CS FOR SENATE BILL NO. 197(RLS) am

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTIETH LEGISLATURE - SECOND SESSION

BY THE SENATE RULES COMMITTEE

Amended: 2/23/98
Offered: 2/23/98

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

A BILL

FOR AN ACT ENTITLED

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

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

*** Section 1.** AS 21.86.060(a) is amended to read:

(a) A health maintenance organization may provide **provider** [PHYSICIAN] services directly, through **provider** [PHYSICIAN] employees, or may provide the services under arrangements with individual **providers** [PHYSICIANS] or one or more groups of **providers** [PHYSICIANS].

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

(c) An evidence of coverage

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

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

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

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

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

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

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

(F) guidelines explaining when treatment may be denied.

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

Sec. 21.86.075. Chiropractic health care services. (a) An enrollee may use the services of a licensed chiropractor of the enrollee's choosing and may not be required to obtain the prior approval of the enrollee's health maintenance organization, a gatekeeper, or primary care physician. Within 10 days after an enrollee's first visit, a chiropractor shall transmit a report containing the enrollee's primary complaint, related history, examination findings, initial diagnosis, and treatment plan to the enrollee's health maintenance organization. If the enrollee and the enrollee's chiropractor determine that the condition of the enrollee has not improved within 30 days after the initial treatment, the chiropractor shall refer the enrollee back to the enrollee's health maintenance organization for examination and possible concurrent care.

(b) If the enrollee's chiropractor recommends chiropractic treatment beyond

30 days, the chiropractor shall conduct a second examination and transmit the findings to the enrollee's health maintenance organization. The transmitted information must include the enrollee's current status regarding the primary complaint, the progress of a revised treatment plan, and the objectives for continued care.

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

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

Sec. 21.86.078. Choice of health care provider. (a) A health maintenance organization shall offer to every enrollee 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 health maintenance organization. The point-of-service plan option may require that an enrollee pay a higher deductible or copayment and higher premium for the plan.

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

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

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

(1) the imposition of limits regarding

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

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

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

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

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