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

Prepared by: Alaska Department of Law

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

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

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

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

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

Section 4. MANDATORY ARBITRATION. This section mandates that a

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

routine review and evaluation of the effectiveness of the commission.

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

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

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

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

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

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

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

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

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

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

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

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

GOVERNOR'S ALASKA HEALTH COMMISSION LEGISLATION

PURPOSE

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

STRATEGY

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

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

COMMISSION RESPONSIBILITIES

Authority to implement changes to current health care system:

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

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

Conduct health care system analysis:

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

Develop policy recommendations:

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

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PROPOSED AMENDMENT TO HB 414

Delete Sections 7, 9, and 11

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

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

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

HEALTH INSURANCE RATE FILING REQUIREMENTS IN THE STATES

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

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

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

Information supplied by NAIC Chart 7/92

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

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

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

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

(2) Either:

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

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

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

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

(2) Either:

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

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

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

3-10-14
To: Reed Stoops
From: Charlie Hunt
Co./Dept: Actna

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

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

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

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

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

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

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

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

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

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

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

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

■ Rate Suppression Found to Affect Health Insurance Availability

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

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

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

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

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

tive than states without such authority; and

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

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

■ Maryland Insurance Division to Probe Insurance Fraud

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

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

■ Texas Regulators to Guide Employers Casualty Co.

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

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

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

**Public Policy Survey
Individual Medical Insurance Market**

AN INDUSTRY STUDY



Milliman & Robertson, Inc.
Actuaries and Consultants

**PUBLIC POLICY SURVEY
INDIVIDUAL MEDICAL
INSURANCE MARKET**

An Industry Study

January 27, 1992

MILLIMAN & ROBERTSON, INC.

Public Policy Survey
Individual Medical Insurance Market

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Public Policy Survey
Individual Medical Insurance Market

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Public Policy Survey
Individual Medical Insurance Market

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INTRODUCTION

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

Specific areas addressed by the survey are:

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

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

SURVEY PROCEDURE

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

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

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

GENERAL CONCLUSIONS

The main conclusions of the study are:

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

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

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

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

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

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

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

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

8-GH2024E ✓
Ford
3/14/94

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

BY THE HOUSE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

Offered:
Referred:

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

A BILL

FOR AN ACT ENTITLED

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 (8) has demonstrated

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

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

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

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

11 (10) has violated AS 18.16.010;

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

13 or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

27 medical specialists.

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

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

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

31 be more than 120 days after the settlement conference.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

26 ARTICLE 5A. CERTAIN CLAIMS AGAINST HEALTH INSURERS.

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

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

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

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

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

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

19 (g) In this section,

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

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

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

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

30 (1) actuarial judgment;

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

1 insurer;

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

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

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

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

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

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

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

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

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

30 (1) actuarial judgment;

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

1 maintenance organization;

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

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

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

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

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

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

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

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

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

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

7 (c) A filing required under this section shall be made at least 75 days before

8 the intended effective date of the subscription rate, rating factor, fee, or payment and

9 is subject to the approval of the Alaska Health Commission. Within 45 days after a

10 filing under this section, the director shall review the filing and make a written

11 recommendation to the Alaska Health Commission as to whether the commission

12 should approve or disapprove the filing. This recommendation is not an order of the

13 director and is not appealable under AS 21.06.230.

14 (d) If a subscriber contract to be issued by the service corporation provides for

15 indemnity benefits and is permitted under this chapter, the service corporation shall

16 include in the rate, fee, or payment required of the subscriber an adequate additional

17 charge for the indemnity benefit, and shall separately set out the amount of the

18 additional charge in the filing required by this section and AS 44.19.629.

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

20 Sec. 21.87.285. RISK SHARING AND PURCHASING POOLS. After

21 consulting with and considering any reports or recommendations of the Alaska Health

22 Commission, the director shall adopt regulations to allow for the creation of pools,

23 including pools for the primary benefit of children, for the purpose of sharing risks or

24 purchasing insurance under this chapter.

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

26 (h) The Alaska Health Commission shall adopt regulations to manage the

27 procurement of supplies, services, and professional services necessary for its operations

28 under AS 44.19.619 - 44.19.639. The regulations must be based on principles of

29 competitive procurement, consistent with this chapter, to satisfy the requirements of

30 the Alaska Health Commission as determined by that commission.

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

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(1) "agency"

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

(B) does not include

(i) the University of Alaska;

(ii) the Alaska Railroad Corporation;

(iii) the Alaska Housing Finance Corporation;

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

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

(vi) the Alaska Aerospace Development Corporation;

(vii) the Alaska State Pension Investment Board;

(viii) the Alaska Health Commission;

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

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

(A) Alaska Gas Pipeline Financing Authority;

(B) Alaska Permanent Fund Corporation;

(C) Alaska Industrial Development and Export Authority;

(D) Alaska Commercial Fisheries Entry Commission;

(E) Alaska Commission on Postsecondary Education;

(F) Alaska Aerospace Development Corporation;

(G) Alaska Health Commission;

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

ARTICLE 12. ALASKA HEALTH COMMISSION.

Sec. 44.19.619. CREATION OF COMMISSION. The Alaska Health

1 Commission is created in the Office of the Governor.

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

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

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

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

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

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

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

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

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

30 (D) determining financing plans for recommended proposals;

31 (E) describing administrative structures necessary to implement

1 recommended proposals;

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

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

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

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

13 (1) a health care provider; or

14 (2) employed by a health insurance company.

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

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

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

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

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

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

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

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

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

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

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

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

16 (b) The commission shall

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

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

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

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

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

28 (6) establish a public health advisory committee that

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8 (d) This section does not apply to

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

11 (2) juries;

12 (3) parole or pardon boards;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8-GH2024N
Ford
3/22/94

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

BY THE HOUSE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

Offered:
Referred:

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

A BILL

FOR AN ACT ENTITLED

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 chapter, or an order of the board;

2 (8) has demonstrated

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

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

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

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

12 (10) has violated AS 18.16.010;

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

14 or

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

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

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

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

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

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

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

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

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

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

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

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

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

15 (9) is professionally incompetent [;

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

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

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

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

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

1 be more than 120 days after the settlement conference.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

27 ARTICLE 5A. CERTAIN CLAIMS AGAINST HEALTH INSURERS.

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

1 submit the claim to the court for arbitration.

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

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

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

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

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

20 (g) In this section,

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

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

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

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

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

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

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

31 Sec. 21.51.360. RISK SHARING AND PURCHASING POOLS. After

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

16 (1) "agency"

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

20 (B) does not include

21 (i) the University of Alaska;

22 (ii) the Alaska Railroad Corporation;

23 (iii) the Alaska Housing Finance Corporation;

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

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

31 (vi) the Alaska Aerospace Development Corporation;

(vii) the Alaska State Pension Investment Board;

(viii) the Alaska Health Commission;

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

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

(A) Alaska Gas Pipeline Financing Authority;

(B) Alaska Permanent Fund Corporation;

(C) Alaska Industrial Development and Export Authority;

(D) Alaska Commercial Fisheries Entry Commission;

(E) Alaska Commission on Postsecondary Education;

(F) Alaska Aerospace Development Corporation;

(G) Alaska Health Commission;

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

ARTICLE 12. ALASKA HEALTH COMMISSION.

Sec. 44.19.619. CREATION OF COMMISSION. The Alaska Health Commission is created in the Office of the Governor.

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

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

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

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

(4) promoting consumer confidence in the health care system by requiring insurers and managed care plans to fully disclose the health care benefits provided under the policy or plan and explain any exclusions or restrictions on benefits; disclosure should include an explanation of limitations on

(A) referral to a specialty physician or other provider;

(B) the insured's choice of provider;

- 1 (C) diagnostic tests, including mammography;
2 (D) prescription drugs;
3 (E) dental services;
4 (F) laboratory tests;
5 (G) mental health services; and
6 (H) reproductive tests;
- 7 (5) promoting the creation of pools, including pools for the primary
8 benefit of children, for the purpose of sharing risks or purchasing insurance for health
9 care services; and
- 10 (6) analyzing health care reform proposals, including a proposal that
11 is based on a market based single payer system; recommending health care reform
12 proposals to the governor and the legislature; and reporting to and making
13 recommendations to the governor and legislature on the following:
- 14 (A) defining a range of potential benefit packages for universal
15 health care coverage for residents of the state; a benefit package must include
16 coverage for health care services without containing an exclusion based on a
17 preexisting condition;
- 18 (B) determining the needs and requirements imposed on the
19 state by federal enactments that affect health care reform; the commission shall
20 make the determination required under this subparagraph within 60 days after
21 each measure is enacted into law;
- 22 (C) determining the prospective costs for recommended
23 comprehensive health care reform proposals, as requested by the governor or
24 as determined by a majority vote of the commission;
- 25 (D) determining financing plans for recommended proposals;
- 26 (E) describing administrative structures necessary to implement
27 recommended proposals;
- 28 (F) identifying a process to implement statewide expenditure
29 measures for health care goods and services;
- 30 (G) investigating health care standards of practice and
31 determining their effect on medical tort liability and other aspects of health care

1 delivery; and

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

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

8 (1) a health care provider; or

9 (2) employed by a health insurance company.

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

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

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

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

19 Sec. 44.19.623. STAFF. The commission may employ staff as necessary to
20 carry out the purposes of this chapter. The staff of the commission is in the exempt
21 service.

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

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

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

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

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

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

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

11 (b) The commission shall

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

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

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

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

21 (5) establish a public health advisory committee that

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

29 (B) advises the commission on public health matters and the
30 integration of public health services under AS 44.19.621;

31 (C) develops a public health improvement plan as described

1 under (c) of this section;

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

4 (c) The plan developed by the committee under (b)(5) of this section may

5 (1) recognize the need for

6 (A) community involvement in health care planning and
7 delivery;

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

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

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

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

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

14 (2) include

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

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

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

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

25 (E) identification of interjurisdictional issues involved in health
26 care access and delivery;

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

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

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

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

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

11 (v) a program designed to give incentives to primary
12 care providers to practice in the state, especially in rural and under
13 served areas of the state.

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

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

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

30 Sec. 44.19.631. DISCLOSURE OF INFORMATION; PENALTY. (a) A
31 person providing or insuring health care services in the state shall provide, upon

1 request or order of the commission, reports, data, health information, insurance
2 schedules, statistics, and other information, as determined necessary by the
3 commission, by regulation, to carry out the purposes of AS 44.19.619 - 44.19.639.
4 This subsection applies to the state and to a municipality; as well as to public and
5 private health care facilities and providers, and health care insurers and self-insurers.

6 (b) Information and data obtained or produced by the commission is subject
7 to AS 09.25.110 and 09.25.120 and regulations adopted under AS 09.25.110 and
8 09.25.120. Information or data that identifies a recipient of health care services is
9 considered to be a medical and related public health record that is subject to the
10 exception to public inspection under AS 09.25.120 and shall be kept confidential.

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

15 Sec. 44.19.632. IMMUNITY FROM LIABILITY. Members of the
16 commission, its employees, its agents, its advisory committee members, and persons
17 providing information and data to the commission as required under AS 44.19.619 -
18 44.19.639 are not liable for civil damages for an act or omission in the execution of
19 their authorized activities or duties under AS 44.19.619 - 44.19.639. This section does
20 not preclude liability for civil damages as a result of reckless or intentional
21 misconduct.

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

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

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

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

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

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

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

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

26 Sec. 44.19.639. DEFINITIONS. In AS 44.19.619 - 44.19.639, unless the
27 context requires otherwise,

- 28 (1) "commission" means the Alaska Health Commission;
29 (2) "division of insurance" means the division of insurance in the
30 Department of Commerce and Economic Development;
31 (3) "health care services" has the meaning given in AS 21.86.900;

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

3 (5) "health insurance" has the meaning given "disability insurance" in
4 AS 21.12.050;

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

9 (7) "market based single payer system" means a system in which a
10 single entity provides health insurance to all residents of the state and the insurance
11 is based on market forces, and may include provider defined fees, defined patient
12 copayments, sliding scale copayments for the indigent, provider fees that are posted
13 or made otherwise available at the point of services, published or disseminated fees in
14 comparative lists that allow fee comparison by consumers, voluntary expenditure
15 targets, provider peer review and control of volume, utilization, and quality of health
16 services, and a regularly published description of the various types of providers
17 licensed to provide services in the benefit package;

18 (8) "pool" means a mechanism to facilitate or provide for sharing risks
19 or the purchase of health insurance in the event coverage is unavailable or
20 unobtainable;

21 (9) "provider" has the meaning given in AS 21.86.900.

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

23 (d) This section does not apply to

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

26 (2) juries;

27 (3) parole or pardon boards;

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

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

1 (6) meetings of the Alaska Health Commission. except for meetings
2 concerning the adoption of regulations.

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

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

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

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

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

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

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

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

20 (1) by July 1, 1995, the director of the division of insurance shall adopt
21 regulations necessary to implement AS 44.19.628(a);

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

25 (3) by July 1, 1996, the commission shall complete the research necessary to
26 report recommendations to the governor and the legislature on the issues described under
27 AS 44.19.621(a)(6)(F);

28 (4) by January 1, 1997, the commission shall complete the research necessary
29 to report recommendations to the governor and the legislature on the issues described under
30 AS 44.19.621(a)(6)(H).

31 (b) Upon request of the commission, and for good cause shown, the governor may

1 grant an extension of a deadline set in (a) of this section. The governor shall inform the
2 legislature of a decision on a request to extend a deadline.

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

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

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

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

24

AMENDMENT

OFFERED IN THE HOUSE

BY REPRESENTATIVE BRICE

TO: CSHB 414(HES)

Page ¹⁴~~4~~, line ¹⁰~~25~~, following "commission":

Insert a new paragraph to read:

"(4) fly to the moon."

Renumber the following paragraph accordingly.

25

8-GH2024J.1 ✓
Ford
3/22/94

A M E N D M E N T

OFFERED IN THE HOUSE

BY REPRESENTATIVE B.DAVIS

TO: CSHB 414(HES)

TOM BRUCE

Page 10, line 12:

Delete "AS 44.19.619 - 44.19.639"

Insert "AS 44.19.619 - 44.19.701"

Page 13, line 28:

Delete "AS 44.19.619 - 44.19.639"

Insert "AS 44.19.619 - 44.19.701"

Page 14, line 10:

Delete "."

Insert ";

(4) exercise the powers granted to insurers under the laws of the state when allowed under AS 44.19.636(c); if the commission acts as an insurer, the commission shall comply with the requirements applicable to insurers under AS 21."

Page 14, line 20:

Delete "AS 44.19.619 - 44.19.639"

Insert "AS 44.19.619 - 44.19.701"

Page 15, line 3:

Delete "."

Insert ";

(7) establish and provide uniform health insurance coverage for all residents of the state and monitor and control health care expenditures in the state;

(8) establish the cost control system required under AS 44.19.642,

44.19.648, 44.19.652, 44.19.656, 44.19.660, 44.19.664, and the voluntary cost control system required under AS 44.19.651 and 44.19.662;

(9) implement the state health insurance plan as a market based single payor system."

Page 17, line 3:

Delete "AS 44.19.619 - 44.19.639"

Insert "AS 44.19.619 - 44.19.701"

Page 17, lines 17 - 18:

Delete "AS 44.19.619 - 44.19.639"

Insert "AS 44.19.619 - 44.19.701"

Page 17, line 19:

Delete "AS 44.19.619 - 44.19.639"

Insert "AS 44.19.619 - 44.19.701"

Page 18, after line 25:

Insert new sections to read:

"Sec. 44.19.636. PROCUREMENT OR PROVISION OF INSURANCE. (a)

The commission shall

(1) solicit proposals from insurance companies that are licensed to transact health insurance in the state under the procurement procedures adopted by the commission under AS 36.30.015(e); and

(2) if the commission does not act as an insurer as provided under (c) of this section, select one or more companies with which it will contract to provide insurance, after considering the cost of the insurance, the availability from the company of program features directed at reducing the cost of providing health care services, and other relevant factors as determined by the commission.

(b) The commission may contract for insurance coverage for enrollees for a term that it considers to be the most advantageous to the commission and its enrollees, for a period not exceeding three years.

(c) If, after the proposal process under (a) of this section has been completed, the commission determines that the desired coverage or benefits are not available from insurers licensed in this state or the commission can provide the desired coverage and benefits at a lower cost per eligible person, the commission may act as an insurer.

Sec. 44.19.638. ENROLLEES. (a) A person is eligible to be an enrollee in the state health insurance plan provided under AS 44.19.641 in a given year if the person is a resident of the state and has complied with the procedures established by the commission under (d) of this section. For purposes of enrollment, the commission shall by regulation define residency in a manner that is consistent with AS 01.10.055 and with this chapter.

(b) A person who is eligible to be an enrollee shall be enrolled by the commission in the state health insurance plan.

(c) The commission shall cancel an enrollee's coverage if, during the fiscal year, the enrollee becomes ineligible to be an enrollee.

(d) The commission shall establish by regulation appropriate procedures for processing applications for enrollment, for determining the eligibility of enrollees, for enrolling enrollees, for determining and collecting the applicable fees, for canceling an enrollee's coverage, and for processing appeals by enrollees of adverse decisions by the commission regarding eligibility, enrollment, determination or collection of applicable fees, or cancellation of coverage.

Sec. 44.19.641. HEALTH INSURANCE PLAN. (a) The commission shall adopt regulations specifying the health care services required to be covered by the state health insurance plan, taking into consideration the services requested by the public, the needs and characteristics unique to state residents, the goal of prevention of illness and promotion of wellness, the cost of providing the benefits package, the cost of providing or procuring the insurance coverage, and the funds available in the state health insurance fund.

(b) The commission shall conduct a comprehensive public involvement process designed to solicit information and opinions regarding the services required to be covered under (a) of this section.

Sec. 44.19.642. DEDUCTIBLES AND COPAYMENTS. Subject to AS 44.19.641, the commission shall establish the deductible and copayment amounts

applicable under the state health insurance plan.

Sec. 44.19.644. **PREMIUMS.** A premium may be charged to an enrollee for coverage as established by the commission by regulation. In establishing a premium, the commission shall establish a standard fee and a sliding scale fee and shall consider the cost of coverage, funding available, and other factors the commission determines are relevant.

Sec. 44.19.646. **HEALTH CARE DATA SYSTEM.** (a) The commission shall develop and periodically update a health care data system. To the extent practicable, the data system base year shall be calendar year 1993 and the system must include

- (1) health care expenditures, including capital expenditures associated with receiving health care;
- (2) demographic data;
- (3) clinical information, including patient diagnosis, type of provider, type of service, location and length of care, referral patterns, quality of care, and result of care;
- (4) billing and payment data; and
- (5) public health data, including vital statistics and health status.

(b) The commission may, by regulation, require health care providers, including providers not being reimbursed by the commission, to submit claims data and additional information necessary to develop or update the data system required under (a) of this section.

Sec. 44.19.648. **STATEWIDE HEALTH CARE EXPENDITURE TARGET.** (a) The commission shall prescribe by regulation a statewide health care expenditure target, based on the data obtained under AS 44.19.646. To the extent practicable, the base year for the statewide health care expenditure target shall be calendar year 1993.

(b) The commission annually shall adjust the health care expenditure target established under this section to reflect changes in the Consumer Price Index and the following factors:

- (1) changes in the size and demographic characteristics of the state's population including aging;
- (2) changes in medical technology;

- (3) changes that improve access to health care services;
- (4) changes in the burden of disease resulting from epidemics, disasters, and reduction or elimination of disease;
- (5) elimination of unnecessary care;
- (6) changes in costs associated with professional liability insurance;
- (7) changes in administrative costs;
- (8) changes in patterns of utilization.

Sec. 44.19.651. **VOLUNTARY HEALTH CARE PROVIDER COMPLIANCE.** The health care expenditure target adopted by the commission under AS 44.19.648 shall constitute a recommended target for expenditures within each specified category or subcategory of health care services or products. Health care providers may voluntarily comply with the expenditure target and may take all appropriate steps not prohibited by law to attempt to ensure that annual expenditures for health care in the state do not exceed the expenditure target adopted by the commission.

Sec. 44.19.652. **REVIEW AND REPORT ON HEALTH CARE EXPENDITURES.** The commission shall annually review and report to the legislature and the governor on

- (1) the total amount of health care expenditures in the state;
- (2) the amount of increase or decrease in health care and capital medical expenditures in the state;
- (3) changes in health care provider prices;
- (4) changes in patterns of utilization or expenditures; and
- (5) factors that are responsible for changes in patterns of utilization or expenditures.

Sec. 44.19.654. **MANDATORY HEALTH CARE PROVIDER COMPLIANCE.** (a) Based on the data compiled under AS 44.19.646, the commission shall monitor the success of voluntary compliance under AS 44.19.651. At any time beginning three years after the voluntary expenditure target has been in effect, if the commission concludes that voluntary compliance has failed substantially to achieve the adopted expenditure target, the commission shall impose by regulation a mandatory expenditure limit as provided under (b) of this section.

- (b) The commission may, by regulation,
- (1) impose a mandatory expenditure limit on one or more subcategories or on specific items within the expenditure limit;
 - (2) directly assume all or part of the cost control functions described in this section;
 - (3) establish mandatory price and utilization controls or guidelines;
 - (4) annually monitor health care expenditures, patterns of utilization, and factors contributing to changes in expenditures or utilization;
 - (5) establish cost sharing recommendations relevant to the mandatory expenditure limit.

(c) A health care provider shall comply with the mandatory cost control provisions that may be established by the commission under (a) and (b) of this section. An enrollee who receives a charge that does not comply with the mandatory cost control provisions that are imposed under this section is not required to pay the portion of the charge that exceeds the mandatory cost control provisions. A health care provider shall refund an amount received that exceeds the mandatory cost control provisions.

(d) The commission shall establish by regulation procedures for monitoring compliance with the mandatory cost control provisions and for providing notice to a person who is determined to have been overcharged.

Sec. 44.19.656. PEER REVIEW OF UTILIZATION AND QUALITY. The commission shall contract with health care providers in the state to develop utilization and quality controls. The contract must include the use of peer specialty groups that are given the goal of controlling utilization within a specialty. The commission shall ensure that the contract stresses the development of the use of incentives to control costs.

Sec. 44.19.658. CLAIMS CLEARINGHOUSE. (a) The commission shall establish a claims clearinghouse in the state. A provider of health care services shall submit all claims for payment for health care services under the state health insurance plan to the claims clearinghouse. The commission may, by regulation, require providers to submit specified additional information pertaining to providing health care services in the state to the claims clearinghouse.

(b) Subject to appropriation, the claims clearinghouse shall pay claims approved for payment by the commission.

(c) The claims clearinghouse may deny a claim only for a reason that has been specified as an acceptable reason under regulations adopted by the commission.

Sec. 44.19.661. REQUIRED AVAILABILITY OF PRICE LIST. (a) A health care provider shall prepare a list of the provider's prices that includes the dates during which the prices will be applicable. The price list shall be made available either by posting the price list in a conspicuous location in the health care provider's office or by similarly posting a notice that the price list is available for review upon request. The corporation shall determine by regulation the contents of the price list required under this section.

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

Sec. 44.19.662. INFORMATION ON PRICES FOR HEALTH CARE SERVICES. The corporation shall at least annually publish a description of types of health care providers licensed to provide covered services and a comparative list of provider prices. The corporation shall make the publications available to the public upon request.

Sec. 44.19.664. COMPARATIVE LISTS OF PRICES. (a) At least annually, the corporation shall compile comparative lists of prices for commonly provided health care services based on abstracted data provided by the claims clearinghouse under AS 44.19.658, on the price lists submitted to the corporation under AS 44.19.661, and on other relevant information as determined by the corporation.

(b) The lists required under this section shall be prepared to allow identification and comparison of prices made by individual providers for the listed services. Hospital services may be compared on the basis of diagnosis related groups."

Page 18, line 26:

Delete "Sec. 44.19.639. DEFINITIONS. In AS 44.19.619 - 44.19.639"

Insert "Sec. 44.19.701. DEFINITIONS. In AS 44.19.619 - 44.19.701"

Page 19, line 21:

Delete "has the meaning given in AS 21.86.900"

Insert "means an acupuncturist licensed under AS 08.06; an audiologist licensed under AS 08.11; a chiropractor licensed under AS 08.20; a dental hygienist licensed under AS 08.32; a dentist licensed under AS 08.36; a marital or family therapist licensed under AS 08.63; a direct-entry midwife certified under AS 08.65; a nurse licensed under AS 08.68; a dispensing optician licensed under AS 08.71; a naturopath licensed under AS 08.45; an optometrist licensed under AS 08.72; a pharmacist licensed under AS 08.80; a physical therapist or occupational therapist licensed under AS 08.84; or a physician's assistant certified under AS 08.64; a physician licensed under AS 08.64; a podiatrist; a psychologist and a psychological associate licensed under AS 08.86; a clinical social worker licensed under AS 08.95; an emergency medical technician certified under AS 18.08.082; a mobile intensive care paramedic trained as required under AS 18.08.082; a hospital as defined in AS 18.20.130, including a governmentally owned or operated hospital; and an employee of a health care provider acting within the course and scope of employment"

Page 20, line 17, through page 21, line 2:

Delete all material.

Insert a new bill section to read:

"* **Sec. 24. PHASED TRANSITION PERIOD.** Notwithstanding the provisions of AS 44.19.619 - 44.19.701, the Alaska Health Commission shall implement the provisions of AS 44.19.619 - 44.19.701 on an orderly and gradual basis as follows:

(1) by December 31, 1994, the commission shall establish the data system required under AS 44.19.646 and begin collecting data and determine the federal waivers necessary to implement AS 44.19.619 - 44.19.701;

(2) by December 31, 1995, the commission shall determine the health care services required under AS 44.19.641 and begin monitoring health care expenditures and utilization patterns;

(3) by January 1, 1996, the commission shall implement the peer review system for utilization and quality required under AS 44.19.656 and shall adopt regulations that establish eligibility criteria for enrollment in the state health insurance plan, including a definition of the term "resident" that is consistent with AS 01.10.055 and the purposes of

this Act;

(4) by December 31, 1996, the commission shall establish the voluntary cost control system required under AS 44.19.651;

(5) by January 1, 1997, the commission shall establish the deductible and copayment amounts required under AS 44.19.642 and present options to the governor and the legislature on how to finance a state health insurance plan under a market based single payer system; in considering options on financing a state health insurance plan the commission shall strive to structure the options in a manner that provides protection for benefits provided to retired employees through public or private retirement systems;

(6) by January 1, 1998, the commission shall establish the statewide health care expenditure target required under AS 44.19.648, and, subject to appropriation, begin to provide health insurance coverage for state residents as required under AS 44.19.619 - 44.19.701."

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A M E N D M E N T

Rep Bettye Davis
Tom Brice

OFFERED IN THE HOUSE
TO: CSHB 414(HES)

Page 1, line 1, through page 21, line 12:

Delete all material and insert:

""An Act establishing the Alaska Health Insurance Corporation and requiring licensed health care providers to comply with certain statutes and regulations relating to the corporation; relating to disability insurance claims processing and to approval of rates for disability insurance, including health insurance; and providing for an effective date."

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

*** Section 1. FINDINGS AND PURPOSE.** (a) The legislature finds that

(1) health care services and health insurance in the state are becoming prohibitively costly, and a growing number of our citizens are unable to obtain health insurance or pay for needed care;

(2) the reasons that health care expenditures are increasing are complex and are accounted for by general inflation; by inflation specific to the health care industry or changes in the cost of labor, capital, and other industry factors; by population growth; by utilization or the number of times people use health care services; by increasingly complex and costly technology and other resources; by the aging of the population; and the practice of defensive medicine;

(3) the primary responsibility for controlling health care expenditures in the state should be borne by Alaska health care providers, particularly physicians, on whose orders and recommendations most health care expenditures are incurred; at present, federal and state antitrust laws effectively preclude health care providers from engaging in voluntary self-regulation regarding fees and volume of services; this Act mandates the participation by health care providers in the peer review process of cost control and volume control to assure that health care expenditures do not increase faster than the general inflation rate; if voluntary

self-regulation fails to control health care costs, mandatory cost controls should be imposed;

(4) in order to increase access to health care by containing the rate of increase of health care expenditures and by making basic health insurance available to the people in the state, it is essential that the factors contributing to the increasing costs of health care and the unavailability of health insurance be addressed comprehensively and consistently;

(5) there is a compelling need for a strong, clear focus on public health issues in the interest of protecting and promoting the public health of the residents of the state;

(6) there are inherent problems in our health system infrastructure, including the lack of physical access to services in many areas of the state;

(7) the state should immediately begin to create a system that will provide health insurance to all residents of the state, control health care expenditures, preserve the high quality of care that residents demand, preserve the individual's choice of health care provider, and, by doing so, avoid the imposition of a federally mandated health care reform system on the state;

(8) because the state constitution's single subject rule precludes the consideration of comprehensive tort reform in the same legislative enactment as health care reform, tort reform should be addressed in a separate legislative enactment;

(9) a market based single payer system is preferable to either an employer mandate or a "pay or play" approach because

(A) both of the employer mandate approaches are based on the current mix of public, employer, and individual financing that inevitably creates coverage gaps for some people, particularly when their employment status changes;

(B) health care financing approaches that require all businesses to provide health care benefits or that levy additional taxes on those businesses threaten the economic viability of many small businesses in the state;

(C) multiple payer systems would not necessarily address the problems of cost shifting that exist in our current system; and

(D) systems that are built upon the existing public and private financing arrangements can be expected to inherit the inefficiencies in those arrangements.

(b) The purpose of this Act is to

(1) increase access to health care by containing the rate of increase of health

care expenditures and by making health insurance available to the people in the state;

(2) create a market based single payer state health insurance system that provides health insurance to all residents of the state, that utilizes market forces to make consumers more aware of the actual costs of health services, and that provides consumers with information enabling them to make more informed purchasing decisions;

(3) provide a structure for addressing the health care needs of the state including

(A) developing a comprehensive long-term care plan that integrates support services and that promotes human dignity;

(B) use of preventive and wellness programs to reduce health care costs; and

(C) the different health care needs of urban and rural areas of the state.

(c) It is not the purpose of this Act to change the existing agreements between employers and employees, including retirees, in a manner that would diminish health care benefits.

* Sec. 2. AS 08.02 is amended by adding a new section to read:

Sec. 08.02.025. COMPLIANCE WITH REQUIREMENTS OF STATE HEALTH INSURANCE CORPORATION. A health care provider shall comply with the required price list availability provisions of AS 21.58.230 and the health care data system provisions of AS 21.58.260 that are applicable to health care providers including regulations adopted by the Alaska Health Insurance Corporation under those provisions. Notwithstanding another provision of law, the license of a health care provider is not valid unless the health care provider complies with this section. In this section, "health care provider" has the meaning given in AS 21.58.400.

* Sec. 3. AS 21.39.020 is amended to read:

Sec. 21.39.020. APPLICABILITY. (a) This chapter applies to disability insurance, to all forms of casualty insurance, including fidelity, surety, and guaranty bonds, to all forms of fire, marine, and inland marine insurance, and to a combination of any of them, or risks or operations in this state. Inland marine insurance includes insurance defined by statute, or by interpretation of statute, or if not defined or interpreted, by ruling of the director, or as established by general custom of the

business, as inland marine insurance.

(b) This chapter does not apply to

(1) reinsurance, other than joint reinsurance to the extent stated in AS 21.39.110;

(2) [DISABILITY INSURANCE;

(3)] insurance of vessels or craft, their cargoes, marine builders' risks, marine protection and indemnity, or other risks commonly insured under marine, as distinguished from inland marine insurance policies;

(3) [(4)] insurance against loss of or damage to aircraft or against liability, other than workers' compensation and employer's liability, arising out of the ownership, maintenance, or use of aircraft; or, to insurance of hulls of aircraft, including their accessories and equipment.

* Sec. 4. AS 21.39.030(a) is amended to read:

(a) Rates shall be made in accordance with the following provisions:

(1) rates may [SHALL] not be excessive, inadequate, or unfairly discriminatory;

(2) consideration shall be given to past and prospective loss experience inside and outside this state, to the conflagration and catastrophe hazards, to a reasonable margin for underwriting profit and contingencies, to dividends, savings, or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members, or subscribers, to past and prospective expenses both countrywide and those specially applicable to this state, and to all other relevant factors inside and outside this state;

(3) the systems of expense provisions included in the rates for use by an insurer or group of insurers may differ from those of other insurers or group of insurers to reflect the requirements of the operating methods of the insurer or group of insurers with respect to any kind of insurance, or with respect to a subdivision or combination of them [THEREOF] for which subdivision or combination separate expense provisions are applicable;

(4) risks may be grouped by classifications for the establishment of rates and minimum premiums; classification rates may be modified to produce rates for individual risks in accordance with rating plans that establish standards for

CORRECTION

**THIS DOCUMENT
HAS BEEN REPHOTOGRAPHED
TO ASSURE LEGIBILITY**

business, as inland marine insurance.

(b) This chapter does not apply to

(1) reinsurance, other than joint reinsurance to the extent stated in AS 21.39.110;

(2) [DISABILITY INSURANCE;

(3)] insurance of vessels or craft, their cargoes, marine builders' risks, marine protection and indemnity, or other risks commonly insured under marine, as distinguished from inland marine insurance policies;

(3) [(4)] insurance against loss of or damage to aircraft or against liability, other than workers' compensation and employer's liability, arising out of the ownership, maintenance, or use of aircraft; or, to insurance of hulls of aircraft, including their accessories and equipment.

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(2) consideration shall be given to past and prospective loss experience inside and outside this state, to the conflagration and catastrophe hazards, to a reasonable margin for underwriting profit and contingencies, to dividends, savings, or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members, or subscribers, to past and prospective expenses both countrywide and those specially applicable to this state, and to all other relevant factors inside and outside this state;

(3) the systems of expense provisions included in the rates for use by an insurer or group of insurers may differ from those of other insurers or group of insurers to reflect the requirements of the operating methods of the insurer or group of insurers with respect to any kind of insurance, or with respect to a subdivision or combination of them [THEREOF] for which subdivision or combination separate expense provisions are applicable;

(4) risks may be grouped by classifications for the establishment of rates and minimum premiums; classification rates may be modified to produce rates for individual risks in accordance with rating plans that establish standards for

measuring variations in hazards or expense provisions, or both; the standards may measure any differences among risks that can be demonstrated to have a probable effect upon losses or expenses;

(5) in the case of fire insurance rates, consideration may be given to the experience of the fire insurance business during a period of not more than the most recent five-year period for which experience is available;

(6) when there is an established program to inspect new and existing dwellings and the program has been certified by the director as likely to reduce the incidence of fires in inspected dwellings, then in any rate plan used in this state, dwellings that have been found by the inspection to meet the standards established by the program shall have credits applied to the rate in amounts approved by the director;

(7) in the case of disability insurance rates, rates shall be made on a statewide basis: rates may vary depending on age and family status.

* Sec. 5. AS 21.54 is amended by adding a new section to read:

Sec. 21.54.025. CLAIMS PROCESSING. (a) An insurer authorized to transact disability insurance in the state shall

(1) pay each claim within 15 business days after a claim is received or, within that same time period, give the person that submitted the claim notice that the claim is denied; and

(2) adopt a claims grievance procedure and submit the procedure to the division for approval; after the procedure has been approved, the insurer shall follow the procedure.

(b) If a claim form is fully completed and an insurer fails to pay a claim or give notice that the claim is denied within the time specified in (a) of this section, the insurer shall pay interest at the rate specified in AS 45.45.010, from the 16th business day after the claim was received until paid, on the amount finally determined to be due.

(c) If an insurer denies a claim, the notice that the claim is denied must include a statement of the reason for the denial. The statement must be sufficiently clear to allow the provider to understand the reason for the denial and to take corrective action, including resubmission of the claim, if appropriate.

* Sec. 6. AS 21 is amended by adding a new chapter to read:

CHAPTER 58. ALASKA HEALTH INSURANCE CORPORATION.

Sec. 21.58.010. CREATION AND PURPOSE. (a) The Alaska Health Insurance Corporation is established. The corporation is a public corporation and an instrumentality of the state in the Department of Commerce and Economic Development but has a legal existence independent of and separate from the state. The exercise by the corporation of the powers conferred by this chapter is considered an essential function of the state.

(b) The purposes of the corporation are to establish and provide uniform health insurance coverage for all residents of the state and to monitor and control all health care expenditures in the state.

Sec. 21.58.020. BOARD OF DIRECTORS. The corporation is managed by a board of seven directors.

Sec. 21.58.030. APPOINTMENT AND REMOVAL OF DIRECTORS. (a) The directors of the corporation are appointed by the governor, subject to confirmation by the legislature. A director may be removed only for good cause.

(b) In appointing directors to the board, the governor shall ensure that

(1) a majority of the board are experts in health care issues and fairly represent the interests of the general public in having access to quality and affordable health care;

(2) the interests of consumers and health care providers are fairly represented;

(3) the director is a resident of the state; and

(4) the board has a gender and geographic composition that approximates the population of the state.

Sec. 21.58.040. TERM OF SERVICE. The term of a director is four years. Terms of directors shall be staggered. A director may be appointed to successive terms. A director appointed to fill a vacancy serves for the unexpired term of the director. A term shall be measured from January 1 of the year in which the term of the vacant position begins, regardless of when the vacancy is filled.

Sec. 21.58.050. COMPENSATION AND EXPENSES. A director is entitled to receive compensation at the rate of \$400 for each day spent in performing duties as a board member and to travel and per diem expenses authorized by law for boards