SENATE BILL NO. 166

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTIETH LEGISLATURE - FIRST SESSION

BY SENATORS DUNCAN, Ellis

Introduced: 4/10/97
Referred: HESS, Finance

A BILL

FOR AN ACT ENTITLED

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

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

*** Section 1.** SHORT TITLE. This Act may be known as the "Managed Care Consumer Protection Act."

*** Sec. 2.** PURPOSE AND INTENT. The purpose of this Act is to provide authority for the state to ensure that enrollees receive quality health care services under a managed care system. The intent of this Act is to ensure that

(1) enrollees have full and timely access to clinically and culturally appropriate health care personnel and facilities;

(2) enrollees have adequate choice among health care providers who are accessible and qualified;

(3) there is open communication between physicians and enrollees;

(4) enrollees have access to comprehensive pharmaceutical services;

(5) enrollees have access to information regarding limits on coverage of experimental treatments;

(6) there is high quality of care within a managed care plan;

(7) medical decisions are made by the appropriate medical personnel;

(8) health care providers within a plan are practitioners in good standing;

(9) managed care plan data is available as appropriate;

(10) there is full public access to information regarding health care service delivery within plans;

(11) the state has authority to oversee all managed care plans;

(12) there is a fair vehicle for resolving enrollee complaints in a managed care system; and

(13) there is timely resolution of enrollee grievances and appeals.

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

Chapter 85. Regulation of Managed Care.

Sec. 21.85.010. Applicability and scope. This chapter applies to all managed care entities operating within the state.

Sec. 21.85.020. Access to personnel and facilities. (a) A managed care plan must

(1) include a sufficient number and type of primary care practitioners and specialists throughout the service area to meet the needs of enrollees and to provide a choice of health care providers; a managed care plan must offer

(A) an adequate number of accessible acute care hospital services within a reasonable distance or travel time;

(B) an adequate number of accessible primary care practitioners within a reasonable distance or travel time, including family practice and general practice physicians, chiropractors, internists, obstetricians, gynecologists, and pediatricians;

(C) an adequate number of accessible specialists and subspecialists within a reasonable distance or travel time; when the type of medical specialist needed for a specific condition is not represented on the specialty panel, enrollees shall be given access to nonparticipating health care

providers;

(D) specialty medical services, including physical therapy, occupational therapy, and rehabilitation services; and

(E) nonpanel specialists when an enrollee's unique medical circumstances warrant it;

(2) provide for continuity of care with established primary care practitioners when the health care provider's contract is terminated, including allowing enrollees, at no additional out-of-pocket cost, to continue receiving services from a primary care practitioner whose contract with the plan is terminated without cause; this continuation of service requirement must be effective for 60 days after the enrollee requests continued care;

(3) provide telephone access to the managed care plan for sufficient time during business and evening hours to ensure enrollee access for routine care and 24-hour telephone access to either the plan or a participating health care provider for emergency care or authorization for care;

(4) establish reasonable standards for waiting times to obtain appointments, except as provided in this section for emergency services; standards must include appointment scheduling guidelines based on the type of health care service, including prenatal care appointments, well-child visits and immunizations, routine physicals, follow-up appointments for chronic conditions, and urgent care;

(5) be required to cover and reimburse expenses for emergency care obtained without prior authorization in situations where a prudent layperson could reasonably believe the condition required immediate attention at the nearest facility;

(6) demonstrate that it has developed an access plan to meet the needs of vulnerable and under-served populations; an access plan must provide culturally appropriate services to the greatest extent possible; when a significant number of enrollees in the plan speak a first language other than English, the plan must provide access to personnel fluent in languages other than English, to the greatest extent possible; an access plan must develop standards for continuity of care following enrollment, including sufficient information on how to access care within the plan;

(7) hold harmless enrollees against claims from participating health care

providers in the managed care plan for payment of the cost of covered health services.

Sec. 21.85.030. Choice of health care provider. (a) An enrollee shall have adequate choice among managed care plan health care providers who are qualified and accessible.

(b) A managed care plan must

(1) permit enrollees to choose their own primary care practitioner from a list of health care providers within the plan; this list shall be updated as health care providers are added or removed and must include a sufficient

(A) number of primary care practitioners who are accepting new enrollees; and

(B) mix of primary care practitioners that reflects a diversity that is adequate to meet the needs of the enrolled population's varied characteristics, including age, sex, race, and health status;

(2) develop a system to permit enrollees to use a medical specialist primary care practitioner when the enrollee's medical conditions warrant it; this may include enrollees suffering from chronic diseases as well as those with other special needs;

(3) provide continuity of care and appropriate referral to specialists within the plan when specialty care is warranted; enrollees shall have access to medical specialists on a timely basis and shall be provided with a choice of specialists when a referral is made;

(4) offer a point-of-service option; a point-of-service option may require that the enrollee in the plan pay a reasonable portion of the costs of the out-of-plan care, but the enrollee's portion may not exceed 20 percent of the cost of the out-of-plan care;

(5) provide enrollees with access to a consultation for a second medical opinion.

Sec. 21.85.040. Gag rules. (a) A managed care plan may not

(1) contract with a health care provider to limit the health care provider's disclosure to an enrollee or on behalf of an enrollee of any information relating to the enrollee's medical condition or treatment options;

(2) limit disclosure to the enrollee by an employee of the managed care plan of any information relating to the enrollee's medical condition or treatment options.

(b) A health care provider may not be penalized or the provider's contract with the managed care plan terminated because the health care provider offers referrals or discusses medically necessary or appropriate care with, or on behalf of, the enrollee. A health care provider may discuss all treatment options and disclose other information determined by the health care provider to be in the best interests of the enrollee.

(c) A health care provider may not be penalized for discussing financial incentives and financial arrangements between the health care provider and the managed care entity.

Sec. 21.85.050. Drugs and devices. (a) A managed care plan must

(1) provide coverage for all drugs and devices approved under federal law whether that drug or device has been approved for the specific treatment or condition so long as the primary care practitioner or other medical specialist treating the enrollee determines the drug or device is medically necessary and appropriate for the enrollee's condition;

(2) establish and operate a drug use review program that includes the following:

(A) retrospective review of prescription drugs furnished to enrollees; and

(B) education of physicians, enrollees, and pharmacists regarding the appropriate use of prescription drugs;

(3) provide for a drug use review program with ongoing periodic examination of data on outpatient prescription drugs to ensure quality therapeutic outcomes for enrollees as follows:

(A) the program's primary emphasis must be to enhance quality of care for enrollees by assuring appropriate drug therapy;

(B) the program must include the following:

(i) clinically relevant criteria and standards for drug therapy;

(ii) nonproprietary criteria and standards, developed and revised through an open, professional consensus process; and

(iii) interventions that focus on improving therapeutic outcomes;

(C) confidentiality of the relationship between enrollees and health care providers shall be protected at all times.

(b) The health care services plan must provide an educational outreach program as part of the drug use review program. The outreach program shall be directed to enrollees, pharmacists, and other health care providers and must emphasize the appropriate use of prescription drugs.

(c) Prospective review of drug therapy may only deny services in cases of enrollee ineligibility, coverage limitations, or fraud.

(d) A prescribing health care provider shall determine the appropriate drug therapy for the enrollee. Substitutions may not be made without the direct approval of the prescribing health care provider.

Sec. 21.85.060. Mental health and chemical dependency benefits. A managed care plan that provides coverage for diagnosis or treatment of a mental condition or a condition related to chemical dependency may not impose more restrictive day or visit limits or higher cost-sharing requirements than imposed on other health care services covered by the plan.

Sec. 21.85.070. Experimental health care services. (a) A managed care plan that provides coverage for prescribed drugs or devices approved by the United States Food and Drug Administration may not exclude coverage of an approved drug or device on the basis that the approved drug or device has not been specifically approved by the United States Food and Drug Administration for treatment of the disease or condition for which it has been prescribed; however, the drug or device must be

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

(2) recommended for use by article or editorial comment in a peer

reviewed medical or scientific journal.

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

(1) the treatment is for life-threatening, degenerative, or permanently disabling conditions, or a condition associated with a complication of such a condition;

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 21.85.080. Quality assurance program. (a) A managed care plan

(1) shall develop comprehensive quality assurance standards adequate to identify, evaluate, and remedy problems relating to access, continuity, and quality of care; these standards must include

(A) an ongoing, written, internal quality assurance program;

(B) specific written guidelines for quality of care studies and monitoring, including attention to vulnerable populations;

(C) performance and clinical outcomes-based criteria;

(D) a procedure for remedial action to correct quality problems, including written procedures for taking appropriate corrective action;

(E) a plan for data gathering and assessment in compliance with AS 21.85.090; and

(F) a peer review process.

(2) must have a process for selection of health care providers who will be on the plan's participating practitioner list with written policies and procedures for review and approval used by the plan; the plan must establish minimum professional requirements and demonstrate that it has consulted with appropriately qualified health care providers to establish the requirements; the plan's process must include verification of the individual practitioner's license, history of suspension or revocation, and liability claims history;

(3) must establish a formal, written, ongoing, process for the re-evaluation of all participating physicians within a specified number of years after the initial acceptance; re-evaluations must include updates of the previous review criteria and an assessment of the performance pattern based on criteria, including enrollee clinical outcomes, number of complaints, and malpractice actions;

(4) may not use a health care provider beyond or outside of the provider's occupational license.

Sec. 21.85.090. Data systems and confidentiality. A managed care plan must

(1) provide information on a plan's structure, decision making process, health care benefits and exclusions, cost and cost sharing requirements, list of contracting health care providers, and grievance and appeal procedures to all potential enrollees, all enrollees covered by the plan, and to the state oversight agency;

(2) collect and report annually to the director of the division of public health specified data, including

(A) gross outpatient and hospital use data;

(B) enrollee clinical outcome data;

(C) the number and types of enrollee grievances or complaints during the year, the status of decisions, and the average time required to reach a decision; and

(D) the number, amount, and disposition of malpractice claims resolved during the year by the managed care plan and any of its participating health care providers;

(3) report all data specified under (1) and (2) of this section to the director of the division of public health and shall make the data available to the public on a timely basis;

(4) establish written policies and procedures for the handling of medical records and enrollee communications to ensure enrollee confidentiality;

(5) ensure the confidentiality of specified enrollee information, including prior medical history, medical record information, and claims information, except when disclosure of this information is required by law;

(6) prohibit from being released an individual enrollee's record information unless the release is authorized in writing by the enrollee.

Sec. 21.85.100. Clinical decision making. A managed care entity shall

(1) appoint a medical director who is a licensed physician in the state; the medical director is responsible for treatment policies, protocols, quality assurance activities, and use management decisions of the plan;

(2) inform enrollees of the financial arrangements between the managed care plan and contracting health care providers if those arrangements include incentives

or bonuses for restriction of services.

Sec. 21.85.110. Oversight authority. (a) The director shall oversee managed care entities and managed care plans operating within the state or contract with an outside entity to perform the oversight required in this section.

(b) A managed entity or managed care plan may not operate in the state unless authorized by the director.

(c) The director shall perform audits on an annual basis to review enrollee clinical outcome data, enrollee service data, and operational and other financial data.

(d) The director may investigate complaints and grievances or appeals on behalf of enrollees or health care providers.

(e) The director shall develop standards for compliance of plans regarding mandated requirements and adopt regulations relating to types of penalties for violations.

Sec. 21.85.120. Grievance procedures; reviews and appeals. (a) A managed care plan shall provide written notification to enrollees, in a language the enrollee understands, regarding the right to file a grievance. At a minimum, notification shall be given

(1) prior to enrollment in the plan; and

(2) at the time care is denied or limited under the plan.

(b) At the time of a denial, the plan shall notify the enrollee of the right to file a grievance. The notice shall be written and must include the reason for denial, the name of the individual responsible for the decision, the criteria for determination, and the enrollee's right to file a grievance.

(c) The grievance procedure must include

(1) identification of the reviewing body and an explanation of the process of review;

(2) an initial investigation and review;

(3) notification within a reasonable amount of time of the outcome of the grievance; and

(4) an appeal procedure.

(d) The managed care plan must

(1) set reasonable time limits for each part of the review process, but the review process may not extend beyond 30 days;

(2) provide for expedited review for cases involving an imminent, emergent or serious threat to the health of the enrollee; the plan must require that the enrollee be informed immediately of this right and provide the enrollee with a written statement of the disposition or pending status of the grievance within 72 hours of the commencement of the review process;

(3) report to the director the number of grievances and appeals received by the plan within a specified time period, including, if applicable, the outcome or current status of the grievance or appeal as well as the average time taken to resolve.

Sec. 21.85.250. Definitions. In this chapter,

(1) "appeal" means a formal process by which an enrollee whose care has been reduced, denied, or terminated, or by which the enrollee finds the care inappropriate, can contest an adverse grievance decision by the health care services plan;

(2) "emergency" means a medical condition, the onset of which is sudden and unexpected, that manifests itself by symptoms of sufficient severity that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably assume that the condition requires immediate medical treatment and could expect that the absence of medical attention would result in serious impairment to bodily functions or place the person’s health in serious jeopardy;

(3) "enrollee" means an individual who is enrolled in a managed care plan;

(4) "expedited review" means a review process that takes no more than 72 hours after the review is commenced;

(5) "experimental treatment" means treatment that, while not commonly used for a particular condition or illness, is recognized for treatment of the particular condition or illness, and there is no clearly superior, nonexperimental treatment alternative available to the enrollee;

(6) "grievance" means a written complaint submitted by or on behalf of the enrollee;

(7) "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 and 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 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;

(8) "health care services" means services for the diagnosis, prevention, or treatment of a health condition, illness, injury, or disease.

(9) "managed care entity" means any entity, including a licensed insurance company, hospital or medical service plan, health maintenance organization, limited health services organization, preferred provider organization, third-party administrator, or any person or entity that establishes, operates, or maintains a network of participating health care providers;

(10) "managed care plan" means a plan operated by a managed care entity that provides for the financing and delivery of health care services to persons enrolled in the plan with financial incentives for persons enrolled in the plan to use the participating health care providers and procedures covered by the plan;

(11) "participating practitioner" means a health care provider who has entered into an agreement with a managed care entity to provide health care services to an enrollee in the managed care plan;

(12) "point-of-service option" means an option for the enrollee to choose to receive service from a nonparticipating health care provider;

(13) "primary care practitioner" means a health care provider under contract with the plan who has been designated by the plan to coordinate, supervise, or provide ongoing care to the enrollee;

(14) "prudent layperson" is a person without specific medical training for the illness or condition in question who acts as a reasonable person would under similar circumstances;

(15) "quality assurance" means the ongoing evaluation of the quality of health care provided to enrollees.

*** Sec. 4.** This Act takes effect July 1, 1997.