

SENATE BILL NO. 282

IN THE LEGISLATURE OF THE STATE OF ALASKA

NINETEENTH LEGISLATURE - SECOND SESSION

BY SENATORS DUNCAN, Ellis

Introduced: 2/9/96

Referred: L&C, JUD, FIN

A BILL

FOR AN ACT ENTITLED

1 "An Act relating to regulation of managed care health insurance plans and
2 utilization review companies; and providing for an effective date."

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

4 * **Section 1.** SHORT TITLE. This Act may be known as the Managed Care Bill of Rights.

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

6 CHAPTER 07. REGULATION OF MANAGED CARE AND
7 UTILIZATION REVIEW.

8 Sec. 21.07.010. CERTIFICATION BY DIRECTOR. (a) The director shall
9 adopt regulations for the certification of managed care plans and utilization review
10 companies. Certification shall authorize a plan or company to offer services to state
11 residents, and a plan or company may not operate within the state without certification.

12 (b) A managed care plan may not be certified unless the plan

13 (1) assures both availability and accessibility of adequate personnel and
14 facilities in a manner enhancing availability, accessibility, and continuity of health care

1 services;

2 (2) has an internal quality assurance system to identify, evaluate, and
3 remedy problems relating to access, continuity, underutilization, and quality of care;

4 (3) has an appeals procedure that allows consumers and providers to
5 obtain timely review and resolution of decisions to deny, reduce, terminate, or refuse
6 payment for services;

7 (4) has mechanisms and the financial ability to provide or arrange for
8 provision of basic health care services on a prepaid basis;

9 (5) complies with state and federal confidentiality laws;

10 (6) has procedures to prevent discrimination against potential or current
11 enrollees or providers;

12 (7) uses marketing practices that comply with state law;

13 (8) has the ability to collect necessary data;

14 (9) includes the names and addresses of the plan's executive officers
15 and members of the Enrollee Advisory Board;

16 (10) complies with all other provisions of this chapter pertaining to
17 operation of managed care plans; and

18 (11) meets other requirements determined by the director.

19 (c) A utilization review company may not be certified unless the company

20 (1) identifies a medical director responsible for all clinical decisions;

21 (2) provides assurance that a decision to deny, reduce, or terminate
22 health care services will be made by a person with appropriate experience and based
23 on sound clinical reasoning;

24 (3) does not provide financial or other incentives to encourage decisions
25 to deny, reduce, or terminate care;

26 (4) provides assurance of due process appeals rights for enrollees, the
27 enrollee's representatives, and providers; and

28 (5) meets other requirements determined by the director.

29 (d) The director may grant certification to a managed care plan or utilization
30 review company that meets requirements of a state licensure or national accreditation
31 body that are at least equivalent to those established by the director.

1 (e) A decision to grant or deny a certificate of authority shall be made to the
2 applying managed care plan or utilization review company in writing. A denial shall
3 be accompanied with the reason for the denial, and the plan or company shall be
4 provided with an opportunity to provide additional information in response to the
5 denial.

6 (f) The director shall conduct an annual review of each certified managed care
7 plan or utilization review company, including review of the number, types, and
8 resolution of grievances and appeals, medical audits, reports of quality assurance
9 reviewers, enrollee satisfaction surveys, the rate and survey of individuals who
10 voluntarily disenroll, provider surveys, health care service delivery, and medical
11 outcomes compared to the medical objectives in the plan's quality assurance plan,
12 records of organization, and its contractors. After conducting the annual review
13 required under this subsection, the director shall

- 14 (1) recertify the plan;
- 15 (2) require remedial actions; or
- 16 (3) revoke certification.

17 Sec. 21.07.020. ACCESS TO HEALTH CARE PROVIDERS. (a) A managed
18 care plan must include a sufficient number of each category of health care provider,
19 including specialists within each category, throughout the service area to meet the
20 needs of its enrollees and to provide enrollees a meaningful choice of provider within
21 each category of provider. The director shall determine enrollee provider requirements
22 for each plan. Enrollee provider requirements must be based on the characteristics of
23 the plan's enrollee population, including age, sex, and health status, acute or chronic
24 conditions, and special needs.

25 (b) The director shall by regulation establish uniform access standards for
26 managed care plans operating in the state, including travel and distance standards for
27 both primary and specialty care, waiting times for appointments, and ability of plans
28 to meet the linguistic and cultural needs of the population served.

29 Sec. 21.07.030. ACCESS TO SPECIALITY AND ESSENTIAL CARE. (a)
30 An enrollee who has a degenerative, disabling, or life-threatening disease or condition,
31 or another disease or condition that has been designated by the director as requiring

1 the regular care of a specialist, shall be able to designate an appropriate specialist as
2 the enrollee's care coordinator. An enrollee's care coordinator shall, when referring
3 an enrollee to a specialist, provide the enrollee with a choice of a sufficient number
4 of providers to offer the enrollee a meaningful choice among providers.

5 (b) An enrollee who is enrolled in a managed care plan and who, at the time
6 of enrollment or in the year previous to enrollment, has been receiving treatment from
7 a provider who is not part of the plan for a degenerative, disabling, or life-threatening
8 disease or condition, or any other disease or condition that has been designated by the
9 director as requiring the regular care of a specialist, may continue to receive treatment
10 from the provider for a reasonable period of time, to be determined by the director.
11 An enrollee who receives treatment by a nonparticipating provider may not be required
12 to pay additional out-of-pocket costs other than those that would be incurred for
13 receiving care from a participating provider. The plan may not require the enrollee
14 who is receiving care from a nonparticipating provider to receive care from a
15 participating provider without first establishing that the participating provider is
16 qualified to provide the necessary level of care and without establishing procedures to
17 assure that the transition to a participating provider does not jeopardize the health of
18 the enrollee.

19 (c) An enrollee may seek and receive care from a nonparticipating provider in
20 a particular speciality when a specialist who is a participating provider and who is
21 appropriately qualified to care for the enrollee's health condition is not promptly
22 available. Out-of-pocket costs to an enrollee who receives care under these
23 circumstances may not exceed costs imposed if the enrollee had received care from a
24 participating provider.

25 (d) A managed care plan must enter into contracts with essential community
26 providers on terms at least as favorable as those with other providers. In this
27 subsection, "essential community providers" includes federally qualified health centers,
28 school based clinics, family planning and sexually transmitted disease clinics,
29 municipal health departments, public hospitals, and special care providers.

30 (e) A managed care plan must guarantee access to specialized treatment
31 expertise by entering into agreements with specialized care centers to ensure enrollees

1 may elect to receive treatment at specialized care centers. A plan is in compliance
2 with this subsection if the plan agreement allows the enrollee to elect to be referred
3 to a special care center in a timely manner, informs enrollees of the availability of
4 referral care, and establishes an appeals mechanism through which the enrollee may
5 challenge referrals to a specialized care center.

6 Sec. 21.07.040. CHOICE OF HEALTH CARE PROVIDER. (a) A managed
7 care plan must allow an enrollee to designate the enrollee's own care coordinator from
8 a list of providers who serve as care coordinators supplied by the plan. The care
9 coordinator list must include a sufficient number of each category of provider,
10 including each category of specialist. The list of providers must include the following
11 information about each provider: speciality, board certification, years in practice,
12 hospital affiliation, location of office, office hours, and whether the specialist is
13 currently accepting new patients.

14 (b) An enrollee

15 (1) under the age of 18 may designate a pediatrician as the enrollee's
16 care coordinator;

17 (2) may, if a female, designate a specialist in obstetrics or gynecology
18 as the enrollee's care coordinator;

19 (3) who has a degenerative, disabling, or life-threatening disease or
20 condition, or another disease or condition that has been designated by the director as
21 requiring the regular care of a specialist, may designate an appropriate specialist as the
22 enrollee's care coordinator;

23 (4) may designate as a separate care coordinator for mental health
24 services a psychiatric physician, psychologist, psychiatric nurse, or licensed social
25 worker who is a participating provider; in the event that an enrollee designates a
26 mental health care coordinator who is not a physician, the mental health care
27 coordinator shall be responsible for assuring coordination of care of services other than
28 mental health services with the enrollee's care coordinator;

29 (5) may change the designation of care coordinator within 30 days of
30 the first visit to the care coordinator, at least once every six months, or any time that
31 the enrollee shows good cause.

1 (c) An enrollee's care coordinator shall, when referring an enrollee to another
2 provider, provide the enrollee with a choice of a sufficient number of providers to
3 provide a meaningful choice among providers.

4 (d) In this section, "care coordinator" means a licensed or certified health care
5 professional who supervises, coordinates, and provides initial and basic care, provides
6 speciality care when appropriate, initiates referral to specialists and maintains
7 continuity of care, and includes a primary care physician, specialist physician,
8 physician's assistant, nurse practitioner, or nurse midwife.

9 Sec. 21.07.050. NONPARTICIPATING PROVIDERS. A managed care plan
10 must allow a provider to participate in the managed care plan if the provider is willing
11 to abide by the terms and conditions of the plan contract or arrangement.

12 Sec. 21.07.060. HEALTH CARE SERVICES OUTSIDE OF PLAN. An
13 enrollee in a managed care plan may seek health care services covered by the plan
14 from providers who are not participating providers in the plan. The plan must
15 reimburse nonparticipating providers when a plan enrollee elects to seek their services,
16 and reimbursement must be at rates that are reasonable and customary. An enrollee
17 may elect a nonparticipating provider as the enrollee's care coordinator. The plan may
18 charge an enrollee a reasonable, affordable, and appropriate deductible and copayment,
19 subject to a reasonable, appropriate, and affordable out-of-pocket limit, when an
20 enrollee seeks care from a nonparticipating provider. The director shall determine the
21 permitted levels of deductibles, coinsurance, and out-of-pocket expenses; however, the
22 limit may not be greater than that customarily charged by a health insurance plan that
23 does not impose upon enrollees lower out-of-pocket expenses for care received within
24 a provider network. The director may not allow charges that impede access to
25 necessary provider services. The director may establish lower out-of-pocket expenses
26 for enrollees with lower incomes if the director finds that this will avoid impeding
27 access of enrollees to necessary health care services.

28 Sec. 21.07.070. UTILIZATION REVIEW. (a) A plan's utilization review
29 system must be based on sound clinical evidence and must be established,
30 administered, evaluated, and periodically updated under the supervision of health care
31 providers with demonstrated experience and expertise in the relevant field.

1 (b) Upon request, a managed care plan must make available to an enrollee, a
2 prospective enrollee, a plan provider, or the public, at no charge, the criteria used in
3 the utilization review system, the methods by which they are applied, and the method
4 of development. When a specific determination is being made, a plan shall make
5 available to the enrollee and to the provider, at no charge, the specific review
6 standards, criteria, and procedures used in making the particular determination.

7 (c) A plan's utilization review system

8 (1) must have personnel available and accessible by toll-free telephone
9 at least 40 hours a week during normal business hours in the provider's local time
10 zone and at other times determined by the director to discuss patient care and to
11 receive information and inquiries regarding review decisions; at times when the
12 telephone line is not staffed by personnel, the plan's utilization review system must
13 have a system in place for recording incoming calls and to ensure a response to
14 accepted messages not less than one business day after the date on which the call was
15 received;

16 (2) must collect only information that is necessary to make a
17 determination for the particular patient; requests for records shall be made on a
18 reasonable basis based on the characteristics of the patient, condition or health care
19 procedure, treatment or service; an adverse action by the plan may not be based on
20 lack of access to records as long as the patient's provider has made available the
21 specific information described in this paragraph;

22 (3) must make utilization review determinations within one business
23 day either by telephone, facsimile, or in writing to the health care provider and to the
24 enrollee; if the initial notification of a decision was not made in writing, a written
25 transmission shall be provided to the provider and enrollee within three business days
26 of the determination; utilization review of continued care or treatment that has been
27 previously approved or for which reimbursement has been made may not be made
28 more frequently than is reasonably required to assess whether the health care
29 procedures, treatments, or services under review are necessary; notification of
30 continued services shall include the number of extended days or next review date and
31 the new total number of days or services approved; if the review of continuing care

1 results in an adverse action, plan coverage or reimbursement shall be continued until
2 the patient is notified of the adverse decision and afforded an opportunity to appeal the
3 decision;

4 (4) must make utilization review determinations of a treatment or
5 service that has already been provided within 30 days of receipt of the necessary
6 information;

7 (5) may not permit or provide compensation or anything of value to its
8 employees or agents based on a utilization review determination;

9 (6) may not evaluate or set performance standards for its employees or
10 agents based on the value or volume of adverse actions, establishment of limitations
11 on the provision of services, treatments, procedures, supplies, or pharmaceuticals
12 provided by a managed care plan, or on the number or frequency of communications
13 with health care providers or patients.

14 Sec. 21.07.080. EMERGENCY CARE. (a) An enrollee

15 (1) may file a grievance in the event of a determination by a managed
16 care plan that provider services did not come under the definition of emergency care;

17 (2) may seek and receive emergency care without prior approval or
18 authorization by a managed care plan;

19 (3) may seek and receive emergency care from the provider that is the
20 most accessible in terms of time to the enrollee regardless of whether that provider is
21 a participating provider;

22 (4) or a person acting on the enrollee's behalf shall notify the managed
23 care plan as soon as practical, with regard to the facts and circumstances under which
24 emergency care was sought and received;

25 (5) who was admitted as an inpatient after receiving emergency care
26 from a nonparticipating provider, may not be transferred to a participating provider
27 until the enrollee's medical condition has stabilized and the transfer would not in any
28 way endanger the health of the enrollee; an enrollee may appeal a transfer decision by
29 the filing of a grievance.

30 (b) Nonparticipating providers who provided emergency care to an enrollee
31 shall be reimbursed at reasonable and customary rates. Out-of-pocket expenses for an

1 enrollee who receives emergency care must be the same as if the care received was not
2 emergency care for comparable services, regardless of whether the emergency care was
3 provided by a participating provider or a nonparticipating provider.

4 (c) In this section, "emergency care" means those health care procedures,
5 treatments, or services that are provided after the onset of a medical condition that
6 manifests itself by symptoms of sufficient severity, including severe pain, so that the
7 absence of immediate medical attention could reasonably be expected by a prudent
8 layperson to result in

- 9 (1) placing the patient's health in serious jeopardy;
- 10 (2) serious impairment of bodily functions;
- 11 (3) serious dysfunction of a bodily organ or part; or
- 12 (4) disfigurement of the patient.

13 Sec. 21.07.090. EXPERIMENTAL HEALTH CARE SERVICES. (a) A
14 managed care plan that provides coverage for prescribed drugs or devices approved by
15 the United States Food and Drug Administration may not exclude coverage of an
16 approved drug or device on the basis that the approved drug or device has not been
17 specifically approved by the United States Food and Drug Administration for treatment
18 of the disease or condition for which it has been prescribed; however, the drug or
19 device must be

20 (1) recognized for treatment of the specific disease or condition in the
21 American Medical Association Drug Evaluation, the American Hospital Association
22 Formulary Service Drug Information, or the United States Pharmacopeia Drug
23 Information; or

24 (2) recommended for use by article or editorial comment in a peer
25 reviewed medical or scientific journal.

26 (b) A managed care plan must provide coverage and reimbursement for care
27 that it considers investigational or experimental under the same terms as it would for
28 care that is not considered investigational or experimental if

- 29 (1) the treatment is for life-threatening, degenerative, or permanently
30 disabling conditions, or a condition associated with a complication of such a condition;
- 31 (2) the treatment is provided with therapeutic or palliative intent;

1 (3) the proposed treatment has been reviewed and approved by a
2 qualified institutional review board;

3 (4) the facility and personnel providing the treatment are qualified by
4 virtue of their experience and training; and

5 (5) there is no clearly superior, noninvestigational alternative to the
6 treatment.

7 (c) A managed care plan must cover the patient costs incurred in clinical trials
8 of experimental or investigational treatments to the extent that the costs would be
9 covered in noninvestigational treatments, providing that the following conditions are
10 satisfied:

11 (1) the treatment is being provided under a clinical trial approved by
12 one of the National Institutes of Health, a National Institute of Health cooperative
13 group or center, the United States Food and Drug Administration in the form of an
14 investigational new drug exemption, the federal Department of Veterans Affairs, or a
15 qualified nongovernmental research entity as identified in guidelines issued by
16 individual National Institutes of Health for center support grants;

17 (2) there is not a clearly superior, noninvestigational alternative to the
18 treatment;

19 (3) the available clinical or preclinical data provide a reasonable
20 expectation that the protocol treatment will be at least as effective as an available
21 noninvestigational alternative treatment;

22 (4) the treatment is for life-threatening, degenerative, or permanently
23 disabling conditions, or a condition associated with a complication of that condition;

24 (5) the treatment is provided with therapeutic or palliative intent;

25 (6) the proposed treatment has been reviewed and approved by a
26 qualified institutional review board; and

27 (7) the facility and personnel providing the treatment are qualified by
28 virtue of their experience and training.

29 Sec. 21.07.100. REQUIRED PLAN PROVISIONS. (a) A managed care plan
30 may not charge a deductible, copayment, or impose another out-of-pocket expense
31 upon an enrollee who is a Medicaid beneficiary. A plan must also provide that an

1 enrollee who can demonstrate income below the federal poverty level is not required
2 to pay a deductible, copayment, or another out-of-pocket cost.

3 (b) Out-of-pocket costs imposed by a plan must be reasonable, appropriate, and
4 affordable and must not be so great as to discourage an enrollee from seeking needed
5 care. A plan may not impose a deductible for health care services provided to an
6 enrollee who can demonstrate an income that is less than 200 percent of the federal
7 poverty level. The director shall establish a schedule of maximum deductibles,
8 copayments, and out-of-pocket costs for all enrollees that takes into consideration the
9 income of enrollees.

10 (c) A managed care plan may not require an enrollee to pay the cost of
11 transportation to and from a health care provider if the enrollee is eligible to receive
12 medical assistance under 42 U.S.C. 1396 - 1396p (Social Security Act).

13 (d) A plan enrollee shall be notified in writing of the provisions of this section
14 and how to apply to have out-of-pocket costs eliminated or reduced if the enrollee is
15 qualified. Notification shall occur at initial enrollment and on an annual basis.

16 Sec. 21.07.110. REPORTING REVENUE; REQUIRED EXPENDITURE. (a)
17 A managed care plan must report on an annual basis, on a form prescribed by the
18 director, all revenue, expenses, surpluses, and losses, including revenue from
19 premiums, investments, and other sources, and expenses for health care services
20 including marketing, advertising, utilization review, grievance procedures, enrollment,
21 and compensation for officers. The director shall calculate the ratio of all dollars spent
22 on the direct provision of health care services in relation to the total dollars of all
23 revenue. The annual report required under this subsection shall be made available to
24 the public and shall be sent to enrollees or prospective enrollees upon request.

25 (b) A managed care plan with a ratio calculated under (a) of this section of
26 less than 85 percent must enter into an agreement with the director to return the excess
27 revenue to the plan's enrollees by reducing health insurance premiums, providing
28 direct credits to enrollees, or increasing expenditures on health care services.

29 Sec. 21.07.120. QUALITY OF CARE STANDARDS; INTERNAL QUALITY
30 ASSURANCE. (a) The director shall establish by regulation uniform requirements
31 for managed care plans, including entities with which they contract, that include

1 performance and outcome based quality standards.

2 (b) A managed care plan must establish and implement an internal quality
3 assurance system adequate to identify, evaluate, and remedy problems relating to
4 access, continuity and quality of care, and utilization review. The internal quality
5 assurance system must provide for

6 (1) the designation of the corporate board, committee, or a designated
7 executive staff responsible for implementation and continuous monitoring of the
8 internal quality assurance system;

9 (2) a detailed set of quality assurance objectives, with timetables,
10 including assurance of adequate resources to deliver a full continuum of care and
11 guarantee geographic availability, cultural sensitivity, and planning for enrollees with
12 disabilities;

13 (3) health service delivery standards or practice guidelines that are
14 aimed at curing illness and at maintaining function and improving quality of life;
15 guidelines must be updated continuously with input from providers, disseminated to
16 providers, developed for the full spectrum of plan populations, based on reasonable
17 scientific knowledge, focused on outcomes and access, and supplied to individual and
18 group providers;

19 (4) written guidelines for quality of care studies and care monitoring,
20 including evaluation of vulnerable populations;

21 (5) a methodology for identifying quality indicators relating to specific
22 clinical or health service delivery areas; the methodology must be objective,
23 measurable, and based on current knowledge and clinical experience, including the
24 utilization of epidemiological data, chart reviews, patterns of care, patient surveys, spot
25 checks, and continuous review by health professionals;

26 (6) the identification, evaluation, and remediation of problems relating
27 to access, continuity, and quality of care, including a system for evaluating health
28 outcomes consistent with current technology;

29 (7) involvement by plan enrollees and providers;

30 (8) credentialing and recredentialing of medical services providers;

31 (9) reports to the director within 30 days of the occurrence of any of

1 the following: the suspension, restriction, termination, or curtailment of training of a
2 health care provider for any reason relating to alleged mental or physical impairment,
3 incompetence, malpractice or misconduct, or impairment of patient safety or welfare;
4 the voluntary or involuntary termination of a contract to avoid the imposition of
5 disciplinary measures against a health care provider; the receipt of information that
6 indicates that a provider has been convicted of a crime; or the denial of staff privileges
7 to a physician or the refusal to enter into or renew a contract with a physician for the
8 provision of services if the reasons stated for denial or refusal are related to alleged
9 mental or physical impairment, incompetence, malpractice, misconduct, or impairment
10 of patient safety or welfare;

11 (10) a system to protect and promote enrollee rights, including an
12 appeals and grievance system and confidentiality standards; and

13 (11) a system to ensure compliance with all quality assurance standards
14 by an entity providing services under a contractual agreement, including evidence that
15 the plan will monitor compliance and require remedial action if necessary.

16 (c) A plan must provide a process for the credentialing and recredentialing of
17 providers that, at a minimum,

18 (1) establishes written policies and procedures that are reviewed and
19 approved by the plan's governing body and that are based on objective standards of
20 quality developed in consultation with appropriately qualified health care providers;

21 (2) affords all health care providers within the plan's geographic service
22 area the ability to apply for provider credentials and to have their applications
23 reviewed by a credentialing committee with appropriate representation of the provider's
24 specialty or professional discipline and, if a plan denies credentials, informs the
25 provider for the reasons for the denial, including economic considerations, in writing;

26 (3) guarantees access to specialized treatment expertise by entering into
27 agreements with centers of specialized care;

28 (4) for individual practitioners, requires verification of current license;
29 submission of the history of any license suspension, sanction, or revocation;
30 submission of records relating to medical school, residency, work history, clinical
31 privileges, liability claims history, history of chemical dependency or abuse within the

1 last 12 months; and compliance with continuing education requirements;

2 (5) establishes review and approval procedures for health delivery
3 organizations with which the plan intends to contract, including an initial site visit;

4 (6) prohibits the use of economic considerations or economic profiling
5 of providers unless the considerations or profiles use objective criteria adjusted to
6 recognize case mix, severity of illness, and age;

7 (7) prohibits the termination without cause of a provider;

8 (8) prohibits the termination of a provider for advocating for a
9 particular treatment or service on behalf of an enrollee or for filing an appeal or
10 appearing as a witness at a hearing on behalf of an enrollee;

11 (9) provides a written notice of a termination proceeding and an
12 opportunity to complete a corrective action plan, except where there is imminent harm
13 to patient health;

14 (10) includes a process to recredential providers at least every two
15 years, considering member complaints, medical record reviews, member satisfaction
16 surveys, and results of quality reviews; and

17 (11) establishes an appeals mechanism and procedures by which
18 credential denials, credential reductions, or provider terminations can be challenged
19 including notice of the complaint, an opportunity to be heard, and an opportunity to
20 take corrective action, except where action is needed to protect the life, health, or
21 safety of plan enrollees.

22 Sec. 21.07.130. PLAN AUDIT; REQUIRE DATA. (a) The director shall
23 annually conduct an audit or contract with one or more independent quality assurance
24 organizations to audit the quality of care and services furnished by a managed care
25 plan. The director may not contract with a quality assurance organization that is
26 owned, operated, or controlled by a plan or that has a financial relationship with a
27 plan. Plan enrollees or participating providers may request that the director review all
28 or a portion of a plan's quality assurance program.

29 (b) An annual audit must include the following:

30 (1) compliance with performance and outcome based quality standards
31 adopted by the director;

1 (2) appropriateness, accessibility, timeliness, and quality of care
2 delivered by providers;

3 (3) coordination, management, and cost effectiveness of care;

4 (4) delivery of medically necessary covered services, including referrals
5 for necessary services and capacity and scope of the network of providers;

6 (5) the plan's ability to provide information to an enrollee in clear and
7 coherent terms that are commonly used and in a culturally and linguistically
8 appropriate and understandable manner in light of the enrollee's needs, circumstances,
9 and language proficiency; and

10 (6) any other requirements established by the director.

11 (c) Upon request, a provider employed by a plan shall collect and submit to
12 the director or independent quality assurance organization conducting the audit, in a
13 standardized format, enrollee care and satisfaction data including

14 (1) encounter and service utilization data, including special care and
15 chronic care utilization data;

16 (2) emergency medical care utilization data;

17 (3) outcome based data;

18 (4) grievance and appeals data;

19 (5) disenrollment data, including reasons for disenrollment;

20 (6) access data, including waiting times, travel times, enrollee-to-
21 provider ratios, and unduplicated provider capacity; and

22 (7) any other data required by the director.

23 (d) The director or independent quality assurance organization shall analyze
24 the data provided under (c) of this section and annually prepare a summary report.
25 The report must include results of the quality assurance review and recommendations
26 for remedial action.

27 Sec. 21.07.140. REQUIRED SURVEY. The director shall periodically conduct
28 and publish surveys of managed care enrollees and participating providers to determine
29 satisfaction with plan services. A survey must differentiate between infrequent and
30 frequent utilizers of plan services.

31 Sec. 21.07.150. COMPLAINT AND GRIEVANCE PROCEDURE. (a) A

1 managed care plan must establish and maintain a complaint and grievance procedure
2 to assure that enrollees may seek a review of an adverse action or a practice of the
3 plan that affects an enrollee's access to, satisfaction with, or quality of health care
4 services or treatments. A grievance filed by an enrollee may include the following
5 practices:

- 6 (1) distance or time necessary to travel to a participating provider;
- 7 (2) waiting times for appointments;
- 8 (3) waiting times after arrival for an appointment;
- 9 (4) languages spoken by participating providers;
- 10 (5) access to specialists needed to treat members' health problems;
- 11 (6) cleanliness and safety of participating providers' facilities;
- 12 (7) qualifications and experience of participating providers;
- 13 (8) sufficient choice of participating provider with qualifications and
14 experience necessary to provide needed health care services;
- 15 (9) the manner in which the enrollee is treated by managed care
16 employees or agents or by a participating provider;
- 17 (10) access to appropriate services and treatments;
- 18 (11) timeliness with which referrals, treatments, and services are
19 approved and provided;
- 20 (12) approval of emergency care.

21 (b) A managed care plan must inform all enrollees of the complaint and
22 grievance procedure, orally and in writing, in each enrollee's own language at the time
23 of initial enrollment, at annual intervals thereafter, and at any time that an adverse
24 action is taken with respect to the enrollee.

25 (c) Written descriptions of the grievance procedure shall be posted in
26 conspicuous locations in each reception area at a facility where services are offered by
27 or on behalf of a managed care plan. Notices to enrollees describing the complaint
28 and grievance procedure, as well as posted notices, must explain

- 29 (1) the process for filing a grievance with the managed care plan;
- 30 (2) that the enrollee has the right to request a hearing under
31 AS 21.07.160 regarding an adverse action taken by the plan without first filing a

1 grievance with the managed care plan;

2 (3) that the enrollee is entitled to a second opinion by a physician
3 offering services for or on behalf of the managed care plan and, if circumstances
4 warrant, by a physician independent of the plan;

5 (4) the circumstances under which treatment or services must be
6 continued pending the resolution of a complaint;

7 (5) the right to have a representative, including an attorney, of the
8 enrollee's own choice; and

9 (6) the time periods within which a grievance must be resolved by a
10 managed care plan.

11 (d) An enrollee may file a grievance either orally or in writing. Complaint
12 forms must be readily available in each reception area at a facility where services are
13 offered, and shall be furnished promptly upon request. Personnel shall be available to
14 provide assistance, as requested, in the completion of complaint forms. Oral
15 grievances may be filed either in person or by telephone. A managed care plan must
16 provide a telephone procedure for filing grievances. A telephone number must be
17 prominently displayed on all notices describing the grievance procedure. A telephone
18 procedure must have personnel available and accessible by toll-free telephone at least
19 40 hours a week during normal business hours, and at other times determined by the
20 director, with the capacity to accept grievances in those languages commonly utilized
21 by enrollees of the plan. At times when the telephone line is not staffed by personnel,
22 the plan must have a system in place for recording incoming calls and to ensure a
23 response to accepted messages not less than one business day after the date on which
24 the call was received.

25 (e) A plan must establish procedures to facilitate the filing of a grievance and
26 the appeal of an adverse action for enrollees who do not speak English, who have
27 literacy problems, and who have physical or mental disabilities that impede their
28 ability to file a grievance.

29 (f) An enrollee may designate a representative to file and pursue a grievance
30 on the enrollee's behalf.

31 (g) Within five business days of receipt of a grievance, a notice of

1 acknowledgment shall be sent to the enrollee. The notice must contain the name and
2 telephone number of the individual responsible for the resolution of the grievance. A
3 grievance must be resolved in the most expeditious possible manner, and not more
4 than 24 hours after the grievance is filed if the adverse action could jeopardize a
5 enrollee's health or well-being, or not more than 15 business days after the grievance
6 is filed in all other instances.

7 (h) A grievance shall be reviewed by appropriate providers who are specified
8 by the managed care plan, and who

9 (1) have expertise in managing the medical condition, procedure, or
10 treatment under appeal, are in the same licensed profession as the health care provider
11 who proposed or delivered the health care services, and, if the health care provider is
12 a physician, shall be made by another physician in the same or a similar specialty;

13 (2) are not involved in the adverse action giving rise to the grievance;
14 and

15 (3) do not have a financial interest in the resolution of the grievance.

16 (i) The enrollee shall receive written notification of the resolution of a
17 grievance. The notification must include

18 (1) the decision reached by the managed care plan, the reasons for the
19 decision, and the policies or procedures of the plan that provide the basis for the
20 decision;

21 (2) the identity of the individuals who reviewed and resolved the
22 grievance on behalf of the managed care plan; and

23 (3) notification of the enrollee's right to seek further review of the
24 decision reached by the managed care plan through a hearing.

25 (j) If an adverse action taken by a managed care plan involves the reduction,
26 suspension, or termination of ongoing treatment or services that have been ordered by
27 a provider, and an enrollee files an oral or written grievance seeking continued
28 treatment or services within 10 days of receiving actual notice of reduction,
29 suspension, or termination of the treatment or services, the treatment or services shall
30 be continued at the level ordered by the provider pending a final decision on the
31 enrollee's grievance or the outcome of a hearing requested by the enrollee with respect

1 to the adverse action, whichever is later.

2 (k) An enrollee who is dissatisfied with a decision about treatment or services
3 made by a plan provider may request and receive a second opinion from another
4 provider. A second opinion shall be rendered by a provider who is not employed in
5 the same office as the provider rendering the original decision.

6 (l) A managed care plan

7 (1) may not retaliate or take discriminatory action against an enrollee
8 filing a grievance; and

9 (2) shall maintain records, and report to the director on a regular basis,
10 on the grievances filed by its enrollees, the issues raised in grievances, and the manner
11 in which grievances have been resolved, including the appropriate corrective actions
12 taken to address underlying or systemic problems.

13 Sec. 21.07.160. HEARINGS; PROCEDURES. A plan must provide an
14 enrollee with the opportunity to have a hearing before an impartial hearing officer if
15 the enrollee appeals an adverse action or decision reached by a managed care plan.
16 The hearing process established under this section may be used by an enrollee without
17 first utilizing the grievance procedure provided by the plan. A hearing provided under
18 this section must include

19 (1) a process by which the director appoints impartial hearing officers
20 who shall hear appeals from enrollees with regard to an adverse action or decision
21 reached by a managed care plan;

22 (2) the appointment of hearing officers in each region of the state to
23 assure that hearings are held within the times required by this section;

24 (3) a hearing time and location that is accessible to the enrollee and to
25 the managed care plan;

26 (4) the right to file an appeal orally or in writing; the plan shall provide
27 written acknowledgment of an appeal, including notice of a hearing officer to consider
28 the appeal, within five business days of the filing of an appeal; in the event that the
29 enrollee's health is in serious jeopardy, the plan shall provide acknowledgment of the
30 appeal within 24 hours of receiving notice of the appeal;

31 (5) access, at no charge, to all records regarding the adverse action or

1 grievance under appeal, including all deliberations with regard to the item under
2 appeal, all records of communication between the managed care plan, its employees,
3 and agents, and all records used in utilization review of an original or continuing
4 review of the enrollee's care;

5 (6) the right to a hearing and a decision rendered within 48 hours of
6 the filing of an appeal if the item under appeal threatens serious jeopardy to the health
7 of the enrollee; in all other instances, a hearing shall be held within 15 business days
8 of the filing of an appeal;

9 (7) the right of the hearing officer to seek an opinion on the appeal
10 from a provider who has expertise in managing the medical condition, procedure, or
11 treatment under appeal;

12 (8) the right of an enrollee, an enrollee's designee, the managed care
13 plan, and the plan's designee to present testimony regarding the appeal before the
14 hearing officer;

15 (9) a requirement that the decision of a hearing officer must be
16 transmitted in writing to the enrollee or the enrollee's designee, the managed care plan,
17 and the director;

18 (10) the right to appeal a decision of a hearing officer by filing an
19 appeal in the appropriate court.

20 Sec. 21.07.170. PLAN DOCUMENTATION. (a) Upon request by a
21 prospective enrollee and not less than annually for an enrollee, participating provider,
22 and the director, the following material must be provided by a plan:

23 (1) information detailing coverage provisions, health care benefits, or
24 benefit maximums, drug formularies, and exclusions of specific conditions, ailments,
25 or disorders; this information must include prominent notice of services excluded on
26 the basis of being experimental or investigational;

27 (2) a description of all prior authorization or other requirements for
28 health care services and a description of utilization review mechanisms used by the
29 plan;

30 (3) a description of financial arrangements or contractual provisions
31 with health care providers or utilization review agents that may restrict referral or

1 treatment options or limit the service offered to an enrollee;

2 (4) a description of plan payment arrangements with physicians and
3 other providers, both within and out of the plan;

4 (5) a description of circumstances when enrollees may use out-of-plan
5 providers without additional charges, and when additional coinsurance and deductibles
6 will be charged;

7 (6) a description of the grievance procedure used to resolve disputes
8 between a managed care plan and an enrollee or the enrollee's health care provider,
9 including names, addresses, and phone numbers to access the procedures, including
10 available ombudsman services;

11 (7) a description of the procedure for providing care and coverage 24
12 hours a day for emergency health services, including those received outside of the
13 enrollee's service area;

14 (8) a description of limitations on an enrollee's freedom to select
15 primary and specialty care providers covered by the plan;

16 (9) whether the plan is for profit or is a nonprofit plan;

17 (10) the percentage of premiums expended on health services,
18 administrative services, and plan marketing;

19 (11) the procedures for ensuring prompt exchange of information about
20 an enrollee among all the enrollee's providers;

21 (12) the criteria used to determine that a service or drug is experimental
22 or investigational if coverage is denied as a consequence;

23 (13) a description of how enrollees and their consumer representatives
24 may participate in the development of the policies of the plan;

25 (14) a quarterly update by geographic region, of the name, address,
26 phone number, office hours, specialty, hospital affiliations, language proficiency,
27 professional experience, and credentials of the providers enrolled in the plan and
28 whether the providers are accepting new patients;

29 (15) the waiting time statistics, including the average waiting time for
30 primary care appointments, specialist referrals and appointments, referrals and
31 appointments for laboratory services, and for inpatient services;

1 (16) information on key performance measures, including the number
2 and proportion of women enrolled in the plan over the age of 35 who have not had
3 annual pap tests and mammograms; the proportion and number of children enrolled
4 who have not had complete immunizations before age five; the percentage of pregnant
5 women not receiving prenatal care during the first trimester; and the number and
6 proportion of enrollees with known human immunodeficiency virus infection who are
7 not receiving treatment;

8 (17) enrollee satisfaction information, including average enrollment
9 period for plan members, reenrollment and disenrollment statistics, and enrollee
10 reasons for leaving the plan;

11 (18) the proportion of requests for treatment or services that were
12 denied by the plan to the number of requests for treatment or services received;

13 (19) the number of claims or requests for services denied on the
14 grounds that (A) the service was not medically necessary or (B) the service was
15 experimental or investigative in nature; and the ratio of this number to the total claims
16 paid by the plan;

17 (20) the number of claims or requests for treatment or services denied
18 and later reversed, the ratio of this number to the total number of claims paid, and the
19 ratio of this number to the total number of appeals filed;

20 (21) the results of the quality review and evaluation, including
21 recommendations for remedial action required under AS 21.07.120;

22 (22) an explanation of an enrollee's financial responsibility for payment
23 for premiums, coinsurance, copayments, deductibles, or other noncovered health care
24 procedures, treatments, or services;

25 (23) an explanation of an enrollee's financial responsibility for payment
26 when services are provided by a health care provider who is not part of the plan or by
27 a provider without required plan authorization;

28 (24) a description of how

29 (A) the plan will address the needs of non-English speaking
30 enrollees;

31 (B) the plan will address the needs of enrollees with disabilities;

1 (C) to obtain information about the plan, including notice of a
2 toll-free telephone number for inquiries by enrollees;

3 (D) an enrollee, a person acting on behalf of an enrollee, or the
4 enrollee's health care provider may initiate a review under the complaint and
5 grievance resolution process;

6 (25) the circumstances under which a patient in treatment with a
7 participating provider can remain with the provider when the provider leaves the plan;

8 (26) the procedures for changing a primary care provider within the
9 plan; and

10 (27) the procedures for protecting the confidentiality of medical records
11 and other patient information, and the circumstances under which patient information
12 will be released to third parties.

13 (b) Information provided to enrollees, prospective enrollees, providers, and
14 prospective providers must be

15 (1) standardized on a form developed by the plan and approved by the
16 director; the form shall be designed to allow plans to be compared;

17 (2) provided in a clear and coherent manner using words with a
18 common, everyday usage;

19 (3) easily understood, linguistically appropriate, and objective; materials
20 shall be available in a language other than English, if the other language is spoken by
21 at least 10 percent of the population in the plan's service area.

22 (c) The plan must make appropriate provisions for those enrollees who cannot
23 read or who need specialized information because of a disability.

24 Sec. 21.07.180. REPORT. The director shall annually compile all the required
25 disclosure information for each managed care plan operating in the state in a format
26 to facilitate comparison among plans. This report shall be made available to the
27 public, to each plan operating in the state, and to the legislature.

28 Sec. 21.07.190. DISCRIMINATION PROHIBITED; CONFIDENTIALITY.
29 A managed care plan

30 (1) may not discriminate or engage directly or through contractual
31 arrangements in any activity, including the selection of its service area, that has the

1 effect of discriminating against an individual on the basis of race, national origin,
2 gender, language, socio-economic status, age, sexual orientation, payor source,
3 disability, health status, or anticipated need for health services;

4 (2) may not discriminate in the selection of members of the provider
5 network or in establishing the terms and conditions for membership in the network of
6 the plan based on the race, national origin, sexual orientation, or disability of the
7 provider; or the socio-economic status, payor source, disability, health status, or
8 anticipated need for health services of the patients of the health provider;

9 (3) may not engage in marketing or other practices intended to
10 discourage or limit enrollment based on an individual's health condition, geographic
11 area, industry, or other risk factors;

12 (4) must comply with all existing state and federal antidiscrimination
13 and confidentiality statutes;

14 (5) must ensure that the confidentiality of enrollee patient information
15 and records is protected; a health plan must have written confidentiality policies and
16 procedures; policies and procedures must, at a minimum,

17 (A) maintain the confidentiality of enrollee patient information
18 within the administration structure of the plan;

19 (B) protect medical record information;

20 (C) protect claim information;

21 (D) establish requirements for the release of information; and

22 (E) inform enrollees of the confidentiality policies and
23 procedures;

24 (6) must ensure that providers and facilities responsible for providing
25 covered items or services to plan enrollees have implemented policies and procedures
26 to prevent the unauthorized or inadvertent disclosure of confidential patient information
27 to individuals who should not have access to the information;

28 (7) must provide an enrollee with the opportunity to approve or
29 disapprove the release of identifiable personal patient information by the health plan,
30 except where the release is required under applicable law;

31 (8) may not release information to an employer that would directly or

1 indirectly indicate to the employer which services an enrollee is receiving or has
2 received from a provider covered by the plan, or another provider unless authorized
3 by the enrollee.

4 Sec. 21.07.200. ENROLLEE PARTICIPATION RIGHTS. A managed care
5 plan must establish procedures, with defined rights, under which plan enrollees may
6 participate in the establishment and review of the plan's guidelines and procedures for
7 medical policy, medical management, utilization review, quality assurance, and
8 grievance resolution.

9 Sec. 21.07.210. ENROLLEE ADVISORY BOARD; PARTICIPATION ON
10 GOVERNING BOARD. (a) A managed care plan must

11 (1) establish an enrollee advisory board, consisting of at least seven
12 enrollees, that shall review and advise the board of the managed care plan on all
13 aspects of the plan's operations and the plan's effects on access to quality, affordable
14 care by plan enrollees; and

15 (2) be organized in a manner that provides that at least one-third of the
16 members of its governing board are enrollees in the plan.

17 (b) Enrollees serving on the governing board shall be chosen to reflect the
18 diversity of the plan's enrollees, including race, sex, age, economic status, disability,
19 and health status; enrollees on the governing board or members of an enrollee's
20 immediate family may not be current or former employees of, nor may they have an
21 ownership interest in, the plan, an entity that has an ownership or management interest
22 in the plan, any subsidiary of the plan, or an entity that has a contract to provide
23 services to enrollees of the plan.

24 (c) A plan must dedicate at least 10 percent of the plan's administrative budget
25 for the expenses of the enrollee representatives on the governing board and the enrollee
26 advisory board.

27 Sec. 21.07.220. MANAGED CARE OVERSIGHT BOARD. (a) The director
28 shall appoint a managed care advisory board to oversee and monitor the development
29 and implementation of the director's regulation of managed care plans. The board
30 shall ensure that all enrollees in managed care plans are provided access to quality
31 health services and review and comment on policy recommendations, changes in

1 policy, and proposed regulations with regard to the provision of health care and health
2 coverage to residents of the state.

3 (b) The director shall appoint at least seven, but no more than 15
4 representatives, to the board. Members shall serve two-year terms and may be
5 reappointed. Board members may not be compensated except for per diem and travel
6 expenses authorized for boards and commissions under AS 39.20.180.

7 (c) The director shall appoint members of the board from individuals who are
8 advocates for health care consumers, persons with mental illnesses, children, persons
9 with disabilities, senior citizens, public assistance, persons who are eligible to receive
10 medical assistance under 42 U.S.C. 1396 - 1396p (Social Security Act), and from other
11 persons who have demonstrated a knowledge of the effect of the health care delivery
12 system on consumers within the state. Members shall be chosen to reflect the diversity
13 of consumers, including race, sex, age, economic status, disability, and health status.
14 However, members may not include a person with a financial or other conflict of
15 interest, a person who is directly and substantially involved in the delivery of health
16 care, an employee or principal of a health insurer, a health care plan supplier,
17 manufacturer of medical care goods and services, or a health care provider.

18 (d) The board shall meet at least four times a year. The board shall elect its
19 own officers and shall designate its own committees and other organizational
20 structures.

21 (e) The director shall appoint a technical advisory board to assist the board that
22 will include representatives of state agencies with responsibility for areas of interest
23 to the board. The department shall provide staff support to the board.

24 (f) In this section, "board" means the Managed Care Advisory Board.

25 Sec. 21.07.230. ENROLLEES AS THIRD-PARTY BENEFICIARIES. (a) An
26 enrollee is a third-party beneficiary of any agreement between the director and a
27 managed care plan. A provision of an agreement between the director and a plan that
28 deprives or attempts to deprive enrollees of third-party beneficiary status is void and
29 unenforceable.

30 (b) An enrollee is a third-party beneficiary of any agreement between a
31 managed care plan and another entity that contracts with the plan to provide health

1 coverage and other contractual benefits to the enrollee. A provision of an agreement
2 between a plan and an entity that contracts with the plan to provide health coverage
3 and other contractual benefits to the enrollee that deprives or attempts to deprive
4 enrollees of intended third-party beneficiary status is void and unenforceable.

5 Sec. 21.07.240. ENFORCEMENT; PENALTY. The director shall establish
6 enforcement procedures to ensure compliance with this chapter. Material violations
7 of a standard or requirement may be punished by a civil penalty of up to \$2,000. In
8 the case of conduct constituting a pattern of repeated, material violations, the director
9 may also rescind or limit the operation of a plan. Before imposing a sanction, the
10 director shall provide a managed care plan with an opportunity to be heard in
11 connection with the alleged violations and the possible sanctions.

12 Sec. 21.07.500. DEFINITIONS. In this chapter,

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

28 (2) "managed care contractor" means a contractor who establishes,
29 operates, or maintains a network of participating health care providers, conducts or
30 arranges for utilization review activities, and contracts with an insurer, a hospital or
31 medical service plan, an employer or employee health care organization, or another

1 entity providing coverage for health care services to operate a managed care plan;

2 (3) "managed care entity" includes an insurer, hospital or medical
3 service plan, health maintenance organization, an employer or employee health care
4 organization, or a managed care contractor that operates a managed care plan;

5 (4) "managed care plan" means a health care plan operated by a
6 managed care entity; "managed care plan" does not include an integrated medical
7 group contracting with a health care plan for the direct provision of health care
8 services to a health care plan enrollee;

9 (5) "participating health care provider" means a health care provider
10 who has entered into an agreement with a managed care entity to provide services or
11 supplies to a patient enrolled in a managed care plan;

12 (6) "plan" means a managed care plan;

13 (7) "provider" means a health care provider;

14 (8) "utilization review" means a system of reviewing the medical
15 necessity, appropriateness, or quality of health care services and supplies provided
16 under a managed care plan using specified guidelines, including preadmission
17 certification, the application of practice guidelines, continued stay review, discharge
18 planning, preauthorization of ambulatory procedures, and retrospective review.

19 * **Sec. 3.** This Act takes effect July 1, 1996.