

HOUSE BILL NO. 359

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTIETH LEGISLATURE - SECOND SESSION

BY REPRESENTATIVE RYAN

Introduced: 1/28/98

Referred: State Affairs, Labor and Commerce

A BILL

FOR AN ACT ENTITLED

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

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

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

5 **Chapter 07. Regulation of Health Insurance Plans.**

6 **Sec. 21.07.010. Required filing with director.** (a) An insurer that offers a
7 health insurance plan to residents of this state shall file a form, as prescribed by the
8 director, with the director. The form must contain at least

9 (1) the official address and telephone number of the place of business
10 of the insurer; and

11 (2) a description of the insurer's internal patient appeals process
12 available to cover persons to contest a denial, reduction, or termination of benefits, if
13 any.

14 (b) A health maintenance organization that holds a certificate of authority

1 under AS 21.86.020 is exempt from the filing requirements of this section but shall
2 comply with the other provisions of this chapter.

3 **Sec. 21.07.020. Required plan disclosure.** (a) An insurer shall disclose in
4 writing to a subscriber the terms and conditions of the insurer's health insurance plan
5 and shall promptly provide the subscriber with written notification of a change in the
6 terms and conditions before the effective date of the change. The insurer shall provide
7 the required information at the time of enrollment and on request thereafter.

8 (b) The information required to be disclosed by this section includes a
9 description of

10 (1) covered services and benefits to which the subscriber or other
11 covered person is entitled;

12 (2) restrictions or limitations on covered services and benefits,
13 including physical and occupational therapy services, clinical laboratory tests, hospital
14 and surgical procedures, prescription drugs and biologics, radiological examinations,
15 and behavioral health services;

16 (3) financial responsibility of the covered person, including copayments
17 and deductibles;

18 (4) prior authorization and other review requirements with respect to
19 obtaining covered services;

20 (5) where and in what manner covered services may be obtained;

21 (6) changes in covered services or benefits, including an addition,
22 reduction, or elimination of specific services or benefits;

23 (7) the covered person's right to appeal and the procedure for initiating
24 an appeal of a utilization review decision made by or on behalf of the insurer with
25 respect to the denial, reduction, or termination of a health care benefit or the denial of
26 payment for a health care service;

27 (8) the procedure to initiate an appeal through the director; and

28 (9) other information that the director may require.

29 (c) The insurer shall file the information required under this section with the
30 director.

31 **Sec. 21.07.030. Managed care plan disclosure and notice.** (a) In addition

1 to the disclosure requirements provided under AS 21.07.020, an insurer that offers a
2 managed care plan shall disclose to a subscriber, in writing, the following information
3 at the time of enrollment and annually thereafter:

4 (1) a current participating provider directory providing information on
5 a covered person's access to primary care physicians and specialists, including the
6 number of available participating physicians, by provider category or speciality; the
7 directory shall include the professional office address of a primary care physician and
8 any hospital affiliation the primary care physician has; the directory shall also provide
9 information about participating hospitals;

10 (2) general information about the financial incentives between
11 participating physicians under contract with the insurer and other participating health
12 care providers and facilities to which the participating physicians refer their managed
13 care patients;

14 (3) the percentage of the insurer's managed care plan's network
15 physicians who are board certified;

16 (4) the insurer's managed care plan's standard for customary waiting
17 times for appointments for urgent and routine care; and

18 (5) the availability through the director, on request of a member of the
19 general public, of independent consumer satisfaction survey results and an analysis of
20 quality outcomes of health care services of managed care plans in the state.

21 (b) On request of a covered person, an insurer shall promptly inform the
22 person whether a particular network physician is

23 (1) board certified; and

24 (2) currently accepting new patients.

25 (c) An insurer shall

26 (1) promptly notify each covered person before the termination or
27 withdrawal from the insurer's provider network of the covered person's primary care
28 physician; and

29 (2) provide a prospective subscriber with information about the provider
30 network, including hospital affiliations, and, on request, other information specified in
31 this section.

1 (d) The insurer shall file the information required by this section with the
2 director.

3 **Sec. 21.07.040. Managed care medical director.** (a) An insurer that offers
4 a managed care plan or uses a utilization review system in a health plan shall designate
5 a licensed physician to serve as medical director. The medical director shall be
6 designated to serve as the medical director for medical services provided to covered
7 persons in the state and is required to be licensed to practice medicine in this state.
8 The medical director shall be responsible for treatment policies, protocols, quality
9 assurance activities, and utilization review decisions of the insurer. The treatment
10 policies, protocols, quality assurance program, and utilization review decisions of the
11 insurer shall be based on generally accepted standards of health care practice. The
12 quality assurance and utilization review program shall be consistent with standards
13 adopted by regulation of the director.

14 (b) The medical director shall ensure that

15 (1) a utilization review decision to deny, reduce, or terminate a health
16 care benefit or to deny payment for a health care service because that service is not
17 medically necessary shall be made by a physician; in the case of a health care service
18 prescribed or provided by a dentist, the decision shall be made by a dentist;

19 (2) a utilization review decision may not retrospectively deny coverage
20 for health care services provided to a covered person when prior approval has been
21 obtained from the insurer for those services unless the approval was based on
22 fraudulent information submitted by the covered person or the participating provider;

23 (3) in the case of a managed care plan, a procedure is implemented
24 whereby participating physicians and dentists have an opportunity to review and
25 comment on all medical and surgical and dental protocols, respectively, of the insurer;

26 (4) the utilization review program is available on a 24-hour basis to
27 respond to authorization requests for emergency and urgent services and is available,
28 at a minimum, during normal working hours for inquiries and authorization requests
29 for nonurgent health care services; and

30 (5) in the case of a managed care plan, a covered person is permitted
31 to choose or change a primary care physician from among participating providers in

1 the provider network and, when appropriate, choose a specialist from among
 2 participating network providers following an authorized referral if required by the
 3 insurer and subject to the ability of the specialist to accept new patients.

4 **Sec. 21.07.050. Employment of health care providers.** (a) An application
 5 for participation by a health care provider that is submitted to an insurer that offers a
 6 managed care plan shall be reviewed by a committee of the insurer that includes
 7 appropriate representation of health care professionals with knowledge of the
 8 applicant's scope of professional practice.

9 (b) An insurer that offers a managed care plan shall establish a policy
 10 governing removal of a health care provider from the provider network that includes
 11 the following:

12 (1) the insurer shall inform a participating health care provider of the
 13 insurer's removal policy at the time the insurer contracts with the health care provider
 14 to participate in the provider network and at each renewal of the contract;

15 (2) if a health care provider's participation will be terminated before the
 16 date of the termination of the contract, the insurer shall provide the health care
 17 provider with a 90-day written notice of the termination and notice of a right to a
 18 hearing; if requested by the health care provider, the insurer shall provide the reasons
 19 for the termination in writing and shall hold a hearing within 30 days of the date of
 20 the request; the hearing shall be conducted by a panel appointed by the insurer and
 21 consisting of at least three persons, at least one of whom is a clinical peer in the same
 22 discipline and the same or similar speciality as the health care provider whose
 23 participation is being terminated; the panel shall decide whether the health care
 24 provider shall be terminated, reinstated, or provisionally reinstated, subject to
 25 conditions set out by the panel; the panel's determination shall be in writing and shall
 26 be made in a timely manner;

27 (3) the notice and opportunity for a hearing required under (2) of this
 28 subsection do not apply when

29 (A) the contract expires and is not renewed;

30 (B) the termination is for breach of contract;

31 (C) in the opinion of the medical director, the health care

1 provider represents an imminent danger to an individual patient or the public
2 health, safety, or welfare; or

3 (D) there is a determination of fraud;

4 (4) if the insurer finds that a health care provider represents an
5 imminent danger to an individual patient or to the public health, safety, or welfare, the
6 medical director shall promptly notify the appropriate state licensing board.

7 **Sec. 21.07.060. Managed care provider and patient protection.** A contract
8 between a participating health care provider and an insurer that offers a managed care
9 plan

10 (1) must state that the health care provider may not be penalized or the
11 contract terminated by the insurer because the health care provider acts as an advocate
12 for the patient in seeking appropriate, medically necessary health care services;

13 (2) may not provide financial incentives to the health care provider for
14 withholding covered health care services that are medically necessary; and

15 (3) must protect the ability of a health care provider to communicate
16 openly with a patient about all appropriate diagnostic testing and treatment options.

17 **Sec. 21.07.070. Required contract provisions.** A health insurance plan
18 offered to residents of the state must provide that

19 (1) coverage for a medical procedure that has been preapproved by the
20 insurer may not be denied if denial occurs less than 96 hours before the medical
21 procedure is scheduled to commence; and

22 (2) if the insured has coverage under more than one health insurance
23 plan, the primary insurer may not coordinate benefits with the secondary insurer if the
24 coordination reduces the benefits the insured is eligible to receive under the primary
25 or secondary health insurance plan.

26 **Sec. 21.07.080. Choice of health care provider.** (a) An insurer that offers
27 a managed care plan shall offer to every contract holder a point-of-service plan option
28 that would allow a covered person to receive covered services from an out-of-network
29 health care provider without obtaining a referral or prior authorization from the insurer.
30 The point-of-service plan option may require that a subscriber pay a higher deductible
31 or copayment and higher premium for the plan.

1 (b) An insurer shall provide each subscriber in a plan whose contract holder
2 elects the point-of-service plan option with the opportunity at the time of enrollment
3 and during the annual open enrollment period to enroll in the point-of-service plan
4 option. The insurer shall provide written notice of the point-of-service plan option to
5 each subscriber in a plan whose contract holder elects the point-of-service plan option
6 and shall include in that notice a detailed explanation of the financial costs to be
7 incurred by a subscriber who selects that option.

8 (c) The requirements of this section do not apply to an insurer contract that
9 offers a managed care plan that provides health care services to Medicaid recipients
10 or to a federally qualified, nonprofit health maintenance organization.

11 **Sec. 21.07.090. Health Care Appeals Board.** (a) The director shall appoint
12 a Health Care Appeals Board to provide independent medical necessity or an
13 appropriateness of service review of a final decision by an insurer to deny, reduce, or
14 terminate benefits when the final decision is contested by the covered person. The
15 board may not review decisions regarding benefits not covered by the covered person's
16 health insurance plan.

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

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

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

4 (e) The director shall appoint a technical advisory board to assist the board.
5 The technical advisory board must include representatives of state agencies with
6 responsibility for areas of interest to the board. The department shall provide staff
7 support to the board.

8 (f) A covered person may apply to the Health Care Appeals Board for a
9 review of a decision to deny, reduce, or terminate a benefit if the person has already
10 completed the insurer's appeal process, if any, and the person contests the final
11 decision by the insurer. The person shall apply to the board within 60 days after the
12 date the final decision was issued by the insurer in a manner determined by the
13 director.

14 **Sec. 21.07.100. Insurance benefit review.** (a) If a covered person applies
15 for an insurance benefit review under AS 21.07.090(f), the board shall promptly
16 review the pertinent medical records of the person to determine the appropriate,
17 medically necessary health care services the person should receive based on applicable,
18 generally accepted practice guidelines developed by the federal government, national
19 or professional medical societies, boards or associations, and any applicable clinical
20 protocols or practice guidelines developed by the insurer. The board shall complete
21 its review and make its determination within 90 days of receipt of a completed
22 application for a review or within less time, as prescribed by the director.

23 (b) On completion of a review, the board shall state its findings in writing and
24 make a determination of whether the insurer's denial, reduction, or termination of
25 benefits deprived the covered person of medically necessary services covered by the
26 person's health care insurance plan. If the board determines that the denial, reduction,
27 or termination of benefits deprived the person of medically necessary covered services,
28 it shall make a recommendation to the covered person and insurer regarding the
29 appropriate, medically necessary health care services the person should receive. On
30 receiving the board's recommendation, the insurer shall promptly notify the covered
31 person and the director of what action the insurer will take with respect to the

1 recommendation. If the covered person is not in agreement with the board's findings
2 and recommendation or the insurer's action on the recommendation, the person may
3 seek the desired health care services outside of the person's health benefits plan, at the
4 person's own expense.

5 (c) If the director determines that an insurer exhibits a pattern of
6 noncompliance with the findings and recommendations of the board, the director shall
7 review the insurer's utilization management program to ensure that the insurer is in
8 compliance with all relevant state laws and regulations, including utilization
9 management standards. If the director determines that the insurer is in violation of
10 patient rights and other applicable regulations, the director may impose penalties and
11 sanctions on the insurer, as provided by law.

12 (d) The director shall require the board to establish procedures to provide for
13 an expedited review of an insurer's denial, reduction, or termination of a benefit
14 decision when a delay in receipt of the service could seriously jeopardize the health
15 or well-being of the covered person.

16 (e) A covered person's medical records provided to the board and the findings
17 and recommendations of the board are confidential and shall be used only by the
18 director, the board, and the affected insurer for the purposes of this chapter. The
19 medical records, findings, and recommendations may not otherwise be divulged or
20 made public in a manner that discloses the identity of a person to whom they relate
21 and may not be included under materials available for public inspection.

22 (f) The cost of an insurance benefit review shall be paid by the insurer under
23 a schedule of fees established by the director.

24 **Sec. 21.07.110. Immunity under appeal program.** (a) A member of the
25 board who participates in an insurance benefit review may not be held liable for civil
26 damages for an action taken within the scope of the member's function on the board.
27 The attorney general shall defend the board member in such a civil action, and the
28 state shall provide indemnification for any damages awarded.

29 (b) An insurer that is the subject of an insurance benefit review is not liable
30 for civil damages to a person for an action taken to implement a recommendation of
31 the board.

1 **Sec. 21.07.120. Required report.** The director shall annually report to the
2 legislature and to the governor on the status of the health care insurance benefit review
3 program. The report must include

4 (1) a summary of the number of reviews conducted and medical
5 specialties affected;

6 (2) a summary of the findings and recommendations made by the
7 board;

8 (3) a list of actions taken by the director against an insurer; and

9 (4) any other information and recommendations determined appropriate
10 by the director.

11 **Sec. 21.07.130. Consumer surveys.** An insurer that offers a managed care
12 plan shall comply with the director's reporting requirements with respect to quality
13 outcome measures of health care services and independent consumer satisfaction
14 surveys. The director shall make available to a member of the general public, on
15 request, the results of the independent consumer satisfaction survey and the analysis
16 of quality outcome measures of health care services provided by managed care plans
17 in the state, prepared by the director.

18 **Sec. 21.07.140. Employer notice.** An employer who provides a
19 comprehensive self-funded health insurance plan to employees or their dependents, or
20 both, in the state shall annually, and on request of an employee at other times during
21 the year, notify the employees that they are covered by a self-insured plan that is not
22 subject to regulation by the state and specify those mandated health insurance benefits
23 established by law that are not covered by the self-insured plan. The director shall
24 notify the commissioner of labor of any health insurance mandates enacted into law,
25 and the commissioner of labor shall notify employers in a timely manner of the health
26 insurance mandates subject to the provisions of this section.

27 **Sec. 21.07.150. Enforcement; penalty.** The director shall establish
28 enforcement procedures to ensure compliance with this chapter. Material violations
29 of a standard or requirement may be punished by a civil penalty of up to \$2,000. In
30 the case of conduct constituting a pattern of repeated, material violations, the director
31 may also rescind approval of or limit the operation of a plan. Before imposing a

1 sanction, the director shall provide a managed care plan with an opportunity to be
 2 heard in connection with the alleged violations and the possible sanctions.

3 **Sec. 21.07.500. Definitions.** In this chapter,

4 (1) "board" means the Health Care Appeals Board;

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

20 (3) "health insurance" has the meaning given in AS 21.12.050;

21 (4) "managed care contractor" means a contractor who establishes,
 22 operates, or maintains a network of participating health care providers, conducts or
 23 arranges for utilization review activities, and contracts with an insurer, a hospital or
 24 medical service plan, an employer or employee health care organization, or another
 25 entity providing coverage for health care services to operate a managed care plan;

26 (5) "managed care entity" includes an insurer, hospital or medical
 27 service plan, health maintenance organization, an employer or employee health care
 28 organization, or a managed care contractor that operates a managed care plan;

29 (6) "managed care plan" means a health care plan operated by a
 30 managed care entity; "managed care plan" does not include an integrated medical
 31 group contracting with a health care plan for the direct provision of health care

1 services to a health care plan enrollee;

2 (7) "participating health care provider" means a health care provider
3 who has entered into an agreement with a managed care entity to provide services or
4 supplies to a patient enrolled in a managed care plan;

5 (8) "provider" means a health care provider;

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

11 * **Sec. 2.** RECOMMENDATIONS FOR LEGISLATION. (a) The director of the division
12 of insurance shall develop recommendations for legislative action to address the issue of
13 regulating health care or managed care entities that seek to contract directly with employers
14 or other purchasers on a risk-assuming basis. The recommendations must identify the type
15 of health care or managed care entities and the scope of activities of these entities that should
16 be subject to regulation by the state. In preparing the recommendations, the director shall
17 consider the current state statutory and regulatory requirements for health maintenance
18 organizations and insurance companies issuing health benefits plans in the state, as well as
19 federal legislation and laws and court rulings, to determine how these health care and managed
20 care entities that assume risk should be regulated.

21 (b) The director shall report to the legislature and to the governor as required by (a)
22 of this section within one year of the effective date of this Act.

23 * **Sec. 3.** This Act takes effect July 1, 1998.