CS FOR HOUSE BILL NO. 211(FIN)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FIRST LEGISLATURE - SECOND SESSION

BY THE HOUSE FINANCE COMMITTEE

Offered: 4/14/00
Referred: Rules

Sponsor(s): REPRESENTATIVE ROKEBERG BY REQUEST

A BILL

FOR AN ACT ENTITLED

"An Act relating to regulation of managed care insurance plans; amending Rule 602, Alaska Rules of Appellate Procedure; and providing for an effective date."

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

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

SHORT TITLE. Section 2 of this Act may be known as the Alaska Patients' Bill of Rights.

*** Sec. 2.** 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) provides for a reasonable mechanism to identify all health care services to be provided by the managed care entity;

(2) clearly states or references an attachment that states the health care provider's rate of compensation;

(3) 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;

(4) provides that, in the event of a dispute between the parties to the contract, a fair, prompt, and mutual dispute resolution process must be used; at a minimum, the process must provide

(A) for an initial meeting at which all parties are present or represented by individuals with authority regarding the matters in dispute; the meeting shall be held within 10 working days after the plan receives written notice of the dispute or gives written notice to the provider, unless the parties otherwise agree in writing to a different schedule;

(B) that 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) that if, after a period of 60 days following commencement of mediation, the parties are unable to resolve the dispute, either party may seek other relief allowed by law;

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

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

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

(7) defines words in a clear and concise manner.

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

(1) has as its predominant purpose the creation of direct financial incentives to the health care provider for withholding covered health care services that are medically necessary; nothing in this paragraph shall be construed to prohibit a contract between a participating health care provider and a managed care entity from containing incentives for efficient management of the utilization and cost of covered health care services;

(2) requires the provider to contract for all products that are currently offered or that may be offered in the future by the managed care entity; and

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

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

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

(1) a provision that preauthorization for a covered medical procedure on the basis of medical necessity may not be retroactively denied unless the preauthorization is based on materially incomplete or inaccurate information provided by or on behalf of the provider;

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

(3) a provision that covered health care services be reasonably available in the community in which a covered person resides or that, if referrals are required by the plan, adequate referrals outside the community be available if the health care service is not available in the community;

(4) a provision that any utilization review decision

(A) must be made within 72 hours after receiving the request for preapproval for nonemergency situations; for emergency situations, utilization review decisions for care following emergency services must be made as soon as is practicable but in any event no later than 24 hours after receiving the request for preapproval or for coverage determination; and

(B) to deny, reduce, or terminate a health care benefit or to deny payment for a health care service because that service is not medically necessary shall be made by an employee or agent of the managed care entity who is a licensed health care provider;

(5) a provision that provides for an internal appeal mechanism for a covered person who disagrees with a utilization review decision made by a managed care entity; except as provided under (6) of this section, this appeal mechanism must provide for a written decision

(A) from the managed care entity within 18 working days after the date written notice of an appeal is received; and

(B) on the appeal by an employee or agent of the managed care entity who holds the same professional license as the health care provider who is treating the covered person;

(6) a provision that provides for an internal appeal mechanism for a covered person who disagrees with a utilization review decision made by a managed care entity in any case in which delay would, in the written opinion of the treating provider, jeopardize the covered person's life or materially jeopardize the covered person's health; the managed care entity shall

(A) decide an appeal described in this paragraph within 72 hours after receiving the appeal; and

(B) provide for a written decision on the appeal by an employee or agent of the managed care entity who holds the same professional license as the health care provider who is treating the covered person;

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

(8) a provision that discloses covered benefits, optional supplemental benefits, and benefits relating to and restrictions on nonparticipating provider services;

(9) a provision that describes the preapproval requirements and whether clinical trials or experimental or investigational treatment are covered;

(10) a provision describing a mechanism for assignment of benefits for health care providers and payment of benefits;

(11) a provision describing availability of prescription medications or a formulary guide, and whether medications not listed are excluded; if a formulary guide is made available, the guide must be updated annually; and

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

Sec. 21.07.030. Choice of health care provider. (a) If a managed care entity offers a group health plan that provides for coverage of health care services only if the services are furnished through a network of health care providers that have entered into a contract with the managed care entity, the managed care entity shall also offer a non-network option to enrollees at initial enrollment, as provided under (c) of this section. The non-network option may require that a covered person pay a higher deductible, copayment, or premium for the plan if the higher deductible, copayment, or premium results from increased costs caused by the use of a non-network provider. The managed care entity shall provide an actuarial demonstration of the increased costs to the director at the director's request. If the increased costs are not justified, the director shall determine the appropriate costs allowed and determine the appropriate amount of higher deductible, copayment, or premium. This subsection does not apply to an enrollee who is offered non-network coverage through another group health plan or through another managed care entity in the group market.

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

(c) An enrollee may make a change to the health care coverage option

provided under this section only during a time period determined by the managed care entity. The time period described in this subsection must occur at least annually.

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

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

(1) "appropriate referral procedures" means procedures for referring patients to other health care providers as set out in the applicable member contract and as described under (a) of this section;

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

(f) If a contract between a health care provider and a managed care entity is terminated, a covered person may continue to be treated by that health care provider as provided in this subsection. If a covered person is pregnant or being actively treated by a provider on the date of the termination of the contract between that provider and the managed care entity, the covered person may continue to receive health care services from that provider as provided in this subsection, and the contract between the managed care entity and the provider shall remain in force with respect to the continuing treatment. The covered person shall be treated for the purposes of benefit determination or claim payment as if the provider were still under contract with the managed care entity. However, treatment is required to continue only while the group managed care plan remains in effect and

(1) for the period that is the longest of the following:

(A) the end of the current plan year;

(B) up to 90 days after the termination date, if the event triggering the right to continuing treatment is part of an ongoing course of treatment; or

(C) through completion of postpartum care, if the covered person is in the second trimester of pregnancy on the date of termination; or

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

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

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

(b) This section does not apply to medical information that is disclosed if

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

(2) the information is disclosed for research

(A) that is subject to federal law and regulations protecting the rights and welfare of research participants; or

(B) using health information that protects the confidentiality of participants by coding or encryption of information that would otherwise identify the patient;

(3) the information is disclosed for purposes of obtaining reimbursement under health insurance;

(4) the information is disclosed at the written request of the covered person;

(5) the disclosure is required by law.

Sec. 21.07.050. External health care appeals. (a) A managed care entity offering group health insurance coverage shall provide for an external appeal process that meets the requirements of this section in the case of an externally appealable

decision for which a timely appeal is made in writing either by the managed care entity or by the enrollee.

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

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

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

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

(3) that all costs of the process, except those incurred by the enrollee or treating professional in support of the appeal, shall be paid by the managed care entity and not by the enrollee.

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

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

(2) an external appeal agency shall determine whether the managed care entity's decision is (A) in accordance with the medical needs of the patient involved, as determined by the managed care entity, taking into account, as of the time of the managed care entity's decision, the patient's medical needs and any relevant and reliable evidence the agency obtains under (3) of this subsection, and (B) in accordance with the scope of the covered benefits under the plan; if the agency determines the decision complies with this paragraph, the agency shall affirm the decision, and, to the extent that the agency determines the decision is not in

accordance with this paragraph, the agency shall reverse or modify the decision;

(3) the external appeal agency shall include among the evidence taken into consideration

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

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

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

(D) the group managed care plan;

(4) the external appeal agency may also take into consideration the following evidence:

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

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

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

(D) government-issued coverage and treatment policies;

(E) generally accepted principles of professional medical practice;

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

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

(H) the community standard of care; and

(I) anomalous utilization patterns;

(5) an external appeal agency shall determine

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

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

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

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

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

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

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

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

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

(D) inform the enrollee of the individual's rights, including any time limits, to seek further review by the courts of the external appeal determination.

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

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

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

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

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

(g) An appeal of a final decision of an external appeal agency must be filed within six months after the date of the decision of the external appeal agency.

(h) In this section, "externally appealable decision"

(1) means

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

(B) a denial that is based on a failure to meet an applicable deadline for internal appeal under AS 21.07.020;

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

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

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

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

(2) the agency conducts external appeal activities through a panel of two clinical peers, unless otherwise agreed to by both parties; and

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

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

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

(2) compensation received by a peer or entity in connection with the external review is reasonable and not contingent on any decision rendered by the peer or entity;

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

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

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

(1) with respect to

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

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

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

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

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

(5) the covered person; or

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

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

Sec. 21.07.080. Religious nonmedical providers. This chapter may not be construed to

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

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

(A) apply medically based eligibility standards;

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

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

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

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

Sec. 21.07.090. Construction. This chapter may not be construed to supersede or change the provisions of 29 U.S.C. 1001 - 1191 (Employee Retirement Income Security Act of 1974) as those provisions apply to self-insured employers.

Sec. 21.07.250. Definitions. In this chapter,

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

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

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

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

(B) a serious impairment to bodily functions; or

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

(4) "group managed care plan" or "plan" means a group health insurance plan operated by a managed care entity;

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

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

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

(8) "managed care" means a contract given to an individual, family, or group of individuals under which a member is entitled to receive a defined set of health care benefits in exchange for defined consideration and that requires the member to comply with utilization review guide lines; "managed care" does not include Medicaid coverage under 42 U.S.C. 1396 - 1396p (Social Security Act);

(9) "managed care contractor" means a contractor who establishes, operates, or maintains a network of participating health care providers, conducts or arranges for utilization review activities, and contracts with a managed care entity;

(10) "managed care entity" means an insurer, a hospital or medical service corporation, a health maintenance organization, an employer or employee health care organization, a managed care contractor that operates a group managed care

plan, or a person who has a financial interest in health care services provided to an individual;

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

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

(B) a serious impairment to bodily functions; or

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

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

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

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

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

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

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

*** Sec. 3.** AS 21.36.125 is amended by adding a new paragraph to read:

(16) violate a provision contained in AS 21.07.

*** Sec. 4.** The uncodified law of the State of Alaska is amended by adding a new section

to read:

INDIRECT COURT RULE AMENDMENT. AS 21.07.050(g), as enacted by sec. 2 of this Act, has the effect of amending Rule 602, Alaska Rules of Appellate Procedure, by providing that an appeal from a decision of an external appeal agency must be filed within six months of the decision of the external appeal agency.

*** Sec. 5.** The uncodified law of the State of Alaska is amended by adding a new section to read:

CONDITIONAL EFFECT. AS 21.07.050(g), as enacted by sec. 2 of this Act, takes effect only if sec. 4 of this Act receives the two-thirds majority vote of each house required by art. IV, sec. 15, Constitution of the State of Alaska.

*** Sec. 6.** This Act takes effect July 1, 2001.