CS FOR HOUSE BILL NO. 359(STA)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTIETH LEGISLATURE - SECOND SESSION

BY THE HOUSE STATE AFFAIRS COMMITTEE

Offered: 3/13/98
Referred: Labor and Commerce

Sponsor(s): REPRESENTATIVE RYAN

A BILL

FOR AN ACT ENTITLED

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

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

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

Chapter 07. Regulation of Health Insurance Plans.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(9) other information that the director may require.

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

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

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

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

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

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

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

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

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

(1) board certified; and

(2) currently accepting new patients.

(c) An insurer shall

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

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

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

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

(b) The medical director shall ensure that

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

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

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

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

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

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

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

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

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

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

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

(A) the contract expires and is not renewed;

(B) the termination is for breach of contract;

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

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

(D) there is a determination of fraud;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(e) The director shall appoint a technical advisory board to assist the board. The technical advisory board must include representatives of state agencies with responsibility for areas of interest to the board.

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

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

(b) On completion of a review, the board shall state its findings in writing and make a determination of whether the insurer's denial, reduction, or termination of benefits deprived the covered person of medically necessary services covered by the person's health care insurance plan. If the board determines that the denial, reduction, or termination of benefits deprived the person of medically necessary covered services, it shall make a recommendation to the covered person and insurer regarding the appropriate, medically necessary health care services the person should receive. On receiving the board's recommendation, the insurer shall promptly notify the covered person and the director of what action the insurer will take with respect to the recommendation. If the covered person is not in agreement with the board's findings

and recommendation or the insurer's action on the recommendation, the person may seek the desired health care services outside of the person's health benefits plan, at the person's own expense.

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

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

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

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

Sec. 21.07.110. Immunity under appeal program. (a) A member of the board who participates in an insurance benefit review may not be held liable for civil damages for an action taken within the scope of the member's function on the board.

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

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

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

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

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

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

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

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

Sec. 21.07.150. Enforcement; penalty. The director shall establish enforcement procedures to ensure compliance with this chapter. Material violations of a standard or requirement may be punished by a civil penalty of up to $2,000. In the case of conduct constituting a pattern of repeated, material violations, the director may also rescind approval of or limit the operation of a plan. Before imposing a sanction, the director shall provide a managed care plan with an opportunity to be heard in connection with the alleged violations and the possible sanctions.

Sec. 21.07.500. Definitions. In this chapter,

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

(2) "health care provider" means an acupuncturist licensed under AS 08.06; an audiologist licensed under AS 08.11; a chiropractor licensed under AS 08.20; a dental hygienist licensed under AS 08.32; a dentist licensed under AS 08.36; a marital or family therapist licensed under AS 08.63; a direct-entry midwife licensed 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; a physician's assistant certified under AS 08.64; a physician licensed under AS 08.64; a podiatrist licensed under AS 08.64; 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;

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

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

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

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

(7) "participating health care provider" means a health care provider who has entered into an agreement with a managed care entity to provide services or

supplies to a patient enrolled in a managed care plan;

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

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

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

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

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