

CS FOR SENATE BILL NO. 197(RLS)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTIETH LEGISLATURE - SECOND SESSION

BY THE SENATE RULES COMMITTEE

Offered: 2/23/98

Referred: Today's Calendar

Sponsor(s): SENATORS DONLEY, Taylor, Ellis, Duncan

A BILL

FOR AN ACT ENTITLED

1 "An Act relating to health care services provided by, and practices of, a health
2 maintenance organization; providing that an enrollee in a health maintenance
3 organization has the right to select a treating chiropractor; specifying certain
4 chiropractic health care reports, examinations, and limits on treatment; and
5 prohibiting health maintenance organizations from limiting free speech of health
6 care providers."

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

8 * **Section 1.** AS 21.36.090(d) is amended to read:

9 (d) Except to the extent necessary to comply with AS 21.42.365 and AS 21.56,
10 a person may not practice or permit unfair discrimination against a person who
11 provides a service covered under a group health insurance policy that extends coverage
12 on an expense incurred basis, or under a group service or indemnity type contract
13 issued by a health maintenance organization or a nonprofit corporation, if the

1 service is within the scope of the provider's occupational license. In this subsection,
 2 "provider" means a state licensed physician, dentist, osteopath, optometrist,
 3 chiropractor, nurse midwife, advanced nurse practitioner, naturopath, physical therapist,
 4 occupational therapist, psychologist, psychological associate, or licensed clinical social
 5 worker, or certified direct-entry midwife.

6 * **Sec. 2.** AS 21.86.070(c) is amended to read:

7 (c) An evidence of coverage

8 (1) may not contain a provision or statement that is unjust, unfair,
 9 inequitable, misleading, deceptive, or encourages misrepresentation, or that is untrue,
 10 misleading, or prohibited under AS 21.86.150; and

11 (2) must contain a clear and concise statement [,] if a contract, or a
 12 reasonably complete summary [,] if a certificate, of

13 (A) the health care services and the insurance or other benefits,
 14 if any, to which the enrollee is entitled;

15 (B) limitations on the services, kind of services, benefits, or
 16 kind of benefits, to be provided, including a deductible or copayment feature;

17 (C) where, and in what manner, information is available as to
 18 how services may be obtained;

19 (D) the total amount of payment for health care services and the
 20 indemnity or service benefits, if any, that the enrollee is obligated to pay with
 21 respect to individual contracts; [AND]

22 (E) the health maintenance organization's method for resolving
 23 enrollee complaints; **and**

24 **(F) guidelines explaining when treatment may be denied.**

25 * **Sec. 3.** AS 21.86 is amended by adding new sections to read:

26 **Sec. 21.86.075. Chiropractic health care services.** (a) An enrollee may use
 27 the services of a licensed chiropractor of the enrollee's choosing and may not be
 28 required to obtain the prior approval of the enrollee's health maintenance organization,
 29 a gatekeeper, or primary care physician. Within 10 days after an enrollee's first visit,
 30 a chiropractor shall transmit a report containing the enrollee's primary complaint,
 31 related history, examination findings, initial diagnosis, and treatment plan to the

1 enrollee's health maintenance organization. If the enrollee and the enrollee's
2 chiropractor determine that the condition of the enrollee has not improved within 30
3 days after the initial treatment, the chiropractor shall refer the enrollee back to the
4 enrollee's health maintenance organization for examination and possible concurrent
5 care.

6 (b) If the enrollee's chiropractor recommends chiropractic treatment beyond
7 30 days, the chiropractor shall conduct a second examination and transmit the findings
8 to the enrollee's health maintenance organization. The transmitted information must
9 include the enrollee's current status regarding the primary complaint, the progress of
10 a revised treatment plan, and the objectives for continued care.

11 (c) After receiving a 30-day treatment report from a chiropractor under (b) of
12 this section, the enrollee's health maintenance organization may request a review by
13 another chiropractor. The reviewing chiropractor shall conduct a physical examination
14 of the enrollee. The findings of the reviewing chiropractor must be disclosed to the
15 enrollee and the enrollee's chiropractor. Charges for additional chiropractic care
16 recommended by the reviewing chiropractor must be included as covered health care
17 services provided by the health maintenance organization.

18 (d) If the enrollee's treating chiropractor and the reviewing chiropractor
19 determine that the enrollee's condition has stabilized, ongoing preventative or
20 maintenance care is limited to two chiropractic visits a month. If the treating
21 chiropractor and the reviewing chiropractor disagree on the enrollee's continued
22 treatment, the enrollee and the health maintenance organization shall jointly select a
23 third chiropractor to review the enrollee's chiropractic treatment. Selection of a third
24 chiropractor must occur not more than 60 days after the date of the enrollee's initial
25 treatment by the enrollee's treating chiropractor. Until the third chiropractor's opinion
26 is received in writing by the enrollee and the health maintenance organization, the
27 enrollee may receive chiropractic treatment recommended by the treating chiropractor.
28 The opinion of the third chiropractor as to continued chiropractic treatment is binding
29 on the enrollee and the health maintenance organization. This subsection does not
30 apply if a new documented injury or a substantial exacerbation of the enrollee's
31 previous primary complaint occurs.

1 **Sec. 21.86.078. Choice of health care provider.** (a) A health maintenance
 2 organization shall offer to every enrollee a point-of-service plan option that would
 3 allow a covered person to receive covered services from an out-of-network health care
 4 provider without obtaining a referral or prior authorization from the health maintenance
 5 organization. The point-of-service plan option may require that an enrollee pay a
 6 higher deductible or copayment and higher premium for the plan.

7 (b) A health maintenance organization shall provide each enrollee with an
 8 opportunity at the time of enrollment and during the annual open enrollment period to
 9 enroll in the point-of-service plan option. The health maintenance organization shall
 10 provide written notice of the point-of-service plan option to each enrollee and shall
 11 include in that notice a detailed explanation of the financial costs to be incurred by an
 12 enrollee who selects that option.

13 * **Sec. 4.** AS 21.86.150 is amended by adding a new subsection to read:

14 (i) A health maintenance organization, including a health maintenance
 15 organization operating a managed care plan, or a representative of a health
 16 maintenance organization may not cause, request, or knowingly permit

17 (1) the imposition of limits regarding

18 (A) criticism by a health care provider of health care services
 19 provided by the health maintenance organization; or

20 (B) written or oral communications between a health care
 21 provider and an enrollee regarding health care services;

22 (2) the employment of a health care provider to be terminated unless
 23 the provider receives written notice of the cause for the termination before being
 24 terminated;

25 (3) denial of health care coverage for an enrollee unless the enrollee
 26 has been examined by at least two physicians; or

27 (4) financial incentives to be given or offered to a provider for denying
 28 or delaying health care services.