

HOUSE BILL NO. 211

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FIRST LEGISLATURE - FIRST SESSION

BY REPRESENTATIVE ROKEBERG BY REQUEST

Introduced: 4/22/99

Referred: Labor and Commerce, Judiciary, Finance

A BILL

FOR AN ACT ENTITLED

1 "An Act relating to liability for providing managed care services, to regulation
2 of managed care insurance plans, and to patient rights and prohibited practices
3 under health insurance; and providing for an effective date."

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

5 * **Section 1.** SHORT TITLE. Section 3 of this Act may be known as the Alaska Patients
6 Bill of Rights.

7 * **Sec. 2.** AS 09.65 is amended by adding a new section to read:

8 **Sec. 09.65.175. Civil liability of managed care entity.** (a) A managed care
9 entity has the duty to exercise ordinary care when making a health care treatment
10 decision.

11 (b) A managed care entity is civilly liable for damages for harm to a covered
12 person proximately caused by

13 (1) its failure to exercise ordinary care; or

14 (2) a health care treatment decision that constitutes a failure to exercise

1 ordinary care made by an employee, agent, ostensible agent, or representative who is
2 acting on its behalf if the managed care entity has the right to exercise influence or
3 control or has actually exercised influence or control over the health care treatment
4 decision.

5 (c) This section does not create

6 (1) an obligation on the part of a managed care entity to provide to a
7 covered person care or treatment that is not covered by the health care plan or entity;
8 or

9 (2) civil liability for an employer or an association of employers if the
10 employer or association does not make health care treatment decisions.

11 (d) It is a defense to a civil action asserted against a managed care entity if
12 the managed care entity proves by a preponderance of the evidence that it did not
13 control, influence, or participate in the health care treatment decision and did not deny
14 or delay payment for any treatment prescribed or recommended to a covered person
15 by a treating provider.

16 (e) In a civil action against a managed care entity, a finding that a physician
17 or other health care provider is an employee, agent, ostensible agent, or representative
18 of that managed care entity may not be based solely on proof that the physician's or
19 health care provider's name appears in a list of approved physicians or health care
20 providers made available to a covered person under the health care plan of the
21 managed care entity.

22 (f) In this section,

23 (1) "covered person" means a person enrolled in or insured by a health
24 care plan;

25 (2) "health care treatment decision" means

26 (A) a determination made when medical services are actually
27 provided by a health care plan; and

28 (B) a decision that affects the quality of the diagnosis, care, or
29 treatment provided to a health care plan's insureds or enrollees;

30 (3) "managed care entity" has the meaning given in AS 21.07.250;

31 (4) "ordinary care" means care that satisfies reasonable medical

standards that prevail in the area in which the person being treated is located.

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

Chapter 07. Regulation of Managed Care Insurance Plans.

Sec. 21.07.010. Patient and health care provider protection. (a) A contract between a participating health care provider and a managed care entity that offers a group managed care plan must contain a provision that

(1) clearly identifies all health care services to be provided;

(2) clearly identifies which health care services are to be provided by a contracting health care provider;

(3) clearly identifies and describes each insurance policy used by the group managed care plan to provide identified health care services to a covered person;

(4) clearly states the compensation rates for each provider used by the group managed care plan to provide health care services;

(5) clearly states all ways in which the contract between the health care provider and managed care entity may be terminated; a provision that provides for discretionary termination by either party must apply equitably to both parties;

(6) provides that, in the event of a dispute between the parties to the contract, the following procedure must be used before either party may pursue other remedies:

(A) an initial meeting at which all parties are present or represented by individuals with full decision-making authority regarding the matters in dispute shall be held within seven days after the plan receives notice of the dispute or gives notice to the provider;

(B) if, within 30 days following the initial meeting, the parties have not resolved the dispute, the dispute shall be submitted to mediation directed by a mediator who is mutually agreeable to the parties and who is not regularly under contract to or employed by either of the parties; each party shall bear its proportionate share of the cost of mediation, including the mediator fees;

(C) if, after a period of 60 days following commencement of mediation, the parties are unable to resolve the dispute, either party may submit

1 the dispute to binding arbitration in accordance with (E) of this paragraph;

2 (D) the parties shall agree to negotiate in good faith in the
3 initial meeting and in mediation;

4 (E) after 10 days' written notice to the other party, either party
5 may submit the dispute to final and binding arbitration; binding arbitration shall
6 be held in the judicial district in this state where the services at issue in the
7 dispute were or are to be performed; at the request of either party, an
8 arbitration proceeding may be conducted electronically, including by telephone
9 or video conferencing; and

10 (F) binding arbitration shall be conducted under the rules of the
11 National Health Lawyers Association Alternative Dispute Resolution Project;
12 each party shall be responsible for its own costs and expenses related to the
13 arbitration, including attorney fees, and shall bear a proportionate share of the
14 arbitrator fees; the arbitrator shall be selected by mutual agreement between the
15 parties; the arbitrator shall be an attorney and a member of the National
16 Academy of Arbitrators or the National Health Lawyers Association;

17 (7) states that a health care provider may not be penalized or the health
18 care provider's contract terminated by the managed care entity because the health care
19 provider acts as an advocate for a covered person in seeking appropriate, medically
20 necessary health care services;

21 (8) protects the ability of a health care provider to communicate openly
22 with a covered person about all appropriate diagnostic testing and treatment options;
23 and

24 (9) defines words in a clear and concise manner.

25 (b) A contract between a participating health care provider and a managed care
26 entity that offers a group managed care plan may not contain a provision that

27 (1) provides financial incentives to the health care provider for
28 withholding covered health care services that are medically necessary;

29 (2) describes the products used by the plan as including all products
30 that are currently offered by the managed care entity; and

31 (3) requires the health care provider to be compensated for health care

1 services performed at the same rate as the health care provider has contracted with
2 another managed care entity.

3 (c) A managed care entity may not enter into a contract with a health care
4 provider that includes an indemnification or hold harmless clause for the acts or
5 conduct of the managed care entity. An indemnification or hold harmless clause
6 entered into in violation of this subsection is void.

7 (d) The standard provisions, other than those specifying the exact
8 compensation, of a contract between a health care provider and a managed care entity
9 must be filed and approved by the director before being used.

10 **Sec. 21.07.020. Required contract provisions for group managed care**
11 **plans.** (a) A group managed care plan must contain

12 (1) a provision that payment for a covered medical procedure that has
13 been preapproved by a managed care entity may not be denied after it has been
14 preapproved;

15 (2) a provision for emergency room services if any coverage is
16 provided for treatment of a medical emergency;

17 (3) copayment requirements that are uniform between different types
18 of health care providers;

19 (4) a provision that covered health care services be reasonably available
20 in the community in which a covered person resides; this paragraph is intended to
21 require that a managed care entity contract with a sufficient number of health care
22 providers in each community that it operates in or intends to operate in that allows
23 persons covered by the plan to have access to health care services that fall within the
24 standard of care for that community;

25 (5) a provision that any utilization review decision

26 (A) must be made within three working days after receiving the
27 necessary claim for payment or request for preapproval for nonemergency
28 situations; for emergency situations, utilization review decisions for care
29 following emergency services must be made as soon as is practicable but in
30 any event no later than 24 hours after receiving the request for preapproval or
31 for coverage determination; and

1 (B) to deny, reduce, or terminate a health care benefit or to
 2 deny payment for a health care service because that service is not medically
 3 necessary shall be made by an employee or agent of the managed care entity
 4 who is a licensed health care provider trained in the specialty or subspecialty
 5 pertaining to the health care service involved and only after consultation with
 6 the covered person's treating health care provider;

7 (6) a provision that provides for an internal appeal mechanism for a
 8 covered person who disagrees with a utilization review decision made by a managed
 9 care entity; this appeal mechanism must provide for a response from the managed care
 10 entity within seven working days from the date an appeal is received;

11 (7) a provision that discloses the existence of the right to an external
 12 appeal of a utilization review decision made by a managed care entity; the external
 13 appeal shall be as conducted in accordance with AS 21.07.050;

14 (8) a provision that discloses covered items and services, in- or out-of-
 15 network features, optional supplemental benefits, and restrictions on nonparticipating
 16 provider services;

17 (9) a provision that describes the covered service area, the procedures
 18 for advance directives and organ donations, preapproval requirements, and the
 19 availability of coverage for experimental, clinical trial, or investigational treatment;

20 (10) a provision describing compensation methods, including
 21 assignment of benefits, for health care providers and health care facilities;

22 (11) a provision describing availability of prescription medications or
 23 a list of specific drug formulas, including specific exclusions; and

24 (12) a provision describing available translation or interpreter services,
 25 including audiotape or braille information.

26 **Sec. 21.07.030. Choice of health care provider.** (a) A managed care entity
 27 that offers a group managed care plan shall include in the plan a point-of-service plan
 28 option that would allow a covered person to receive covered services from an out-of-
 29 network health care provider without obtaining a referral or prior authorization from
 30 the managed care entity. The point-of-service plan option may require that a covered
 31 person pay a higher deductible or copayment and a higher premium for the plan if the

1 higher deductible, copayment, or premium results from increased costs caused by the
2 use of an out-of-network provider. The managed care entity shall provide an actuarial
3 demonstration of the increased costs to the director at the director's request. If the
4 increased costs are not justified, the director shall determine the appropriate costs
5 allowed and determine the appropriate amount of higher deductible, copayment, or
6 premium.

7 (b) A managed care entity shall provide each covered person or person
8 applying for coverage the opportunity at the time of enrollment and during an annual
9 open enrollment period to enroll in the point-of-service plan option. The managed care
10 entity shall provide written notice of the point-of-service plan option to each covered
11 person or person applying for coverage and shall include in that notice a detailed
12 explanation of the financial costs to be incurred by a covered person who selects that
13 option.

14 (c) If a contract between a health care provider and a managed care entity is
15 terminated, a covered person may continue to be treated by that health care provider
16 as provided in this subsection. If a covered person was treated by a provider within
17 the six-month period immediately preceding the date of the termination of the contract
18 between that provider and the managed care entity, the covered person may continue
19 to receive health care services from that provider, and the managed care entity shall
20 continue to treat the provider in all respects as if the contract were still in force. The
21 covered person shall be treated for the purposes of benefit determination or claim
22 payment as if the provider were still under contract with the managed care entity.
23 However, treatment is required to continue only while the group managed care plan
24 remains in effect and

25 (1) for the period that is the longest of

26 (A) the end of the current plan year;

27 (B) the end of the medically necessary treatment for the
28 condition, disease, illness, or injury that the covered person was treated for
29 during that most recent six-month period before the termination of the contract
30 between the provider and the managed care entity; or

31 (C) six months; or

1 (2) until the end of the medically necessary treatment for the condition,
2 disease, illness, or injury if the person has a terminal condition, disease, illness, or
3 injury; in this paragraph "terminal" means a life expectancy of less than one year.

4 (d) The requirements of this section do not apply to health care services
5 covered by Medicaid.

6 (e) A managed care entity shall notify a covered person when a contract
7 between a health care provider and a managed care entity is terminated for cause.

8 **Sec. 21.07.040. Confidentiality of managed care information.** Medical and
9 financial information in the possession of a managed care entity regarding an applicant
10 or a current or former person covered by a managed care plan is confidential and is
11 not subject to public disclosure. The director by regulation shall establish reasonable
12 standards for the release of information in specified circumstances, including the
13 release of reasonably necessary information to insurance companies and the release of
14 information with the written authorization of the applicant or covered person.

15 **Sec. 21.07.050. External health care appeals.** (a) A covered person may
16 externally appeal a decision to deny, reduce, or terminate a health care benefit if the
17 person has already completed the internal appeal process required under AS 21.07.020.
18 The director shall establish the external appeal process by selecting an unrelated and
19 objective appeal agency. The director shall adopt regulations to implement this
20 section.

21 (b) The external appeal process must include the following:

22 (1) the external appeal review and decision must be based on the
23 medical necessity for the care, treatment, or service and the appropriateness of the
24 service for which authorization has been denied;

25 (2) neutral health care providers shall be used to make final
26 determinations; neutral providers shall be selected from lists mutually agreed upon by
27 provider associations, insurers, and consumers of health care services;

28 (3) the neutral provider may confer either directly with the covered
29 person's provider or with other providers appointed to represent a provider;

30 (4) payment for an appeal fee charged by a neutral provider shall be
31 shared equally between the parties to the appeal;

1 (5) a decision of an external appeal agency is binding; however, a
 2 person who is aggrieved by a final decision of an external appeal agency may seek
 3 judicial review by the superior court.

4 **Sec. 21.07.250. Definitions.** In this chapter,

5 (1) "emergency room services" means health care services provided by
 6 a hospital or other emergency facility after the sudden onset of a medical condition
 7 that manifests itself by symptoms of sufficient severity, including severe pain, that the
 8 absence of immediate medical attention would reasonably be expected by a prudent
 9 person who possesses an average knowledge of health and medicine to result in

10 (A) the placing of the person's health in serious jeopardy;

11 (B) a serious impairment to bodily functions; or

12 (C) a serious dysfunction of a bodily organ or part;

13 (2) "group managed care plan" or "plan" means a group health
 14 insurance plan operated by a managed care entity; "group managed care plan" does not
 15 include an integrated medical group;

16 (3) "health care provider" means a person licensed in this state or
 17 another state of the United States to provide health care services;

18 (4) "health care services" means treatment of an individual for an
 19 injury, illness, or disability and includes preventative treatment of an injury or illness;

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

21 (6) "integrated medical group" means a group of providers who
 22 contract with a health care plan for the direct provision of health care services to a
 23 person covered by a health care plan;

24 (7) "managed care" means a contract given to an individual, family, or
 25 group of individuals under which a member is entitled to receive a defined set of
 26 health care benefits through an organized system of health care providers in exchange
 27 for defined consideration and that requires the member to use, or creates financial
 28 incentives for the member to use, health care providers managed, employed by, or
 29 under contract with a managed care entity; "managed care" does not include Medicaid
 30 coverage under 42 U.S.C. 1396 - 1396p (Social Security Act);

31 (8) "managed care contractor" means a contractor who establishes,

1 operates, or maintains a network of participating health care providers, conducts or
2 arranges for utilization review activities, and contracts with a managed care entity;

3 (9) "managed care entity" means an insurer, a hospital or medical
4 service corporation, a health maintenance organization, an employer or employee
5 health care organization, or a managed care contractor that operates a group managed
6 care plan;

7 (10) "medical emergency" means the sudden onset of a medical
8 condition that manifests itself by symptoms of sufficient severity, including severe pain
9 that in the absence of immediate medical attention would reasonably be expected by
10 a prudent person who possesses an average knowledge of health and medicine to result
11 in

12 (A) the placing of the person's health in serious jeopardy;

13 (B) a serious impairment to bodily functions; or

14 (C) a serious dysfunction of any bodily organ or part;

15 (11) "medical necessity" means those health care services or products
16 that a prudent physician would provide to a patient for the purpose of preventing,
17 diagnosing, or treating an illness, injury, disease, or its symptoms in a manner that is

18 (A) consistent with generally accepted standards of medical
19 practice;

20 (B) clinically appropriate in terms of type, frequency, extent,
21 site, and duration; and

22 (C) not primarily for the convenience of the patient, physician,
23 or other health care provider;

24 (12) "participating health care provider" means a health care provider
25 who has entered into an agreement with a managed care entity to provide services or
26 supplies to a patient covered by a group managed care plan;

27 (13) "provider" means a health care provider;

28 (14) "utilization review" means a system of reviewing the medical
29 necessity, appropriateness, or quality of health care services and supplies provided
30 under a group managed care plan using specified guidelines, including preadmission
31 certification, the application of practice guidelines, continued stay review, discharge

1 planning, preauthorization of ambulatory procedures, and retrospective review;

2 (15) "working days" means a day of the week that is not a Saturday,
3 Sunday, or a holiday.

4 * **Sec. 4.** AS 21.42 is amended by adding a new section to read:

5 **Sec 21.42.390. Required health insurance coverage provisions.** (a) A
6 health care insurer may not include in a health care insurance plan or contract a
7 provision that

8 (1) prohibits a covered person from obtaining health care services from
9 a health care provider of the person's choice, including a specialist;

10 (2) restricts a covered person's right to receive full information from
11 the person's health care provider regarding the care or treatment options that the health
12 care provider believes are in the best interests of the person.

13 (b) A health care insurer may not deny, reduce, or terminate health care
14 payments or deny payment for a health care service because that service is not
15 medically necessary unless that decision is made by an employee or agent of the
16 insurer who is a licensed health care provider trained in that specialty or subspecialty
17 pertaining to that health care service involved and only after consultation with the
18 covered person's treating health care provider.

19 (c) An insurer may not deny coverage, cancel a health insurance policy or
20 subscriber contract, or otherwise take action against an insured person or a health care
21 provider because that person has asserted a right described in this section.

22 (d) A covered person may bring a civil action against a health care insurer to
23 enforce the person's rights under this section.

24 (e) In this section,

25 (1) "health care provider" means a person licensed in this state or
26 another state of the United States to provide health care services;

27 (2) "health care services" means treatment of an individual for an
28 injury, illness, or disability and includes preventative treatment of an injury or illness.

29 * **Sec. 5.** AS 21.86.150(j) is repealed.

30 * **Sec. 6.** This Act takes effect July 1, 2000.