 (1) "department" means the Department of Commerce and Economic
17 Development;

18 (2) "health care insurer" means a person in the business of making payments for
19 the medical care of others, and includes an insurance company, a nonprofit health service plan,
20 a health maintenance organization, a preferred provider organization, an employee assistance
21 program, and a health insurance service organization;

22 (3) "private review agent" means a person who performs a utilization review and
23 who is affiliated with, under contract to, or acting on behalf of a person doing business in the
24 state, whether or not for profit, or of a health care insurer, but who is not affiliated with a
25 hospital;

26 (4) "provider" means a health care provider as defined in AS 18.23.070;

27 (5) "utilization review" means a system for reviewing the appropriate and efficient
28 allocation of hospital and outpatient resources and services given, being given, or proposed to
29 be given to a patient or group of patients, including the approval or denial, or recommendation
30 of approval or denial, of payment for hospital or medical services;

31 (6) "utilization review plan" means a description of the criteria, procedures, and

1 standards governing utilization review activities performed by a private review agent.

2 * Sec. 3. AS 44.62.330(a) is amended by adding a new paragraph to read:

3 (57) Department of Commerce and Economic Development concerning the
4 licensing and regulation of private review agents under AS 08.85.

5 * Sec. 4. AS 08.85.080 and 08.85.150, enacted by sec. 2 of this Act, take effect immediately under
6 AS 01.10.070(c).

CS FOR HOUSE BILL NO. 269 (HES)

IN THE LEGISLATURE OF THE STATE OF ALASKA

SEVENTEENTH LEGISLATURE - FIRST SESSION

BY THE HOUSE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

Offered: 5/3/91

Referred: Labor & Commerce, Finance

Sponsor(s): REPRESENTATIVES BOYER, Navarre

A BILL

FOR AN ACT ENTITLED

1 "An Act providing for the licensing and regulation of private health care review agents;
2 and providing for an effective date."

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

4 * Section 1. AS 08.01.010 is amended by adding a new paragraph to read:

5 (33) regulation of private review agents under AS 08.85.

6 * Sec. 2. AS 08 is amended by adding a new chapter to read:

7 CHAPTER 85. PRIVATE REVIEW AGENTS.

8 Sec. 08.85.010. PURPOSE. The purpose of this chapter is to

- 9 (1) promote the delivery of quality health care in a cost-effective and efficient
10 manner;
11 (2) foster greater coordination between those paying for health care services and
12 health care providers in the conduct of utilization review activities;
13 (3) assure protection for patients, state employers, and health care providers by
14 ensuring that private health care review agents are qualified to perform utilization review

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1 activities and to make informed decisions on the appropriateness of medical care; and

2 (4) ensure that private review agents maintain the confidentiality of medical
3 records in accordance with applicable state and federal laws.

4 Sec. 08.85.020. LICENSE REQUIRED. (a) A person who is affiliated with, under
5 contract to, or acting on behalf of a health care insurer or a person doing business in the state,
6 whether or not for profit, may not perform a utilization review in this state unless a private
7 review agent license is held by the person, the person's employer, or another for whom the
8 person is providing those services under contract. This section does not apply to a person
9 affiliated with a hospital.

10 (b) The department shall issue a license to an applicant that meets the requirements of
11 this chapter and regulations adopted under this chapter.

12 (c) A license issued under this chapter is not transferable and expires biennially on a date
13 determined by the department.

14 Sec. 08.85.030. APPLICATION FOR LICENSE. (a) An applicant for a private review
15 agent license shall submit an application to the department and pay an application fee set by
16 regulation. The application must be on a form approved by the department.

17 (b) An applicant is entitled to a license if the applicant submits and the department
18 approves a utilization review plan that will be provided to patients and providers that includes

19 (1) the review standards, criteria, and procedures to be used in evaluating hospital
20 or outpatient care that has been proposed or is being or has been delivered;

21 (2) those circumstances under which utilization review may be delegated to a
22 hospital utilization review program;

23 (3) the provisions by which patients or providers may seek prompt reconsideration
24 or appeal of adverse decisions by the private review agent and the time period in which the
25 private review agent must respond to the request for reconsideration or appeal;

26 (4) the number, type, and qualifications of the personnel employed by or under
27 contract with the private review agent to perform the utilization review including

28 (A) the requirement that a private review agent have available the services
29 of sufficient numbers of registered nurses, supported and supervised by physicians trained
30 in the appropriate specialty area, to carry out its utilization review activities, or to have
31 appropriate numbers of physicians trained in the appropriate specialties for which

1 utilization review is being conducted; and

2 (B) a requirement that only a physician trained in a relevant specialty or
3 subspecialty be permitted to make a final determination that care rendered, being
4 rendered, or to be rendered in that specialty or subspecialty is medically inappropriate;

5 (5) the procedures and policies to ensure that a representative of the private
6 review agent is reasonably accessible to patients and providers at least five days a week during
7 normal business hours in this state and that payment will not be denied for treatment rendered
8 that is found to be medically appropriate and within policy coverage;

9 (6) the requirement that, except in exceptional circumstances, a determination that
10 care rendered, being rendered, or to be rendered is medically inappropriate may not be made until
11 an appropriately qualified review physician has conferred with the patient's attending physician
12 and reviewed pertinent information concerning the medical care delivered or proposed;

13 (7) the requirement that a determination that care rendered, being rendered, or to
14 be rendered is medically inappropriate must include the written evaluation and findings of the
15 reviewing physician;

16 (8) the procedures and policies to ensure that all applicable state and federal laws
17 to protect the confidentiality of individual medical records are followed;

18 (9) prohibitions against a private review agent entering a hospital to interview a
19 patient unless the attending physician is advised of the interview with reasonable advance notice.
20 and the attending physician or the physician's designee is allowed to attend the interview;

21 (10) a prohibition against an incentive payment provision or plan contained in a
22 private review agent's contract with an entity paying for health care services under which the
23 agent's compensation is based on controlling the amount charged for services, duration of
24 services, or setting in which services are rendered and a prohibition against the agent receiving
25 the incentive payment;

26 (11) a copy of the written material intended to be sent to patients and providers
27 to inform them of the requirements of the utilization review plan;

28 (12) a list of the health care insurers for which the private review agent is
29 performing utilization review in the state and a brief description of the services it is providing
30 for each client, including an affirmation that a payment incentive provision or plan designed to
31 control the amount, duration, or setting in which services are rendered does not exist with respect

1 to each client;

2 (13) evidence of liability insurance carried by the private review agent to cover
3 potential liability from its activities under this chapter in an amount, type, nature, and carrier
4 satisfactory to the department;

5 (14) provisions that, in the absence of fraud, prohibit retrospective denial of
6 payment for treatment, except in cases of policy limitations or exclusions, after it has been
7 initially approved by the private review agent;

8 (15) other information the department determines to be appropriate.

9 Sec. 08.85.040. RENEWAL OF LICENSE. (a) The department shall renew the license
10 of a private review agent holding a license under AS 08.85.020 if, before the license expires, the
11 agent

12 (1) files an application for renewal, including the information required under
13 AS 08.85.030(b), and submits the appropriate renewal fee; and

14 (2) meets the qualifications for issuance of a license under AS 08.85.020(b).

15 (b) An application for renewal of a private review agent license must include a list of
16 all complaints made to the agent by patients or providers and a brief description of how the
17 complaints were resolved, including the nature of the complaint, the review process, and the time
18 between the filing of the complaint and its resolution.

19 Sec. 08.85.050. DENIAL OF LICENSE OR RENEWAL APPLICATION. (a) Before
20 denying an application for a private review agent license or for renewal of a license, the
21 department shall provide the applicant with reasonable time to supply additional documentation
22 establishing that the applicant is entitled to a license or to renewal of a license.

23 (b) An applicant who is denied a license or renewal of a license shall be afforded the
24 opportunity for a hearing. The hearing shall be conducted by the department. The hearing shall
25 be held in accordance with AS 44.62.330 - 44.62.630.

26 Sec. 08.85.060. REVOCATION OF LICENSE. (a) The department may revoke a
27 license if the holder fails to comply with a utilization review plan filed by the holder under
28 AS 08.85.030(b) or otherwise violates a provision of this chapter or a regulation adopted under
29 this chapter.

30 (b) Before revoking a license under this section, the department shall provide the license
31 holder with reasonable time to supply additional information demonstrating the holder's

1 compliance with the requirements of this chapter.

2 (c) A license holder whose license is proposed for revocation by the department shall be
3 afforded the opportunity for a hearing. The hearing shall be held in accordance with
4 AS 44.62.330 - 44.62.630.

5 Sec. 08.85.070. COMPLAINTS AGAINST LICENSE HOLDER. (a) A patient or
6 provider may file a complaint with the department alleging that a private review agent is not in
7 compliance with this chapter or the regulations adopted under this chapter or with other
8 applicable federal or state law. The complaint may request that the department revoke the license
9 of the agent or require that the agent demonstrate to the department proof of compliance.

10 (b) Proceedings under this section shall be conducted in accordance with AS 44.62.330 -
11 44.62.630.

12 (c) If the department fails to render a decision on a complaint brought by a patient or
13 provider within 90 days, the patient or provider shall have the right to bring suit in the superior
14 court to compel the department to take an action specified in (a) of this section.

15 (d) This section may not be construed to deprive a patient, a provider, a private review
16 agent, or a health care insurer of a right available under other provisions of law.

17 Sec. 08.85.080. REGULATIONS. The department shall adopt regulations to implement
18 the provisions of this chapter, including regulations

19 (1) establishing license application and renewal fees in an amount sufficient to
20 pay for the costs to the department of administering this chapter;

21 (2) establishing rules of procedure consistent with AS 44.62.330 - 44.62.630.

22 Sec. 08.85.090. EXEMPTION. A private review agent that operates solely under contract
23 with the federal government or an agency of the federal government for utilization review of
24 patients eligible for health related services under 42 U.S.C. 1395 - 1395ccc (Subchapter XVIII
25 of the Social Security Act), 42 U.S.C. 1396 - 1396s (Subchapter XIX of the Social Security Act),
26 and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) is exempt
27 from the licensing requirements of this chapter.

28 Sec. 08.85.100. LIST OF PRIVATE REVIEW AGENTS. The department shall
29 periodically provide a list of licensed private review agents and the expiration date for their
30 licenses to all hospital utilization review programs and to other individuals or organizations
31 requesting the list. The department may charge a reasonable fee for providing the list.

1 Sec. 08.85.110. PATIENT CONFIDENTIALITY AND RECORDS. (a) A private review
2 agent may not disclose or publish individual medical records or other confidential information
3 obtained in the performance of activities as a private review agent, except that an agent may
4 provide patient information to a third party to which the agent is under contract or with which
5 it is affiliated.

6 (b) A person seeking payment of a reimbursement for hospital or medical services may
7 not invoke the privilege of confidentiality arising from a physician-patient relationship to
8 withhold pertinent information from review of those services by a private review agent.

9 (c) Notwithstanding the provisions of this chapter or another law, a patient is entitled to
10 inspect and copy records developed or maintained by a private review agent pertaining to the
11 health care rendered, being rendered, or proposed to be rendered to the patient.

12 (d) This chapter may not be construed to allow a private review agent to take actions that
13 violate a state or federal statute or regulation concerning confidentiality of patient records.

14 Sec. 08.85.150. DEFINITIONS. In this chapter,

15 (1) "department" means the Department of Commerce and Economic
16 Development;

17 (2) "health care insurer" means a person in the business of making payments for
18 the medical care of others, and includes an insurance company, a nonprofit health service plan,
19 a health maintenance organization, a preferred provider organization, an employee assistance
20 program, and a health insurance service organization;

21 (3) "private review agent" means a person who performs a utilization review and
22 who is affiliated with, under contract to, or acting on behalf of a person doing business in the
23 state, whether or not for profit, or of a health care insurer, but who is not affiliated with a
24 hospital;

25 (4) "provider" means a health care provider as defined in AS 18.23.070;

26 (5) "utilization review" means a system for reviewing the appropriate and efficient
27 allocation of hospital and outpatient resources and services given, being given, or proposed to
28 be given to a patient or group of patients, including the approval or denial, or recommendation
29 of approval or denial, of payment for hospital or medical services;

30 (6) "utilization review plan" means a description of the criteria, procedures, and
31 standards governing utilization review activities performed by a private review agent.

1 * Sec. 3. AS 44.62.330(a) is amended by adding a new paragraph to read:

2 (57) Department of Commerce and Economic Development concerning the
3 licensing and regulation of private review agents under AS 08.85.

4 * Sec. 4. AS 08.85.080 and 08.85.150, enacted by sec. 2 of this Act, take effect immediately under
5 AS 01.10.070(c).

SENATE BILL NO. 242
IN THE LEGISLATURE OF THE STATE OF ALASKA
SEVENTEENTH LEGISLATURE - FIRST SESSION

BY SENATOR COLLINS

Introduced: 4/5/91
Referred: L&C, HES, Finance

A BILL
FOR AN ACT ENTITLED

1 "An Act relating to health insurance for small employers; and providing for an effective
2 date."

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

4 * Section 1. FINDINGS. The legislature finds that

5 (1) an unacceptable number of residents of this state are without appropriate health care
6 because of the rapid increase in the cost of health care, the lack of access to health care, and the lack
7 of availability of health insurance coverage;

8 (2) maintenance of proper coverage of employees and dependents of employees of small
9 employers under a health benefit plan is important to ensuring the availability of appropriate health care
10 for the residents of this state and provides more stability and predictability of both rate increases and
11 coverage continuation.

12 * Sec. 2. AS 21 is amended by adding a new chapter to read:

13 CHAPTER 55. SMALL EMPLOYER HEALTH INSURANCE.

14 ARTICLE 1. SMALL EMPLOYER HEALTH REINSURANCE ASSOCIATION.

1 Sec. 21.55.010. CREATION; MEMBERSHIP. There is established a nonprofit
2 incorporated legal entity to be known as the Small Employer Health Reinsurance Association.
3 Membership consists of all licensed hospital or medical service corporations in the state that offer
4 subscriber contracts for health benefits, all welfare arrangements, and all insurers licensed to
5 transact health insurance in the state that offer a health benefit plan. All members shall maintain
6 membership in the association as a condition of doing health insurance business, or being able
7 to offer subscriber contracts, in the state.

8 Sec. 21.55.020. BOARD OF DIRECTORS; ORGANIZATION. (a) The board of
9 directors of the association consists of nine individuals selected by participating members, subject
10 to approval by the director. The director or the director's designee shall serve as a nonvoting
11 ex officio member of the board. In approving members of the board, the director shall consider,
12 among other things, whether all types of participating members are fairly represented.

13 (b) To the extent possible, one board member shall represent a health maintenance
14 organization, one board member shall represent a hospital or medical service corporation, at least
15 six board members' principal health insurance business shall be in the small employer market,
16 and one board member's principal health insurance business shall be in the large employer
17 market. Members of the board other than the director or the director's designee may be reim-
18 bursed from the association for expenses incurred by them as members, but may not otherwise
19 be compensated by the association for their services. The costs of conducting meetings of the
20 association and its board of directors shall be borne by the association.

21 Sec. 21.55.030. GENERAL POWERS. The association may

22 (1) exercise the powers granted to insurers under the laws of the state, except that
23 the association may not issue insurance;

24 (2) sue or be sued;

25 (3) enter into contracts with insurers, similar associations in other states, or with
26 other persons for the performance of administrative functions;

27 (4) establish administrative and accounting procedures for the operation of the
28 association;

29 (5) take legal action as necessary to avoid the payment of improper claims against
30 the association;

31 (6) design the array of health coverage products for which reinsurance will be

1 provided and issue reinsurance policies;

2 (7) establish rules, conditions, and procedures pertaining to the reinsurance of
3 members' risks by the association;

4 (8) establish appropriate rates, rate schedules, rate adjustments, rate classifications,
5 and other actuarial functions appropriate to the operation of the association;

6 (9) assess members under the provisions of this chapter and make advance interim
7 assessments as may be reasonable and necessary for organizational and interim operating
8 expenses; interim assessments shall be credited as offsets against regular assessments due
9 following the close of the fiscal year;

10 (10) appoint from among members appropriate legal, actuarial, and other
11 committees as are necessary to provide technical assistance in the operation of the association.

12 Sec. 21.55.040. PLAN OF OPERATION. (a) The association shall submit to the
13 director a plan of operation and amendments necessary or suitable to assure the fair, reasonable,
14 and equitable administration of the association. The plan of operation and amendments become
15 effective upon approval in writing by the director. If the director has not approved or
16 disapproved a plan of operation submitted by the association within 90 days after receiving the
17 plan of operation, the plan of operation is considered approved by the director. If the association
18 fails to submit a suitable plan of operation by a date that is 180 days after the effective date of
19 this Act, or if at subsequent time the association fails to submit suitable amendments to the plan,
20 the director may, after notice and hearing, adopt reasonable regulations necessary or advisable
21 to effectuate the provisions of this chapter. These regulations shall continue in force until mod-
22 ified by the director or superseded by a plan submitted by the association and approved by the
23 director.

24 (b) All members of the association shall comply with the plan of operation.

25 (c) The plan of operation must

26 (1) establish procedures for the performance of the powers and duties of the
27 association under this chapter;

28 (2) establish procedures for handling assets of the association and for an annual
29 fiscal report to the director;

30 (3) establish the amount and method of reimbursing members of the board under
31 AS 21.55.020;

- 1 (4) establish regular places and times for meetings of the board;
- 2 (5) establish procedures for records to be kept of all financial transactions of the
- 3 association, its agents, and the board;
- 4 (6) provide that a member insurer aggrieved by a final action or decision of the
- 5 association may appeal to the director within 30 days after the action or decision;
- 6 (7) establish procedures for the submission to the director of selections for the
- 7 board;
- 8 (8) provide for reinsuring risks under the provisions of this section;
- 9 (9) provide for collecting assessments from all members to provide for claims
- 10 reinsured by the association and for administrative expenses incurred or estimated to be incurred
- 11 during the period for which the assessment is made;
- 12 (10) provide protection for guaranteed issue insurers from the financial risk
- 13 associated with small employers that present poor credit risks;
- 14 (11) establish standards for the coverage of small employers that have high
- 15 employee turnover;
- 16 (12) establish an appeals process for guaranteed issue insurers to seek relief when
- 17 a guaranteed issue insurer has experienced an unfair share of administrative and credit risks;
- 18 (13) determine the adjusted average market premium prices for small employer
- 19 health plans sold in this state;
- 20 (14) establish participation standards at issue and renewal for reinsured cases;
- 21 (15) establish and maintain a list of guaranteed issue insurers;
- 22 (16) establish standards for those conditions under which a guaranteed issue
- 23 insurer would not be required to write business received from a particular agent or broker; and
- 24 (17) provide for selection of an administering insurer and establish the
- 25 administering insurer's powers and duties;
- 26 (18) contain additional provisions necessary or proper for the execution of the
- 27 powers and duties of the association.

28 Sec. 21.55.050. HEALTH CARE REINSURANCE. (a) A member may only reinsure
29 coverage of an eligible employee of a small employer or a dependent of an eligible employee of
30 a small employer with the association under the following provisions:

- 31 (1) regarding a small employer health benefit plan, the association shall reinsure

1 the level of coverage provided;

2 (2) regarding a plan other than a small employer health benefit plan, the
3 association shall reinsure the level of coverage provided up to, but not exceeding, the level of
4 coverage provided in a small employer health benefit plan;

5 (3) regarding the coverage provided to small employers, the insurer or welfare
6 arrangement, or, to the extent permitted under 29 U.S.C. 1001 - 1459, other benefit arrangement
7 shall be required to use high-cost case management, hospital precertification techniques, and other
8 cost containment techniques as established by the association;

9 (4) regarding eligible employees, and their dependents, who are hired subsequent
10 to the commencement of the employer's coverage by an insurer, welfare arrangement, or other
11 benefit arrangement and who are not late enrollees, coverage may be reinsured by a
12 nonguaranteed issue insurer within 60 days of the commencement of coverage under the plan;

13 (5) regarding eligible employees, and their dependents, who are hired subsequent
14 to the commencement of the employer's coverage by a guaranteed issue insurer and who are not
15 late enrollees, coverage may be reinsured by the guaranteed issue insurer

16 (A) within 60 days of the commencement of coverage under the plan; or

17 (B) commencing on a date established by the board but not later than 18
18 months after the association becomes operational on the first plan anniversary after the
19 small employer coverage has been in effect with the small employer for at least three
20 years and every third year anniversary thereafter;

21 (6) regarding eligible employees, and their dependents, who are employed by a
22 small employer as of the date the employer's coverage by the guaranteed issue insurer
23 commences, coverage may be reinsured

24 (A) within 60 days of the commencement of the employer's coverage with
25 the insurer or welfare arrangement, or other benefit arrangement except in the case of late
26 enrollees; or

27 (B) commencing on a date established by the board but not later than 18
28 months after the association becomes operational on the first plan anniversary after the
29 small employer coverage has been in effect with the small employer for at least three
30 years and every third year anniversary thereafter;

31 (7) regarding eligible employees and their dependents, a guaranteed issue insurer

1 may reinsure the entire employer group

2 (A) within 60 days of the commencement of the group's coverage under
3 the plan;

4 (B) in the case where a new entrant to an employer group is reinsured
5 under the provisions of (4) of this subsection, on the first plan anniversary after the new
6 entrant became a member of the employer's plan; or

7 (C) commencing on a date established by the board but not later than 18
8 months after the association becomes operational on the first plan anniversary after the
9 small employer coverage has been in effect with the small employer for at least three
10 years and every third year anniversary thereafter;

11 (8) regarding employees or dependents reinsured under (4), (5), or (6) of this
12 subsection, reinsurance may not be provided until \$5,000 in benefit payments have been made
13 for services provided during that calendar year for that reinsured employee or dependent; in this
14 paragraph "benefit payments" include those payments that would have been reimbursed through
15 reinsurance in the absence of the annual \$5,000 deductible; the amount of the deductible shall
16 be periodically reviewed by the board and may be adjusted for appropriate factors as determined
17 by the board.

18 (b) If an employer group is covered under a plan other than a small employer health plan
19 and the insurer chooses to reinsure the group subsequent to the initial coverage period, or if a
20 new individual joins the group and the insurer wants to reinsure that individual, the insurer may
21 not require the employer to change to a small employer health plan and the insurer shall allow
22 the employer to maintain the same benefit plan and reinsure only the portion of the plan
23 consistent with a small employer health plan.

24 (c) Except as provided in (d) of this section, premium rates charged for coverage
25 reinsured by the association shall be established as follows:

26 (1) for whole group reinsurance coverage, 1.5 multiplied by the adjusted average
27 market premium price established by the association for that classification or group with similar
28 characteristics and coverage, for eligible employees, and dependents of eligible employees, of a
29 small employer all of whose coverage is reinsured with the association, minus a ceding expense
30 factor determined by the association;

31 (2) for individual reinsurance coverage, 5.0 multiplied by the adjusted average

1 market premium price established by the association for an individual in that classification or
2 group with similar characteristics and coverage, with respect to an eligible employee, or the
3 employee's dependents, minus a ceding expense factor determined by the association.

4 (d) Premium rates charged for reinsurance by the association to a health maintenance
5 organization that is approved by the Secretary of Health and Human Services as a federally
6 qualified health maintenance organization under 42 U.S.C. 300 and, as a health maintenance
7 organization, is subject to requirements that limit the amount of risk that may be ceded to the
8 association, may be modified to reflect the portion of risk that may be ceded to the association.

9 (e) If a health benefit plan coverage for a small employer is entirely or partially reinsured
10 with the association, the premium charged to the small employer for a rating period for the
11 coverage issued under this section may not be more than 1.5 times the adjusted average market
12 premium price established by the association for that classification or group with similar
13 characteristics and coverage.

14 (f) In determining the assessment, if any, that is collected from a member, the following
15 provisions apply:

16 (1) following the close of a fiscal year, the administering insurer shall determine
17 the net premiums, the association expenses for administration and the incurred losses, if any, for
18 the year, taking into account investment income and other appropriate gains and losses; for
19 purposes of this subsection, health benefit plan premiums earned by an insurer, welfare
20 arrangement, or other benefit arrangement shall be established by adding paid claim losses and
21 administrative expenses of the insurer, welfare arrangement, or other benefit arrangement; health
22 benefit plan premiums and benefits paid by a member that are less than an amount determined
23 by the board to justify the cost of collection may not be considered for purposes of determining
24 an assessment; in this paragraph, "net premiums" means health benefit plan premiums less
25 administrative expense allowances;

26 (2) a net loss for the year shall be covered first by assessment against members
27 to the extent provided as follows:

28 (A) assessments shall first be apportioned by the board among all
29 members in proportion to the member's respective share of the total premiums net of
30 reinsurance premiums paid for coverage under this chapter earned in this state from health
31 benefit plans covering small employers and to the extent permitted under 29 U.S.C.

1 1001 - 1459, apportioned among other benefit arrangements covering small employers
2 during the calendar year coinciding with or ending during the fiscal year of the
3 association, or apportioned on another equitable basis reflecting coverage of small
4 employers as may be provided in the plan of operation; an assessment shall be made
5 under this subparagraph against a health maintenance organization that is approved by the
6 secretary of health and human services as a federally qualified health maintenance
7 organization under 42 U.S.C. 300e, subject to an assessment adjustment formula adopted
8 by the board and approved by the director for qualified health maintenance organizations
9 that recognizes the restrictions imposed on qualified health maintenance organizations
10 under federal law; the adjustment formula shall be adopted by the board and approved by
11 the director before the first anniversary of the operation of the association;

12 (B) an assessment under (2)(A) of this subsection shall be capped at four
13 percent of premiums charged for health benefit plans covering a small employer;

14 (3) if assessments exceed actual losses and administrative expenses of the
15 association, the excess shall be held in an interest bearing account and used by the board to offset
16 future losses or to reduce association premiums; in this paragraph, "future losses" include a
17 reserve for incurred but not reported claims;

18 (4) the board shall annually determine a member's proportion of participation in
19 the association based on annual statements and other reports determined necessary by the board
20 and filed by the member with the board; an insurer, welfare arrangement, or other benefit
21 arrangement shall report to the board a claim payment made and administrative expense incurred
22 in this state on an annual basis on a form prescribed by the director;

23 (5) the plan of operation must include a provision for the imposition of an interest
24 penalty for late payment of assessments;

25 (6) a member may request a deferment from the director, in whole or in part,
26 from an assessment issued by the board; the director may defer, in whole or in part, the
27 assessment of a member if, in the opinion of the director payment of the assessment would
28 endanger the ability of the member to fulfill the member's contractual obligations;

29 (7) in the event an assessment against a member is deferred in whole or in part,
30 the amount by which the assessment is deferred may be assessed against the other members in
31 a manner consistent with the basis for assessments set out in this subsection; the member

1 receiving a deferment shall remain liable to the association for the amount deferred; the director
2 may attach conditions to a deferment.

3 Sec. 21.55.060. ADMINISTRATIVE PROCEDURE ACT. The association is exempt
4 from the Administrative Procedure Act (AS 44.62).

5 Sec. 21.55.070. TAX EXEMPTION. The association is exempt from the payment of fees
6 and taxes levied by the state or any of its political subdivisions except taxes levied on real or
7 personal property.

8 Sec. 21.55.080. LIMITATION OF LIABILITY. A member of the association is not
9 liable for civil damages resulting from an act or omission of the member on behalf of the
10 association unless the member acts with gross negligence or intentional misconduct.

11 ARTICLE 2. SMALL EMPLOYER HEALTH INSURANCE PLANS.

12 Sec. 21.55.100. APPLICABILITY. (a) An individual or group health benefit plan is
13 subject to the provisions of this chapter if the plan provides health care benefits covering one or
14 more employees of a small employer and if one of the following conditions are met:

15 (1) all or a portion of the premium or benefits is paid by a small employer or a
16 covered individual is reimbursed, through wage adjustments or otherwise, by a small employer
17 for all or a portion of the premium; or

18 (2) the health benefit plan is treated by the employer or a covered individual as
19 part of a plan or program for the purposes of 26 U.S.C. 106 or 26 U.S.C. 162 (Internal Revenue
20 Code).

21 (b) Except as provided in this chapter, other provisions of law requiring the coverage or
22 the offer of coverage of a health care service or benefit and other provisions of law requiring the
23 reimbursement, utilization, or consideration of a specific category of a licensed or certified health
24 care practitioner do not apply to a health benefit plan offered or delivered to a small employer.

25 (c) Except as provided in this chapter, a health benefit plan offered to a small employer
26 is not subject to a law that would

27 (1) inhibit an insurer, welfare arrangement, or other benefit arrangement from
28 contracting with providers or groups of providers regarding health care services or benefits;

29 (2) impose a restriction on the ability to negotiate with providers regarding the
30 level or method of reimbursing care or services provided under the health benefit plan;

31 (3) require an insurer, welfare arrangement, or other benefit arrangement to either

1 include a specific provider or class of provider when contracting for health care services or
2 benefits, or to exclude a class of provider that is generally authorized by law to provide health
3 care.

4 Sec. 21.55.110. UNDERWRITING AND RATING REQUIREMENTS. Health benefit
5 plans covering small employers and, to the extent permitted under 29 U.S.C. 1001 - 1459, other
6 benefit arrangements covering small employers, are subject to the following provisions:

7 (1) preexisting conditions provisions may not exclude or limit coverage for a
8 period beyond 12 months following the individual's effective date of coverage and may only
9 relate to conditions that had, during the six months immediately preceding the effective date of
10 coverage, occurred in a manner that would cause an ordinarily prudent person to seek medical
11 advice, diagnosis, care, or treatment or for which medical advice, diagnosis, care, or treatment
12 was recommended or received, or that related to a pregnancy existing on the effective date of
13 coverage:

14 (2) in determining whether a preexisting condition limitation provision applies to
15 an eligible employee or dependent, all health benefit plans shall credit the time the person was
16 covered under a previous employer based health benefit plan provided by an insurer or welfare
17 arrangement if the previous coverage was continuous to a date not more than 30 days before the
18 effective date of the new coverage, exclusive of the applicable service waiting period under the
19 health benefit plan;

20 (3) the health benefit plan and, to the extent permitted under 29 U.S.C. 1001 -
21 1459, other benefit arrangements covering small employers must be renewable with respect to
22 all eligible employees or dependents at the option of the policyholder, contract holder, or small
23 employer except for

24 (A) nonpayment of the required premiums by the policyholder, contract
25 holder, or employer;

26 (B) noncompliance with health benefit plan provisions;

27 (C) a health benefit plan of an employer under which the total number of
28 insured individuals covered under all of the health benefit plans of one employer is less
29 than the total number of individuals or percentage of individuals required by participation
30 requirements under a specific health benefit plan of that employer; or

31 (D) a health benefit plan issued by an insurer or welfare arrangement that

1 ceases doing business in the small employer market under AS 21.55.140;

2 (4) notwithstanding (3) of this section, a health benefit plan or coverage provided
3 to an individual covered by a health benefit plan subject to the provisions of this chapter may
4 be rescinded, cancelled, or not renewed for fraud, material misrepresentation, or concealment by
5 an applicant, employee, dependent, or small employer or an agent of an applicant, employee,
6 dependent, or small employer;

7 (5) an insurer or a welfare arrangement, and, to the extent permitted by 29 U.S.C.
8 1001 - 1459, a benefit arrangement may not exclude an eligible employee or dependent who
9 would otherwise be covered under a health benefit plan on the basis of an actual or expected
10 health condition of the person, except that an insurer, welfare arrangement, or other benefit
11 arrangement may exclude a late enrollee for the greater of 18 months or the remainder of the
12 three-year reinsurance period, as provided under AS 21.55.060;

13 (6) an insurer or a welfare arrangement doing business in the small employer
14 market retains the authority to underwrite and rate small employer groups using accepted
15 underwriting and actuarial practices; small employer groups that are declined because they fail
16 to satisfy insurer or welfare arrangement underwriting requirements shall be notified by the
17 insurer or welfare arrangement that the insurer or welfare arrangement will not issue a health
18 benefit plan to the small employer, that the small employer is eligible for a small employer health
19 plan provided by a guaranteed issue insurer, and shall be provided with a list, prepared by the
20 board, containing the address, telephone number, and service area of all guaranteed issue insurers;

21 (7) a health benefit plan issued by a insurer, welfare arrangement, or, to the extent
22 permitted by 29 U.S.C. 1001 - 1459, another benefit arrangement, may not limit or exclude, by
23 use of a rider or amendment applicable to a specific individual, coverage by type of illness,
24 treatment, medical condition, or accident, except for preexisting conditions or diseases as
25 permitted under (1) of this section;

26 (8) a health benefit plan and, to the extent permitted by 29 U.S.C. 1001 - 1459,
27 another benefit arrangement shall make coverage available to eligible employees of a small
28 employer without a service waiting period, except that a small employer may impose a service
29 waiting period for eligible employees of the small employer if the small employer chooses from
30 the service waiting periods offered by the insurer or welfare arrangement; a service waiting
31 period offered by an insurer or welfare arrangement may not exceed 90 days;

1 (9) the benefit structure of a health benefit plan subject to the provisions of this
2 chapter may be changed by the insurer or welfare arrangement to make it consistent with the
3 benefit structure contained in a health benefit plan being marketed to new groups;

4 (10) regarding a health benefit plan of an insurer or welfare arrangement, the
5 premium rates charged or offered for a rating period for the same or similar coverage under a
6 health benefit plan covering a small employer with similar case characteristics as determined by
7 the insurer or welfare arrangement may not vary from the applicable midpoint rate by more than
8 35 percent of the applicable midpoint rate, as to

9 (A) a health benefit plan issued on or after July 1, 1991; and

10 (B) within three years after July 1, 1991, for a health benefit plan issued
11 before July 1, 1991;

12 (11) regarding a health benefit plan issued before July 1, 1991, if an insurer or
13 welfare arrangement charged or offered a premium rate for the same or similar coverage under
14 a health benefit plan covering a small employer with similar case characteristics as determined
15 by the insurer or welfare arrangement, and the premium rate exceeds the applicable midpoint rate
16 by more than 35 points of the applicable midpoint rate, an increase in premium rates for a new
17 rating period may not exceed the sum of

18 (A) a percentage change in the base premium rate measured from the first
19 day of the prior rating period to the first day of the new rating period, plus

20 (B) an adjustment due to a change in case characteristics or plan design
21 of the small employer, as determined by the insurer or welfare arrangement;

22 (12) a premium rate may not vary by more than 15 percent based on industry
23 classification;

24 (13) subject to the provisions of (10), (11), and (12) of this section, an increase
25 in a premium rate for a new rating period may not exceed the sum of

26 (A) a percentage change in the base premium rate measured from the first
27 day of the prior rating period to the first day of the new rating period plus 15 percent,
28 adjusted on a pro rata basis for a rating period greater or lesser than one year, of the base
29 premium rate for the new rating period; and

30 (B) an adjustment due to a change in case characteristics or plan design
31 of the small employer, as determined by the insurer or welfare arrangement;

1 (14) when offering for sale a health benefit plan to a small employer, an insurer
2 or welfare arrangement shall make a reasonable disclosure as part of its solicitation and sales
3 materials of

4 (A) the extent to which premium rates for a specific small employer are
5 established or adjusted in part based on the actual or expected variation in claims costs
6 or actual or expected variation in health condition of the employees and dependents of
7 the small employer;

8 (B) the provisions concerning the insurer's or welfare arrangement's right
9 to change a premium rate; and

10 (C) provisions relating to renewability of a policy or contract;

11 (15) compliance with the underwriting and rating requirements contained in this
12 chapter shall be demonstrated through actuarial certification; insurers or welfare arrangements
13 offering a health benefit plan to a small employer shall file annually with the director an actuarial
14 certification stating that the underwriting and rating methods of the insurer or welfare
15 arrangement

16 (A) comply with accepted actuarial practices;

17 (B) are uniformly applied to health benefit plans covering small
18 employers; and

19 (C) comply with the provisions of this chapter.

20 Sec. 21.55.120. GUARANTEED ISSUE INSURERS. (a) Guaranteed issue insurers shall
21 offer at least one small employer health plan to a small employer requesting a small employer
22 health plan and shall provide at least the coverage of a small employer health plan to a small
23 employer requesting the coverage.

24 (b) Guaranteed issue insurers may

25 (1) reinsure an individual with a group or may reinsure an entire group subject
26 to the provisions of AS 21.55.060;

27 (2) as provided for in the association's plan of operation,

28 (A) require advance premium deposits for poor credit risks; and

29 (B) make special arrangements to cover an employee in a small employer
30 group with exceptionally high employee turnover rates;

31 (3) appeal to the board for a finding that the guaranteed issue carrier is

1 experiencing an unfair share of administrative or credit risk; if the board determines that a
2 guaranteed issue carrier has experienced an unfair burden, the board may grant the guaranteed
3 issue carrier a decreased reinsurance price to offset administrative expenses or temporarily
4 suspend the guaranteed issue insurer's requirement to guarantee issue.

5 Sec. 21.55.130. SMALL EMPLOYER HEALTH BENEFIT PLANS. (a) The board shall
6 design small employer health benefit plans that are eligible for reinsurance by the association.
7 The board shall establish the form and level of coverage to be made available by insurer or
8 welfare arrangements, and to the extent permitted under 29 U.S.C. 1001 - 1459, other benefit
9 arrangements in the small employer health benefit plans. In designing the small employer health
10 benefit plans, the board shall also establish benefit levels, deductibles, coinsurance factors,
11 exclusions, and limitations for the small employer health benefit plans. The form and level of
12 coverage established by the board must specify those components of a health benefit plan offered
13 by an insurer of a small employer that may be reinsured.

14 (b) A small employer health benefit plan may include cost containment features
15 including, but not limited to

16 (1) utilization review of health care services, including review of the medical
17 necessity of hospital and physician services;

18 (2) case management benefit alternatives;

19 (3) selective contracting with hospitals, physicians, and other health care
20 providers;

21 (4) reasonable benefit differentials applicable to participating and nonparticipating
22 providers; and

23 (5) other provisions for the cost effective management of a small employer health
24 benefit plan.

25 (c) The small employer health benefit plan established for use by health maintenance
26 organizations must be consistent with the basic method of operation of health maintenance
27 organizations.

28 (d) A small employer health benefit plan shall be submitted to the director for approval.

29 (e) After the director's approval of the small employer health benefit plans submitted by
30 the board, an insurer or welfare arrangement, or, to the extent permitted by 29 U.S.C. 1001 -
31 1459, other benefit arrangements may certify to the director, in the form and manner prescribed

1 by the director, that the small employer health benefit plans filed by the insurer or welfare
2 arrangement, or other benefit arrangement are in substantial compliance with the provisions in
3 the corresponding approved board plan. Upon receipt by the department of certification described
4 in this subsection, the insurer or welfare arrangement, or other benefit arrangement may use the
5 certified plan until the director, after notice and hearing, disapproves the use of the plan.

6 Sec. 21.55.140. CONDITIONS FOR CEASING TO DO BUSINESS. An insurer or a
7 welfare arrangement may cease doing business in the small employer market if the insurer or
8 welfare arrangement provides notice of the decision to cease doing business in the small
9 employer market to the division, the board, the policyholder or contract holder, and the employer,
10 and coverage under a health benefit plan subject to this chapter is continued for one year after
11 the date of the notice required under this section. An insurer or a welfare arrangement that
12 ceases doing business in the small employer marketplace may not reenter the small employer
13 marketplace for a period of five years from the date of the notice required under this section.

14 Sec. 21.55.250. DEFINITIONS. In this chapter,

15 (1) "adjusted average market premium price" means, as determined by the board,
16 the arithmetic mean of all guaranteed issue insurer's premium rates for a given small employer
17 health benefit plan sold to groups with similar case characteristics by all insurers or welfare
18 arrangements selling small employer health benefit plans in the state;

19 (2) "association" means the Small Employer Health Reinsurance Association
20 created in AS 21.55.010;

21 (3) "base premium rate" means

22 (A) as to a health benefit plan covering one or more employees of a small
23 employer, the lowest new business premium rate prescribed by the insurer or welfare
24 arrangement for the same or similar coverage under a plan or arrangement covering a
25 small employer with similar case characteristics; and

26 (B) as to an insurer or welfare arrangement not issuing a new health
27 benefit plan to a small employer, the lowest rate charged a small employer for the same
28 or similar coverage under a plan covering a small employer with similar case
29 characteristics;

30 (4) "board" means the board of directors of the association;

31 (5) "case characteristics" means with respect to a small employer, the geographic

1 area in which the employees reside, the age and sex of the individual employees and dependents,
2 the appropriate industry classification as determined by the insurer or welfare arrangement, or
3 other benefit arrangement, the number of employees and dependents and other objective criteria
4 as may be established by the insurer or welfare arrangement, or other benefit arrangement;

5 (6) "dependent" means the spouse or child of an eligible employee, subject to
6 applicable terms of the health benefit plan covering the employee;

7 (7) "eligible employee" means an employee who works on a full-time basis, with
8 a normal work week of 30 or more hours, and includes a sole proprietor, a partner of a
9 partnership or an independent contractor, provided the sole proprietor, partner, or contractor is
10 included as an employee under a health benefit plan of a small employer, but does not include
11 an employee who works on a part-time, temporary, or substitute basis;

12 (8) "financially impaired" means a member that is not insolvent but is

13 (A) determined by the director to be potentially unable to fulfill the
14 member's contractual obligations; or

15 (B) placed under an order of rehabilitation or conservation by a court of
16 competent jurisdiction;

17 (9) "guaranteed issue insurer" means an insurer that

18 (A) is one of the top 10 insurers based on total premium volume in the
19 small employer market as determined by the board; and

20 (B) an insurer that informs the board that the insurer wishes to become
21 a guaranteed issue insurer, except that an insurer wishing to become a guaranteed issue
22 insurer shall notify the board of the insurer's intention to become a guaranteed issue
23 insurer one year in advance of the insurer becoming a guaranteed issue insurer;

24 (10) "health benefit plan" means a hospital or medical expense policy, health,
25 hospital, or medical service corporation contract, a plan provided by an insurer or welfare
26 arrangement, and a health maintenance organization contract offered by an employer, but does
27 not include a policy covering only accident, credit, dental, disability income, long-term care,
28 hospital indemnity, Medicare supplement, specified disease, vision care, coverage issued as a
29 supplement to liability insurance, worker's compensation insurance, automobile medical payment
30 insurance, or insurance under which benefits are payable with or without regard to fault and that
31 is statutorily required to be contained in a liability insurance policy or equivalent self-insurance;

1 (11) "initial enrollment period" means the period of time specified in the health
2 benefit plan during which an individual is first eligible to enroll in a small employer health
3 benefit plan; the period of time may not be less than 30 days nor more than 60 days commencing
4 on the day following the end of a service waiting period required by the small employer of all
5 employees before the employees are eligible to participate in a small employer health benefit
6 plan;

7 (12) "insurer" has the meaning given in AS 21.90.900 and includes a health
8 maintenance organization, a hospital service corporation, and a medical service corporation;

9 (13) "late enrollee" means an eligible employee or dependent who requests
10 enrollment in a small employer's health benefit plan following the initial enrollment period
11 provided under the terms of the first plan for which the employee or dependent was eligible
12 through the small employer, except that an eligible employee or dependent may not be considered
13 a late enrollee if

14 (A) the individual

15 (i) was covered under another employer provided health benefit
16 plan at the time the individual was eligible to enroll;

17 (ii) states, at the time of the initial eligibility, that coverage under
18 another employer health benefit plan was the reason for declining enrollment;

19 (iii) has lost coverage under another employer health benefit plan
20 as a result of the termination of employment, the termination of the other plan's
21 coverage, death of a spouse, or divorce or dissolution of marriage; and

22 (iv) requests enrollment within 31 days after the termination of
23 coverage under another employer health benefit plan; or

24 (B) the individual is employed by an employer who offers multiple health
25 benefit plans and the individual elects a different health benefit plan during an open
26 enrollment period; or

27 (C) a court has ordered coverage to be provided for a spouse or minor
28 child under a covered employee's plan and request for enrollment is made within 31 days
29 after issuance of the court order;

30 (14) "member" means all insurers issuing health benefit plans, welfare
31 arrangements and, to the extent permitted under 29 U.S.C. 1001 - 1459 (Employee Retirement

1 Income Security Act), other benefit arrangements providing health benefit plans in this state;

2 (15) "midpoint rate" means for a small employer with similar case characteristics
3 and plan designs, as determined by the applicable insurer or welfare arrangement for a rating
4 period, the arithmetic average of the applicable base premium rate and the corresponding highest
5 premium rate;

6 (16) "other benefit arrangement" means a health benefit plan offered by a small
7 employer who is in whole, or in part, self-insured;

8 (17) "plan of operation" means the articles, bylaws, and operating rules of the
9 association adopted by the board;

10 (18) "preexisting conditions provision" means a policy provision that excludes or
11 limits coverage for charges or expenses incurred during a specified period following the insured's
12 effective date of coverage as to a condition that, during a specified period immediately preceding
13 the effective date of coverage, had manifested itself in a manner that would cause an ordinarily
14 prudent person to seek medical advice, diagnosis, care, or treatment, or for which medical advice,
15 diagnosis, care, or treatment was recommended or received and includes a pregnancy existing on
16 the effective date of coverage;

17 (19) "service waiting period" means a period of time after full-time employment
18 begins before an employee is first eligible to enroll in an applicable health benefit plan offered
19 by the small employer;

20 (20) "small employer" means a person, firm, corporation, partnership, or
21 association actively engaged in business whose total employed work force consisted of, on at
22 least 50 percent of its working days during the preceding year, more than two but not more than
23 25 eligible employees, the majority of whom are employed within the state; in determining the
24 number of eligible employees, companies that are affiliated companies or that are eligible to file
25 a combined tax return for purposes of federal taxation, are considered one employer; except as
26 otherwise specifically provided, provisions of this chapter that apply to a small employer that has
27 a health benefit plan continue to apply until the plan anniversary following the date the employer
28 no longer meets the requirements of this definition;

29 (21) "welfare arrangement" means a multiple employer welfare arrangement as
30 defined in 29 U.S.C. 1003, but does not include a multiple employer welfare arrangement that
31 is fully insured as provided in 26 U.S.C. 1060.

1 * Sec. 3. AS 21.86.260(a) is amended to read:

2 (a) Except as provided in AS 21.55 and in this chapter, this title does not apply to a
3 health maintenance organization that obtains a certificate of authority under this chapter. This
4 subsection does not apply to an insurer licensed under AS 21.09 or a hospital or medical service
5 corporation licensed under AS 21.87 except with respect to its health maintenance organization
6 activities authorized by and regulated under this chapter.

7 * Sec. 4. AS 21.87.340 is amended to read:

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

- 14 (1) AS 21.03
- 15 (2) AS 21.06
- 16 (3) AS 21.09, except AS 21.09.090
- 17 (4) AS 21.18.010
- 18 (5) AS 21.18.030
- 19 (6) AS 21.18.040
- 20 (7) AS 21.18.120
- 21 (8) AS 21.21.321
- 22 (9) AS 21.36
- 23 (10) AS 21.42.345 - 21.42.365
- 24 (11) AS 21.51.120
- 25 (12) AS 21.53
- 26 (13) AS 21.54.020
- 27 (14) AS 21.55
- 28 (15) AS 21.69.400
- 29 (16) [(15)] AS 21.69.520
- 30 (17) [(16)] AS 21.69.600, 21.69.620, and 21.69.630
- 31 (18) [(17)] AS 21.78

1 (19) [(18)] AS 21.89.040

2 (20) [(19)] AS 21.89.060

3 (21) [(20)] AS 21.90.

4 * Sec. 5. TRANSITION. Within 180 days after the board is organized under AS 21.55.020, enacted
5 in sec. 2 of this Act, the board of directors of the Small Employer Health Reinsurance Association shall
6 submit a small employer health benefit plan to the director of the division of insurance for approval.
7 Notwithstanding AS 21.55.120(a), enacted in sec. 2 of this Act, a guaranteed issue insurer is not required
8 to offer a small employer a health benefit plan until 60 days after the director of the division of
9 insurance has approved a small employer health benefit plan.
10 * Sec. 6. This Act takes effect July 1, 1991.

SENATE BILL NO. 244

IN THE LEGISLATURE OF THE STATE OF ALASKA

SEVENTEENTH LEGISLATURE - FIRST SESSION

BY SENATOR HOFFMAN

Introduced: 4/8/91

Referred: CRA, HES, Finance

Funding Information: General Fund \$3,400,000

Other Funds -0-

\$3,400,000

A BILL

FOR AN ACT ENTITLED

1 "An Act making an appropriation for a Yupik elders nursing home in Bethel; and
 2 providing for an effective date."

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

4 * Section 1. The sum of \$3,400,000 is appropriated from the general fund to the Department of
 5 Health and Social Services for payment as a grant under AS 37.05.316 to the Association of Village
 6 Council Presidents, Inc., for the planning, design, engineering, and construction of a Yupik elders nursing
 7 home in Bethel.

8 * Sec. 2. The appropriation made by this Act is for a capital project and is subject to AS 37.25.020.

9 * Sec. 3. This Act takes effect July 1, 1991.

SENATE BILL NO. 290

IN THE LEGISLATURE OF THE STATE OF ALASKA

SEVENTEENTH LEGISLATURE - FIRST SESSION

BY SENATOR COLLINS

Introduced: 5/13/91

Referred: L&C, HES, Finance

A BILL

FOR AN ACT ENTITLED

1 "An Act relating to access for children to preventive health services; and providing for
2 an effective date."

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

4 * Section 1. LEGISLATIVE INTENT. The legislature finds that increased access to health care
5 services could improve children's health and reduce the incidence and costs of childhood illness and
6 disabilities among children in the state. Many children do not have preventive services available or
7 funded and, for those who do, lack of access is a restriction to getting service. It is the intent of the
8 legislature that a nonprofit corporation be organized to facilitate a program to bring preventive health
9 care services to children, if necessary, through the use of school facilities when more appropriate sites
10 are unavailable, and to provide comprehensive health insurance coverage to children. A goal for the
11 corporation is to cooperate with existing preventive service programs funded by the public or the private
12 sector.

13 * Sec. 2. AS 18 is amended by adding a new chapter to read:

14 CHAPTER 27. ALASKA HEALTHY KIDS CORPORATION.

1 Sec. 18.27.010. CREATION OF CORPORATION. There is created the Alaska Healthy
2 Kids Corporation, a nonprofit public corporation and government instrumentality in the
3 Department of Health and Social Services, but having a legal existence independent and separate
4 from the state.

5 Sec. 18.27.020. BOARD OF DIRECTORS. (a) The corporation shall operate subject
6 to the supervision and approval of a board of directors chaired by the director of the division of
7 insurance in the Department of Commerce and Economic Development or a designee of the
8 director, and composed of 10 other members selected by the governor for three-year terms of
9 office as follows:

10 (1) one member from among three persons nominated by the Alaska Council of
11 School Administrators;

12 (2) one member from among three persons nominated by the Association of
13 Alaska School Boards;

14 (3) one member who is an employee of the Department of Education;

15 (4) two members from among five members nominated by the Alaska chapter of
16 the American Medical Association;

17 (5) one member representing hospitals in the state;

18 (6) two members who are representatives of authorized health care insurers or
19 subscribers' groups who do business in the state;

20 (7) two members who are employees of the Department of Health and Social
21 Services.

22 (b) Members of the board of directors serve at the pleasure of the governor. The board
23 shall appoint an executive director who is responsible for other staff authorized by the board.

24 (c) Board members who are not state employees do not receive compensation but are
25 entitled to per diem and travel expenses as provided for members of boards and commissions
26 under AS 39.20.180.

27 (d) There is no liability on the part of, and a cause of action may not arise against, a
28 member of the board of directors, or its employees or agents, for an action they take in the good
29 faith performance of their powers and duties under this chapter.

30 Sec. 18.27.030. POWERS AND DUTIES. (a) The corporation shall phase in a program
31 to

1 (1) organize school children groups to facilitate the provision of preventive health
2 care services to children and to provide comprehensive health insurance coverage to children and
3 their family members;

4 (2) arrange for the collection of family or employer payments or premiums, in
5 an amount to be determined by the board of directors, from all participant families or employers
6 to provide for payment for preventive health care services or premiums for comprehensive
7 insurance coverage and for the actual or estimated administrative expenses incurred during the
8 period for which family or employer payments are made;

9 (3) establish the administrative and accounting procedures for the operation of the
10 corporation;

11 (4) establish, with consultation from appropriate professional organizations,
12 standards for preventive health services and providers and comprehensive insurance benefits
13 appropriate to children and their family members;

14 (5) establish eligibility criteria that children and their family members must meet
15 in order to participate in the program;

16 (6) establish procedures under which applicants to and participants in the program
17 may have grievances reviewed by an impartial body and reported to the board of directors of the
18 corporation;

19 (7) establish participation criteria and, if appropriate, contract with an authorized
20 insurer to provide administrative services to the corporation;

21 (8) contract with authorized insurers, or any provider of health care services
22 meeting standards established by the corporation, for the provision of comprehensive insurance
23 coverage and preventive health care services to participants; and

24 (9) develop and implement a plan to publicize the corporation, the eligibility
25 requirements of the program, and the procedures for enrollment in the program and to maintain
26 public awareness of the corporation and the program.

27 (b) The corporation may

28 (1) employ staff necessary to properly administer the corporation;

29 (2) as appropriate, enter into contracts with school districts or other agencies to
30 provide on site information, enrollment, and other services necessary to the operation of the
31 corporation;

1 (3) accept grants, loans, or advances of money or property from a public or
2 private source for the purposes of this chapter;

3 (4) take other actions necessary to implement the purposes of the corporation.

4 Sec. 18.27.040. COVERAGE IS SECONDARY. Coverage under the corporation's
5 program is secondary to any other available private coverage held by the participant child or
6 family member. The corporation may establish procedures for coordinating benefits under this
7 program with benefits under other public and private coverage.

8 Sec. 18.27.050. LICENSING NOT REQUIRED; FISCAL OPERATION. (a) The
9 corporation is not considered an insurer. The officers, directors, and employees of the
10 corporation are not considered to be agents of an insurer. Neither the corporation nor an officer,
11 director, or employee of the corporation is subject to the licensing requirements of AS 21 or the
12 regulations of the Department of Commerce and Economic Development adopted under AS 21.
13 However, the division of insurance may require that a marketing representative used and
14 compensated by the corporation be appointed as a representative of the insurers or health services
15 providers with which the corporation contracts.

16 (b) The board is responsible for all corporate operations.

17 (c) The division of insurance of the Department of Commerce and Economic
18 Development shall supervise liquidation or dissolution of the corporation and shall have, with
19 respect to the liquidation or dissolution, all power granted to it under AS 21.

20 Sec. 18.27.060. THE ALASKA HEALTHY KIDS TRUST FUND. There is created the
21 Alaska healthy kids trust fund in the Department of Health and Social Services. It consists of
22 appropriations made to it. Money in the fund may be used only by the corporation.

23 Sec. 18.27.070. ACCESS TO RECORDS; CONFIDENTIALITY; PENALTIES. (a)
24 Notwithstanding any other laws to the contrary, the corporation shall have access to the medical
25 records of a student upon receipt of permission from a parent or guardian of the student. The
26 medical records may be maintained by state and local agencies. Confidential information
27 obtained by the corporation under this subsection shall remain confidential and is exempt from
28 public inspection and copying under AS 09.25.110 - 09.25.120. The corporation or the staff or
29 agents of the corporation may not release to a state or federal agency, to a private business or
30 person, or to another entity confidential information received under this subsection.

31 (b) A violation of this section is a class B misdemeanor.

1 Sec. 18.27.080. DEFINITIONS. In this chapter,

2 (1) "board" means the board of directors of the corporation;

3 (2) "corporation" means the Alaska Healthy Kids Corporation.

4 * Sec. 3. Notwithstanding AS 18.27, as enacted by sec. 2 of this Act, the Alaska Healthy Kids
5 Corporation may not select more than four sites at which to implement its program without prior
6 approval of the legislature by law.

7 * Sec. 4. This Act takes effect July 1, 1992.

HOUSE BILL NO. 149**IN THE LEGISLATURE OF THE STATE OF ALASKA****SEVENTEENTH LEGISLATURE - FIRST SESSION****BY REPRESENTATIVES DAVIDSON, Kubina, C.Davis, Taylor**

Introduced: 2/20/91

Referred: Health, Education and Social Services, Finance

Funding Information: General Fund \$36,917,116

Other Funds -0-
\$36,917,116**A BILL****FOR AN ACT ENTITLED**

1 "An Act making appropriations for grants to certain hospitals for hospital construction and
2 renovation; and providing for an effective date."

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

4 * Section 1. The sum of \$14,250,000 is appropriated from the general fund to the Department of
5 Health and Social Services for payment as a grant under AS 37.05.316 to the Kodiak Island Borough
6 Hospital and Intermediate Care Facility for construction of the facility, contingent on the Kodiak Island
7 Borough appropriating at least \$4,750,000 for the construction. The borough may make an in kind
8 contribution to satisfy up to five percent of this requirement.

9 * Sec. 2. The sum of \$8,603,438 is appropriated from the general fund to the Department of Health
10 and Social Services for payment as a grant under AS 37.05.316 to the Seward General Hospital for
11 renovation and construction of the hospital, contingent on the City of Seward appropriating at least
12 \$2,867,813 for the renovation and construction. The city may make an in kind contribution to satisfy
13 up to five percent of this requirement.

14 * Sec. 3. The sum of \$14,063,678 is appropriated from the general fund to the Department of Health

1 and Social Services for payment as a grant under AS 37.05.316 to the Ketchikan General Hospital for
2 renovation and construction of the hospital, contingent on the City of Ketchikan appropriating at least
3 \$4,687,893 for the renovation and construction. The city may make an in kind contribution to satisfy
4 up to five percent of this requirement.

5 * Sec. 4. This Act takes effect immediately under AS 01.10.070(c).

HOUSE BILL NO. 150

IN THE LEGISLATURE OF THE STATE OF ALASKA

SEVENTEENTH LEGISLATURE - FIRST SESSION

BY REPRESENTATIVES ELLIS, Brown

Introduced: 2/20/91

Referred: Health, Education and Social Services, Finance

Funding Information: General Fund \$1,280,000

Other Funds -0-
\$1,280,000**A BILL****FOR AN ACT ENTITLED**

1 "An Act making a special appropriation to the Department of Health and Social Services
2 for a grant to the Anchorage Neighborhood Health Center; and providing for an effective
3 date."

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

5 * **Section 1. FINDINGS.** The legislature finds that the Anchorage Neighborhood Health Center
6 provides primary medical, dental, and related health services necessary to meet community needs; the
7 center is the only source of primary health care for low income persons in Anchorage; the center can
8 only treat 25 percent of the over 48,000 low income persons in Anchorage due to a shortage of space;
9 expansion of the center is necessary in order to meet community needs for health care services.

10 * **Sec. 2.** The sum of \$1,280,000 is appropriated from the general fund to the Department of Health
11 and Social Services for payment as a grant under AS 37.05.316 to the Anchorage Neighborhood Health
12 Center for expansion of facilities.

13 * **Sec. 3.** The appropriation made by this Act is for a capital project and lapses under AS 37.25.020.

14 * **Sec. 4.** This Act takes effect July 1, 1991.

HOUSE BILL NO. 311

IN THE LEGISLATURE OF THE STATE OF ALASKA

SEVENTEENTH LEGISLATURE - FIRST SESSION

BY REPRESENTATIVES SHARP, M.W. Miller, Gonzales

Introduced: 5/1/91

Referred: Health, Education & Social Services, Finance

Funding Information: General Fund \$3,500,000

Other Funds -0-
\$3,500,000

A BILL

FOR AN ACT ENTITLED

1 "An Act making a special appropriation to the Department of Health and Social Services
2 for a grant to the Fairbanks Health Center; and providing for an effective date."

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

4 * Section 1. FINDINGS. The legislature finds that

5 (1) the Fairbanks Health Center is the primary source of health care for low income
6 persons in the Interior and provides immunizations and basic health care for infants and elderly, health
7 care for pregnant teens and teenage mothers, family planning, and other basic health care needs;

8 (2) the existing facility and site cannot meet the growing demands of its clientele, which
9 has tripled since the center was built 34 years ago; and

10 (3) construction of a new facility is necessary in order to meet community needs for
11 health care services.

12 * Sec. 2. The sum of \$3,500,000 is appropriated from the general fund to the Department of Health
13 and Social Services for payment as a grant under AS 37.05.316 to the Fairbanks Health Center for
14 construction of a new health care facility.

- 1 * Sec. 3. The appropriation made by this Act is for a capital project and lapses under AS 37.25.020.
- 2 * Sec. 4. This Act takes effect July 1, 1991.

7-LS1486A
Lauterbach
9/17/91

HOUSE BILL NO.

IN THE LEGISLATURE OF THE STATE OF ALASKA
SEVENTEENTH LEGISLATURE - SECOND SESSION

BY REPRESENTATIVE ELLIS

Introduced:
Referred:

A BILL**FOR AN ACT ENTITLED**

1 "An Act establishing the Alaska Children's Health Corporation; and relating to insurance."

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

3 * Section 1. AS 21 is amended by adding a new chapter to read:

4 CHAPTER 55. HEALTHY START PROGRAM.

5 ARTICLE 1. ALASKA CHILDREN'S HEALTH CORPORATION.

6 Sec. 21.55.010. CREATION OF CORPORATION. There is created the Alaska
7 Children's Health Corporation as a public corporation. The corporation is an instrumentality of
8 the state within the Department of Commerce and Economic Development, but it has a legal
9 existence independent of and separate from the state.

10 Sec. 21.55.020. PURPOSE OF THE CORPORATION. (a) The corporation's purpose
11 is to

12 (1) administer the Alaska children's health care plan as described in this chapter;

13 (2) purchase health insurance coverage for children who are eligible for the plan

14 under AS 21.55.110; and