

CS FOR HOUSE BILL NO. 211(L&C)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FIRST LEGISLATURE - SECOND SESSION

BY THE HOUSE LABOR AND COMMERCE COMMITTEE

Offered: 3/8/00

Referred: Judiciary, Finance

Sponsor(s): REPRESENTATIVE ROKEBERG BY REQUEST

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; amending Rule 602(b), Alaska Rules of Appellate
4 Procedure; and providing for an effective date."

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

6 * **Section 1.** The uncodified law of the State of Alaska is amended by adding a new
7 section to read:

8 **SHORT TITLE.** Section 3 of this Act may be known as the Alaska Patients Bill of
9 Rights.

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

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

14 (b) A managed care entity is civilly liable for damages for harm to a covered

1 person

2 (1) proximately caused by

3 (A) its failure to exercise ordinary care; or

4 (B) a health care treatment decision that constitutes a failure to
5 exercise ordinary care made by an employee, agent, ostensible agent, or
6 representative who is acting on behalf of a managed care entity; or

7 (2) resulting from the failure to provide care or treatment covered by
8 the health care plan.

9 (c) This section does not create

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

12 (2) civil liability for an employer, an association of employers, a labor
13 organization, or other employer group if the employer, association, labor organization,
14 or group does not make health care treatment decisions.

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

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

26 (f) In this section,

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

29 (2) "health care treatment decision" means

30 (A) a determination made when medical services are actually
31 provided by a health care plan;

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

3 (C) a decision based on prospective and current review of
4 proposed medical treatment;

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

6 (4) "ordinary care" means care that satisfies reasonable medical
7 standards that prevail in the area in which the person being treated is located.

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

9 **Chapter 07. Regulation of Managed Care Insurance Plans.**

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

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

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

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

18 (4) clearly states the health care provider's rate of compensation;

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

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

25 (A) an initial meeting at which all parties are present or
26 represented by individuals with full decision-making authority regarding the
27 matters in dispute shall be held within seven working days after the plan
28 receives notice of the dispute or gives notice to the provider, unless the parties
29 otherwise agree in writing to a different schedule;

30 (B) if, within 30 days following the initial meeting, the parties
31 have not resolved the dispute, the dispute shall be submitted to mediation

1 directed by a mediator who is mutually agreeable to the parties and who is not
2 regularly under contract to or employed by either of the parties; each party
3 shall bear its proportionate share of the cost of mediation, including the
4 mediator fees;

5 (C) if, after a period of 60 days following commencement of
6 mediation, the parties are unable to resolve the dispute, either party may submit
7 the dispute to binding arbitration in accordance with (E) of this paragraph;

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

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

16 (F) binding arbitration shall be conducted under the rules of the
17 National Health Lawyers Association Alternative Dispute Resolution Project;
18 each party shall be responsible for its own costs and expenses related to the
19 arbitration, including attorney fees, and shall bear a proportionate share of the
20 arbitrator fees; the arbitrator shall be selected by mutual agreement between the
21 parties; the arbitrator shall be a person who is knowledgeable of state law and
22 business practices, an attorney, and a member of the National Academy of
23 Arbitrators or the National Health Lawyers Association;

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

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

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

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

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

5 (2) describes the products used by the plan as including all products
6 that are currently offered or that may be offered in the future by the managed care
7 entity; and

8 (3) requires the health care provider to be compensated for health care
9 services performed at the same rate as the health care provider has contracted with
10 another managed care entity.

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

15 **Sec. 21.07.020. Required contract provisions for group managed care**
16 **plans.** A group managed care plan must contain

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

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

22 (3) a provision that covered health care services be reasonably available
23 in the community in which a covered person resides or that adequate referrals outside
24 the community be available if the health care service is not available in the
25 community; this paragraph is intended to require that a managed care entity contract
26 with a sufficient number of health care providers in each community in which it
27 operates or intends to operate to allow persons covered by the plan to have access to
28 health care services that fall within the standard of care for that community;

29 (4) a provision that any utilization review decision

30 (A) must be made within 72 hours after receiving the necessary
31 claim for payment or request for preapproval for nonemergency situations; for

1 emergency situations, utilization review decisions for care following emergency
 2 services must be made as soon as is practicable but in any event no later than
 3 24 hours after receiving the request for preapproval or for coverage
 4 determination; and

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

11 (5) a provision that provides for an internal appeal mechanism for a
 12 covered person who disagrees with a utilization review decision made by a managed
 13 care entity; this appeal mechanism must provide for a written decision from the
 14 managed care entity within 15 working days from the date an appeal is received;

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

18 (7) a provision that discloses covered items and services, optional
 19 supplemental benefits, and benefits relating to and restrictions on nonparticipating
 20 provider services;

21 (8) a provision that describes the covered service area, preapproval
 22 requirements, and the coverage for clinical trial, experimental, or investigational
 23 treatment;

24 (9) a provision describing compensation methods, including assignment
 25 of benefits, for health care providers and health care facilities;

26 (10) a provision describing availability of prescription medications or
 27 a formulary guide, including specific exclusions; if a formulary guide is made
 28 available, the guide must be updated annually; and

29 (11) a provision describing available translation or interpreter services,
 30 including audiotape or braille information.

31 **Sec. 21.07.030. Choice of health care provider.** (a) If a managed care entity

1 offers a group health plan that provides for coverage of health care services only if the
2 services are furnished through a network of health care providers that have entered into
3 a contract with the managed care entity, the managed care entity shall also offer a non-
4 network option to enrollees at initial enrollment, as provided under (c) of this section.
5 The non-network option may require that a covered person pay a higher deductible or
6 copayment and a higher premium for the plan if the higher deductible, copayment, or
7 premium results from increased costs caused by the use of a non-network provider.
8 The managed care entity shall provide an actuarial demonstration of the increased costs
9 to the director at the director's request. If the increased costs are not justified, the
10 director shall determine the appropriate costs allowed and determine the appropriate
11 amount of higher deductible, copayment, or premium. This subsection does not apply
12 to an enrollee who is offered non-network coverage through another group health plan
13 or through another managed care entity in the group market.

14 (b) The amount of any additional premium charged by the managed care entity
15 for the additional cost of the creation and maintenance of the option described in (a)
16 of this section and the amount of any additional cost sharing imposed under this option
17 shall be paid by the enrollee unless it is paid by the employer through agreement with
18 the managed care entity.

19 (c) An enrollee may make a change to the health care coverage option
20 provided under this section only during a time period determined by the managed care
21 entity. The time period described in this subsection must occur at least annually.

22 (d) If a managed care entity that offers a group managed care plan requires or
23 provides for a designation by an enrollee of a participating primary care provider, the
24 managed care entity shall permit the enrollee to designate any participating primary
25 care provider that is available to accept the enrollee.

26 (e) Except as provided in this subsection, a managed care entity that offers a
27 group managed care plan shall permit an enrollee to receive medically necessary or
28 appropriate specialty care, subject to appropriate referral procedures, from any qualified
29 participating health care provider that is available to accept the individual for medical
30 care. This subsection does not apply to specialty care if the managed care entity
31 clearly informs enrollees of the limitations on choice of participating health care

1 providers with respect to medical care. In this subsection,

2 (1) "appropriate referral procedures" means procedures for referring
3 patients to other health care providers that comply with ethical guidelines established
4 by the American Medical Association;

5 (2) "specialty care" means care provided by a health care provider with
6 training and experience in treating a particular injury, illness, or condition.

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

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

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

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

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

26 (C) six months from the initial treatment by a provider; or

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

30 (h) The requirements of this section do not apply to health care services
31 covered by Medicaid.

1 **Sec. 21.07.040. Confidentiality of managed care information.** (a) Medical
2 and financial information in the possession of a managed care entity regarding an
3 applicant or a current or former person covered by a managed care plan is confidential
4 and is not subject to public disclosure.

5 (b) This section does not apply to medical information that is disclosed for
6 research purposes if

7 (1) the individual whose identity is disclosed gives written consent to
8 the disclosure; or

9 (2) the information is released in a form that does not reveal the
10 identity of an individual.

11 **Sec. 21.07.050. External health care appeals.** (a) A managed care entity
12 offering group health insurance coverage shall provide for an external appeal process
13 that meets the requirements of this section in the case of an externally appealable
14 decision for which a timely appeal is made either by the managed care entity or by the
15 enrollee.

16 (b) A managed care entity may condition the use of an external appeal process
17 in the case of an externally appealable decision upon a final decision in an internal
18 review under AS 21.07.020, but only if the decision is made in a timely basis
19 consistent with the deadlines provided under this chapter.

20 (c) A managed care entity

21 (1) may condition the use of an external appeal process upon payment
22 to the managed care entity of a filing fee that does not exceed \$25;

23 (2) may not require payment of a filing fee in the case of an enrollee
24 who certifies that the enrollee is indigent;

25 (3) shall refund payment of the filing fee under (1) of this subsection
26 if the recommendation of the external appeal agency is to reverse or modify the denial
27 of a claim for benefits that is the subject of the appeal.

28 (d) Except as provided in this subsection, the external appeal process shall be
29 conducted under a contract between the managed care entity and one or more external
30 appeal agencies that have qualified under AS 21.07.060. The managed care entity
31 shall provide

1 (1) that the selection process among external appeal agencies qualifying
2 under AS 21.07.060 does not create any incentives for external appeal agencies to
3 make a decision in a biased manner;

4 (2) for auditing a sample of decisions by external appeal agencies to
5 assure that decisions are not made in a biased manner; and

6 (3) that all costs of the process, except those incurred by the enrollee
7 or treating professional in support of the appeal, shall be paid by the managed care
8 entity and not by the enrollee; this paragraph does not apply to the imposition of a
9 filing fee under (c) of this section.

10 (e) An external appeal process must include at least the following:

11 (1) a fair, de novo determination based on coverage provided by the
12 plan and by applying terms as defined by the plan; however, nothing in this paragraph
13 may be construed as providing for coverage of items and services for which benefits
14 are specifically excluded under the plan or coverage;

15 (2) an external appeal agency shall determine whether the managed care
16 entity's decision, is in accordance with the medical needs of the patient involved, as
17 determined by the managed care entity, taking into account, as of the time of the
18 managed care entity's decision, the patient's medical needs and any relevant and
19 reliable evidence the agency obtains under (4) of this subsection; if the agency
20 determines the decision is in accordance with the patient's needs, the agency shall
21 affirm the decision and to the extent that the agency determines the decision is not in
22 accordance with the patient's needs, the agency shall reverse or modify the decision;

23 (3) in making a determination, the external appeal agency shall
24 consider, but is not bound by, any language in the plan or coverage document relating
25 to the definitions of the terms "medical necessity," "medically necessary or
26 appropriate," "experimental," "investigational," or similar terms;

27 (4) the external appeal agency shall include among the evidence taken
28 into consideration

29 (A) the decision made by the managed care entity upon internal
30 review under AS 21.07.020 and any guidelines or standards used by the
31 managed care entity in reaching a decision;

1 (B) any personal health and medical information supplied with
2 respect to the individual whose denial of claim for benefits has been appealed;
3 and

4 (C) the opinion of the individual's treating physician or health
5 care provider;

6 (5) the external appeal agency may also take into consideration, but is
7 not limited to considering, the following evidence:

8 (A) the results of studies that meet professionally recognized
9 standards of validity and replicability or that have been published in peer-
10 reviewed journals;

11 (B) the results of professional consensus conferences conducted
12 or financed in whole or in part by one or more government agencies;

13 (C) practice and treatment guidelines prepared or financed in
14 whole or in part by government agencies;

15 (D) government-issued coverage and treatment policies;

16 (E) community standard of care and generally accepted
17 principles of professional medical practice;

18 (F) to the extent that the agency determines it to be free of any
19 conflict of interest, the opinions of individuals who are qualified as experts in
20 one or more fields of health care that are directly related to the matters under
21 appeal; and

22 (G) to the extent that the agency determines it to be free of any
23 conflict of interest, the results of peer reviews conducted by the managed care
24 entity involved;

25 (6) an external appeal agency shall determine

26 (A) whether a denial of a claim for benefits is an externally
27 appealable decision;

28 (B) whether an externally appealable decision involves an
29 expedited appeal; and

30 (C) for purposes of initiating an external review, whether the
31 internal review process has been completed;

1 (7) a party to an externally appealable decision may submit evidence
2 related to the issues in dispute;

3 (8) the managed care entity involved shall provide the external appeal
4 agency with access to information and to provisions of the plan or health insurance
5 coverage relating to the matter of the externally appealable decision, as determined by
6 the external appeal agency; and

7 (9) a determination by the external appeal agency on the decision must

8 (A) be made orally or in writing and, if it is made orally, shall
9 be supplied to the parties in writing as soon as possible;

10 (B) be made in accordance with the medical exigencies of the
11 case involved, but in no event later than 21 working days after the appeal is
12 filed, or, in the case of an expedited appeal, 72 hours after the time of
13 requesting an external appeal of the managed care entity's decision;

14 (C) state, in layperson's language, the basis for the
15 determination, including, if relevant, any basis in the terms or conditions of the
16 plan or coverage; and

17 (D) inform the enrollee of the individual's rights, including any
18 limitation on those rights, to seek further review by the courts of the external
19 appeal determination.

20 (f) If the external appeal agency reverses or modifies the denial of a claim for
21 benefits, the managed care entity shall

22 (1) upon receipt of the determination, authorize benefits in accordance
23 with that determination;

24 (2) take action as may be necessary to provide benefits, including items
25 or services, in a timely manner consistent with the determination; and

26 (3) submit information to the external appeal agency documenting
27 compliance with the agency's determination.

28 (g) A decision of an external appeal agency is binding unless a person who is
29 aggrieved by a final decision of an external appeal agency appeals the decision to the
30 superior court.

31 (h) An appeal of a final decision of an external appeal agency must be filed

1 within six months after the date of the decision of the external appeal agency.

2 (i) In this section, "externally appealable decision"

3 (1) means

4 (A) a denial of a claim for benefits that is based in whole or in
5 part on a decision that the item or service is not medically necessary or
6 appropriate or is investigational or experimental, or in which the decision as to
7 whether a benefit is covered involves a medical judgment; or

8 (B) a failure to meet an applicable deadline for internal review
9 under AS 21.07.020;

10 (2) does not include specific exclusions or express limitations on the
11 amount, duration, or scope of coverage that do not involve medical judgment, or a
12 decision regarding whether an individual is a participant, beneficiary, or enrollee under
13 the plan or coverage.

14 **Sec. 21.07.060. Qualifications of external appeal agencies.** (a) An external
15 appeal agency qualifies to consider external appeals if, with respect to a group health
16 plan, the agency is certified by a qualified private standard-setting organization
17 approved by the director or by a health insurer operating in this state as meeting the
18 requirements imposed under (b) of this section.

19 (b) An external appeal agency is qualified to consider appeals of group health
20 plan health care decisions if the agency meets the following requirements:

21 (1) the agency meets the independence requirements of this section;

22 (2) the agency conducts external appeal activities through a panel of
23 not fewer than three clinical peers; and

24 (3) the agency has sufficient medical, legal, and other expertise and
25 sufficient staffing to conduct external appeal activities for the managed care entity on
26 a timely basis consistent with this chapter.

27 (c) A clinical peer or other entity meets the independence requirements of this
28 section if

29 (1) the peer or entity does not have a familial, financial, or professional
30 relationship with a related party;

31 (2) compensation received by a peer or entity in connection with the

1 external review is reasonable and not contingent on any decision rendered by the peer
2 or entity;

3 (3) the plan and the issuer have no recourse against the peer or entity
4 in connection with the external review; and

5 (4) the peer or entity does not otherwise have a conflict of interest with
6 a related party.

7 (d) In this section, "related party" means

8 (1) with respect to

9 (A) a group health plan or health insurance coverage offered in
10 connection with a plan, the plan or the insurer offering the coverage; or

11 (B) individual health insurance coverage, the insurer offering
12 the coverage, or any plan sponsor, fiduciary, officer, director, or management
13 employee of the plan or issuer;

14 (2) the health care professional that provided the health care involved
15 in the coverage decision;

16 (3) the institution at which the health care involved in the coverage
17 decision is provided;

18 (4) the manufacturer of any drug or other item that was included in the
19 health care involved in the coverage decision; or

20 (5) any other party that, under the regulations that the director may
21 prescribe, is determined by the director to have a substantial interest in the coverage
22 decision.

23 **Sec. 21.07.070. Limitation on liability of reviewers.** An external appeal
24 agency qualifying under AS 21.07.060 and having a contract with a managed care
25 entity, and a person who is employed by the agency or who furnishes professional
26 services to the agency, may not be held by reason of the performance of any duty,
27 function, or activity required or authorized under this chapter to have violated any
28 criminal law, or to be civilly liable if due care was exercised in the performance of the
29 duty, function or activity and there was no actual malice or gross misconduct in the
30 performance of the duty, function, or activity.

31 **Sec. 21.07.080. Religious nonmedical providers.** This chapter may not be

1 construed to

2 (1) restrict or limit the right of a managed care entity to include health
3 care services provided by a religious nonmedical provider as health care services
4 covered by the managed care plan;

5 (2) require a managed care entity, when determining coverage for
6 health care services provided by a religious nonmedical provider, to

7 (A) apply medically based eligibility standards;

8 (B) use health care providers to determine access by a covered
9 person;

10 (C) use health care providers in making a decision on an
11 internal or external appeal; or

12 (D) require a covered person to be examined by a health care
13 provider as a condition of coverage; or

14 (3) require a managed care plan to exclude coverage for health care
15 services provided by a religious nonmedical provider because the religious nonmedical
16 provider is not providing medical or other data required from a health care provider
17 if the medical or other data is inconsistent with the religious nonmedical treatment or
18 nursing care being provided.

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

20 (1) "clinical peer" means a health care provider who is licensed to
21 provide the same or similar health care services and who is trained in the specialty or
22 subspecialty applicable to the health care services that are provided;

23 (2) "clinical trial" means treatment, research, study, or investigation
24 over a period of time of an injury, illness, or medical condition;

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

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

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

- 1 (C) a serious dysfunction of a bodily organ or part;
- 2 (4) "group managed care plan" or "plan" means a group health
3 insurance plan operated by a managed care entity;
- 4 (5) "health care provider" means a person licensed in this state or
5 another state of the United States to provide health care services;
- 6 (6) "health care services" means treatment of an individual for an
7 injury, illness, or disability and includes preventative treatment of an injury or illness;
- 8 (7) "health insurance" has the meaning given in AS 21.12.050(a);
- 9 (8) "managed care" means a contract given to an individual, family, or
10 group of individuals under which a member is entitled to receive a defined set of
11 health care benefits in exchange for defined consideration and that requires the member
12 to comply with utilization review guide lines; "managed care" does not include
13 Medicaid coverage under 42 U.S.C. 1396 - 1396p (Social Security Act);
- 14 (9) "managed care contractor" means a contractor who establishes,
15 operates, or maintains a network of participating health care providers, conducts or
16 arranges for utilization review activities, and contracts with a managed care entity;
- 17 (10) "managed care entity" means an insurer, a hospital or medical
18 service corporation, a health maintenance organization, an employer or employee
19 health care organization, a managed care contractor that operates a group managed care
20 plan, or a person who has a financial interest in health care services provided to an
21 individual;
- 22 (11) "medical emergency" means the sudden onset of a medical
23 condition that manifests itself by symptoms of sufficient severity, including severe pain
24 that in the absence of immediate medical attention would reasonably be expected by
25 a prudent person who possesses an average knowledge of health and medicine to result
26 in
- 27 (A) the placing of the person's health in serious jeopardy;
- 28 (B) a serious impairment to bodily functions; or
- 29 (C) a serious dysfunction of any bodily organ or part;
- 30 (12) "medical necessity" means those health care services or products
31 that a prudent physician would provide to a patient for the purpose of preventing,

1 diagnosing, or treating an illness, injury, disease, or its symptoms in a manner that is

2 (A) consistent with generally accepted standards of medical
3 practice;

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

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

8 (13) "participating health care provider" means a health care provider
9 who has entered into an agreement with a managed care entity to provide services or
10 supplies to a patient covered by a group managed care plan;

11 (14) "primary care provider" means a health care provider who provides
12 general health care services and does not specialize in treating a single injury, illness,
13 or condition or who provides obstetrical, gynecological, or pediatric health care
14 services;

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

16 (16) "religious nonmedical provider" means a person who does not
17 provide medical care, but who provides only religious nonmedical treatment or nursing
18 care for an illness or injury;

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

24 (18) "working day" means a day of the week that is not a Saturday,
25 Sunday, or a holiday.

26 * **Sec. 4.** AS 21.36.125 is amended by adding a new paragraph to read:

27 (16) violate a provision contained in AS 21.07.

28 * **Sec. 5.** AS 21.42 is amended by adding a new section to read:

29 **Sec 21.42.390. Required health insurance coverage provisions.** (a) A
30 health care insurer may not include in a health care insurance plan or contract a
31 provision that restricts a covered person's right to receive full information from the

1 person's health care provider regarding the care or treatment options that the health
2 care provider believes are in the best interests of the person.

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

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

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

14 (e) In this section, "health care provider" means a person licensed in this state
15 or another state of the United States to provide health care services.

16 * **Sec. 6.** AS 21.86.150(j) is repealed.

17 * **Sec. 7.** The uncodified law of the State of Alaska is amended by adding a new section
18 to read:

19 **INDIRECT COURT RULE AMENDMENT.** AS 21.07.050(h), as enacted by sec. 3
20 of this Act, has the effect of amending Rule 602(b), Alaska Rules of Appellate Procedure, by
21 providing that an appeal from a decision of an external appeal agency must be filed within
22 six months of the decision of the external appeal agency.

23 * **Sec. 8.** The uncodified law of the State of Alaska is amended by adding a new section
24 to read:

25 **CONDITIONAL EFFECT.** AS 21.07.050(h), as enacted by sec. 3 of this Act, takes
26 effect only if sec. 7 of this Act receives the two-thirds majority vote of each house required
27 by art. IV, sec. 15, Constitution of the State of Alaska.

28 * **Sec. 9.** This Act takes effect July 1, 2000.