SB

197

SENATE COMMITTEE REPORT

DATE: 5/7/97

FURTHER:

Date of 5-Day Notice: 1/8/98
(in accordance with Uniform Rule 23)

DATE TURNED IN TO OFFICE: 1/21/98

HESS Committee considered SENATE BILL NO. 197

"An Act relating to health care services provided by, and practices of, a health maintenance organization; and prohibiting health maintenance organizations from limiting free speech of health care providers."

and recommends:

[ ] be replaced with ______ CS ______________________(________)

[ ] adopt previous _____ CS ______________________(________)

[ ] attached amendment(s)

[ ] adopt Letter of Intent by __________________ Committee

[ ] further referral to the __________________ Committee

Senate Bill:
[ ] same title
[ ] new title

House Bill:
[ ] same title
[ ] technical change
[ ] new: SCR* ______

SIGNING DO PASS	DP	OTHER RECOMMENDATIONS	NR	DNP	AM
[signature]	✓	[signature]	✓		
[signature]	✓	[signature]			✓
		[signature]			✓
CHAIR:		CHAIR:			

NEW FISCAL NOTE(S):

Department	Date	Zero	Fiscal
Commerce + Econ Development	1/13/98	✓	

PREVIOUS FISCAL NOTE(S):*

Department	Date	Zero	Fiscal

[ ] APPROPRIATION -- no fiscal note

*Include fiscal notes accompanying Governor's bill

FISCAL NOTE

STATE OF ALASKA
1998 LEGISLATIVE SESSION

BILL NO. SB 197

Revision Date (Note if correction)

Dept. Affected Commerce & Economic Development
Insurance

Title Regulating Health Maintenance Orgs.

Component Insurance

Sponsor Senator Taylor

Requester Senate Heds

Component Serial No. 354

Expenditures/Revenues (Thousands of Dollars)

OPERATING EXPENDITURES	FY 99	FY 00	FY 01	FY 02	FY 03	FY 04
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY98) cost: 0.0

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

Although there has been enabling legislation since 1990, there are no HMOs in Alaska.

Prepared by Iarianne K. Burke, Director

Phone 465-2515

Division Insurance

Date 1/13/98

Approved by Commissioner Deborah Sedwick

Date 1/ 98

Agency Commerce and Economic Development

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(Rev 9/97) 98Inform xls/OMB

SENATOR DAVE DONLEY
ALASKA STATE LEGISLATURE

SPONSOR STATEMENT - SB 197

Prohibiting HMOs from having gag orders on physicians, requiring HMOs identify medical treatments that may be denied and clarifying access to chiropractic care

Tension between quality medical care and cost containment has been growing in the health care industry. Serious problems have developed in the use of Health Maintenance Organizations (HMOs). Public concern has grown about HMO gag clauses that prohibit physicians from discussing alternative treatment options, financial incentives or second opinions with patients. Some HMOs have not clearly identified medical services that may be denied coverage and guidelines on access to chiropractic care are oftentimes unclear or non-existent. Senate Bill 197 was introduced in response to these concerns and bans gag clauses between physicians and patients, requires HMOs identify treatments that may be denied and clarifies guidelines on access to chiropractic care.

SB 197 bans HMOs from having gag orders which prohibit physicians from discussing alternative treatment options, financial incentives or second opinions with patients. The practice by HMOs of hindering open patient-physician communications was exposed in a December 1995 editorial in the New England Journal of Medicine, and later in a January, 1996 Time magazine cover story. President Clinton has urged Congress, doctors, nurses, health care professionals, and consumers to craft legislation banning gag orders for Americans in HMOs. State legislatures responded and by March, 1997 all but 14 states had enacted legislation or passed rules banning gag clauses. Twelve of the remaining states, including Alaska with SB 197, have introduced legislation banning gag orders.

To prevent confusion about treatments that are not covered, SB 197 requires HMOs clearly identify treatments that may be denied a patient. This prevents the HMO from denying coverage to a patient after treatment has been performed but cost is not covered. In an April, 1997 issue of California Medicine, the California Physician's Alliance identified this problem as a primary abuse by HMOs.

SB 197 allows patients direct access to chiropractic care with a licensed chiropractor of their choice and does not require prior consent of a gatekeeper. HMOs attempt to control costs by requiring all patients initially see a gatekeeper, either a Medical Doctor or Registered Nurse, who refers the patient to an appropriate health care provider. Many times a gatekeeper will not recommend chiropractic care, even if the HMO covers chiropractic services.

The concept behind SB 197 is widely supported by the American public, the Federal government, chiropractors and many medical doctors. Although there are no HMOs currently operating in Alaska, SB 197 bans HMOs from having gag orders on physicians, requires HMOs identify treatments that may be denied and clarifies access to chiropractic care.

If you have further questions, please contact Karen Brand of my staff 3892.

DD/kb 1/11/98

January-May: STATE CAPITOL • JUNEAU, AK • 99801-1182 • (907) 465-3892 • FAX: (907) 465-6595
June-December: 716 W. 4TH AVE. • STE. 430 • ANCHORAGE, AK • 99501 • (907) 258-8181 • FAX: (907) 258-1648

MEMBER: Senate Finance Committee • Legislative Budget & Audit Committee
• Senate Community & Regional Affairs Committee

Produced in House

Tucson Citizen

U.S. to set new rules on HMO doctor fines

Los Angeles Times-Washington Post News Service

HEALTH/MEDICINE

WASHINGTON – In an effort to ensure that patients receive appropriate treatment, the federal government will impose new rules on Medicaid and Medicare providers next week limiting financial penalties levied against doctors who order referrals or expensive procedures.

The new regulation will still allow health maintenance organizations to tie the pay of physicians to their ability to control costs, but will restrict the financial losses they can be forced to absorb for referring patients to specialists, conducting sophisticated tests or prescribing elaborate treatments more often than an HMO prefers.

The move by the Health Care Financing Administration strikes at the heart of the tension between quality care and cost containment that has dominated the health industry in recent years. With the spread of managed care, skyrocketing medical costs in the United States have been reined in, partly by providing doctors with incentives to curb unneeded treatment. But the ledger-book approach has led to rising fears that at times sound medicine has been sacrificed to the bottom line.

"We do want to provide incentives to hold down costs, but not at the expense of avoiding necessary care," said Bruce M. Fried, director of the agency's Office of Managed Care.

The rules on incentive arrangements take effect with the new year.

In September, President Clinton announced he would appoint a commission to study the quality of medical care in the current cost-cutting environment. In October, he signed a law prohibiting insurance companies from forcing new mothers out of hospitals in less than 48 hours. And in November, federal officials warned HMOs not to enforce "gag rules" barring doctors from advising Medicare patients of medically necessary but expensive treatment options.

"All of those are the pendulum swinging a bit back," Fried said.

Industry leaders said yesterday they have no philosophical objections to the new rules and have resolved most of the technical issues that had troubled them.

STATE OF ALASKA

TONY KNOWLES, GOVERNOR

DEPARTMENT OF COMMERCE AND ECONOMIC DEVELOPMENT

DIVISION OF OCCUPATIONAL LICENSING

3601 C STREET, SUITE 722
ANCHORAGE, ALASKA 99503-5986
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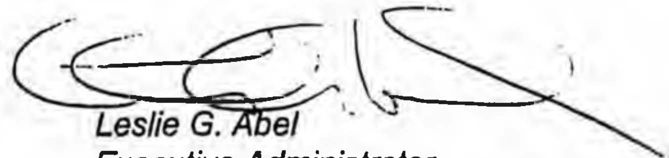
September 30, 1997

Senator Dave Donley
716 West Fourth Avenue Suite 430
Anchorage AK 99501

Senator Donley, the Alaska State Medical Board reviewed your letter and SB 197 at its board meeting on September 25, 1997.

The board asked me to advise you that they are in favor of and support the changes provided in SB 197, Sections 1 and 3 of the statute. The board did not feel it could render an opinion on Section 2 and suggested that perhaps you may wish to refer this section to the Board of Chiropractic for their review.

The board asked me to also convey to you their appreciation for soliciting their opinion of this important legislation and to wish you success in your endeavors.



Leslie G. Abel
Executive Administrator
Alaska State Medical Board

08-H13LH

Petition to Support Senate Bill 197

We, the undersigned, urge members of the Alaska State Legislature to support passage of Senate Bill 197, sponsored by Senator Dave Donley, which clarifies guidelines on access to chiropractic care, bans gag orders on physicians and requires Health Maintenance Organizations identify treatments that may be denied.

Specifically, SB 197:

- Allows patients direct access to chiropractic care with a licensed chiropractor of their choice and does not require prior consent on a medical doctor or registered nurse;
- Bans HMOs from having gag orders which prohibit physicians from discussing alternative treatment options, financial incentives, or second opinions with patients; and
- Prevents confusion about treatments that are not covered by requiring HMOs clearly identify treatments that may be denied a patient.

The concept behind SB 197 is widely supported by consumer groups, chiropractors, and many medical doctors. Thirty seven states have passed legislation or rules banning gag orders and 12 of the remaining 14 have legislation pending.

Name (print)	Signature	Address	Phone
Tyla L Blanchard	[signature]	501 Oceanview Dr.	345-4758
Jessica T. Ames	[signature]	1200 Jackson Dr.	349-7662
Mulligan Charles	Charles Mulligan	1709 Hamilton Dr	345-4626
[illegible]	[signature]	2630 [illegible]	248-2571
Robert Kron	Robert Kron	511 Bounty Dr.	345-7939
Robert J Loranger	Robert J Loranger	3041 W 91st Anchorage	243-4753
Bruce W. Teague	[signature]	11435 Old Seward Hwy	522-7500
Germaine Teague	[signature]	12221 Sultana Ct	345-9992
William Missal	W J Missal	12000 Audubon Dr	345-7520
Allen Hall	Allen Hall	1930 Brigadier Dr.	522-9065
Pamela Murray	Pamela Murray	110 Bree Ave	345-3071
[illegible]	[signature]	2221 [illegible] Cir	345-9580
Brandy Sheppard	Brandi Sheppard	10535 T.K.O.S. Cir. Eagle River	694-4836
Ted Wilterding	[signature]	8515 Blackberry	243-6065

Return completed petitions to ACS at P.O. [illegible]

SANDRA T. JACQUES, D. C.

4316 KINGSTON DRIVE
ANCHORAGE, AK. 99504
TELEPHONE (907) 337-6770
FAX (907) 337-9604

Senator Gary Wilken
State Capitol, Room 510
Juneau, AK 99801

7 November, 1997

Dear Senator Wilken,

I would like to address House Bill 219 and Senate Bill 197 currently passing through the Legislature. I understand that these bills are designed to allow patients enrolled in HMOs to self-refer for chiropractic services if their HMOs do not offer this type of referral service.

I fully support both bills. I feel that it is of utmost importance for patients to be able to select the type of treatment they desire. HMOs should consider patient choice when referring them to health care providers. Additionally, HMOs should be required to utilize funds paid by patients in the form of health care premiums to pay for the treatment of the patients' choice first.

Please consider both of these bills favorably when they come to vote.

Thank You,

Sandra Talt, D.C.

Sandra Talt, D.C.

Northern Chiropractic

Gregory M. Culbert, D.C.
11723 Old Glenn Highway, Suite 101
(Parkgate Building)
Eagle River, Alaska 99577

Telephone: (907) 696-4878

November 10, 1997

Senator Gary Wilken, Chair
State Capitol, Room 510
Juneau, AK 99801

RE: SB 197

Dear Senator Wilken:

Senator Dave Donley is sponsoring SB 197, a bill prohibiting HMO's from placing "gag orders" on physicians, requiring HMO's to identify medical treatments that may be denied, and clarifying access to chiropractic care.

I urge you to support this bill. Currently, there are no HMO's in the State of Alaska, but it is only a matter of time. Being proactive in dealing with HMO's would benefit Alaskans.

This bill will also allow patient's direct access to chiropractic care by a licensed chiropractor of their choice without prior consent from a gate keeper. Most gate keepers, as they often do not understand chiropractic care, do not refer the patient for chiropractic care when it may indeed be warranted. Senate bill 197 would prevent "gag orders" from being placed on physicians and would allow direct access to chiropractic care when appropriate.

By March of 1997, all but 14 states had enacted legislation or passed rules banning gag clauses. Including Alaska, 12 of the remaining states are in the process of doing this. Alaska Senate Bill 197 would ban gag clauses on physicians, would require HMO's to identify treatment that is denied, and further clarify access to chiropractic care.

Please support this bill.

Sincerely,

Gregory M. Culbert, D.C.
kd

NORTHERN LIGHTS CHIROPRACTIC
AMBER ALEXANDER, D.C.
1867 Airport Way, Ste. 140-C
Fairbanks, Alaska 99701

Telephone: (907) 452-3309

RECEIVED
NOV 17 1997

November 14, 1997

Senator Gary Wilken, Chair
State Capitol
Room 510
Juneau, AK 99801

Dear Mr. Wilken,

I would like to encourage your support for House Bill 219 and Senate Bill 197, allowing patients in HMO's to self-refer for chiropractic services. This legislation is necessary to allow patients freedom of choice in health care and to help keep HMO's responsible for preventative health care as well as crisis care.

Very truly yours,

Dr. Amber Alexander

Dr. Amber Alexander

gd/aa

Ketchikan Chiropractic Center
R. Clark Davis, D.C.
320 Bawden, Suite 306
Ketchikan, Alaska 99901

RECEIVED
NOV 1 4 1997

November 12, 1997

Senator Gary Wilken, Chair
State Capitol, Room 510
Juneau, AK 99801
FAX: 465-4714

Dear Senator Gary Wilken,

I am writing to encourage your support of Senate Bill 197. This bill will allow patients to self refer themselves for chiropractic care if an HMO health maintenance organization gatekeeper (medical doctor) refuses to refer the patient for chiropractic care. Many conditions, for example back pain, are helped by chiropractic care when medical care has failed. Medical school curriculum does not regularly teach chiropractic methods, chiropractic research, or chiropractic referral. Some people also prefer chiropractic care over medical or surgical treatment. The Alaskan public deserves proper access to chiropractic care. Thank you for your time on this important matter.

Please let me know your thoughts on this issue so I can inform my patients. Thanks again.

Sincerely,

R. Clark Davis, D.C.

Chapter 21.86. HEALTH MAINTENANCE ORGANIZATIONS

Sec. 21.86.010. Establishment of health maintenance organizations.

(a) A person may apply to the director for and obtain a certificate of authority to establish and operate a health maintenance organization in compliance with this chapter. A person may not establish or operate a health maintenance organization in this state unless the person obtains a certificate of authority under this chapter. A foreign corporation may, subject to its registration, qualify under this chapter to do business in this state as a foreign corporation.

(b) An application for a certificate of authority must be verified by an officer or authorized representative of the applicant, must be in a form prescribed by the director, and must contain or be accompanied by

(1) a copy of the organizational documents of the applicant, including the articles of incorporation, articles of association, partnership agreement, trust agreement, or other applicable documents, and all amendments to the documents;

(2) a copy of the bylaws, regulations, or similar document, if any, regulating the conduct of the internal affairs of the applicant;

(3) a list of the names, addresses, and official positions of the persons who are responsible for the conduct of the affairs of the applicant, including all members of the board of directors, board of trustees, executive committee, or other governing board or committee, the principal officers in the case of a corporation, and the partners or members in the case of a partnership or association;

(4) a copy of contracts made or to be made between the applicant and providers or between the applicant and persons listed in (3) of this subsection;

(5) a copy of the form of evidence of coverage that is to be issued to the enrollees;

(6) a copy of the form or group contract, if any, that is to be issued to employers, unions, trustees, or other organizations;

(7) financial statements showing the applicant's assets, liabilities, and sources of financial support; if the applicant's financial affairs are audited by independent certified public accountants, a copy of the applicant's most recent certified financial statement satisfies the requirement of this paragraph unless the director finds that additional or more recent financial information is required for the proper administration of this chapter;

(8) a description of the proposed method of marketing, a financial plan that includes a projection of operating results anticipated until the organization has had net income for at least one year, and a statement as to the sources of working capital as well as any other sources of funding;

(9) a power of attorney executed by the applicant, if not domiciled in this state, appointing the director and the director's successors in office, and authorized deputies, as the true and lawful attorney of the applicant in and for this state, upon whom all lawful process in any legal action or proceeding

against the health maintenance organization, on a cause of action arising in this state, may be served;

(10) a statement reasonably describing the geographic area or areas to be served;

(11) a description of the complaint procedures to be used, as required under AS 21.86.100;

(12) as required by regulations adopted by the director, a description of the procedures and programs to be implemented to assure compliance with state and federal statutes and regulations regarding the quality of health care;

(13) a description of the mechanism by which enrollees will be afforded an opportunity to participate in matters of policy and operation under AS 21.86.040;

(14) the deposit required under AS 21.86.140(b);

(15) other information that the director requires in order to make a determination under AS 21.86.020;

(16) the application fee prescribed under AS 21.06.250.

(c) An applicant, or a health maintenance organization holding a certificate of authority granted under this chapter, shall, unless otherwise provided for, file a notice describing any material modification of the organization's operation as described in the information submitted under (b) of this section. The notice shall be filed with the director before the modification. If the director does not disapprove the modification within 30 days after the filing of the notice, the modification is considered approved. The director may adopt regulations exempting from the filing requirements of this subsection those items that the director considers unnecessary to report.

(d) An applicant, or a health maintenance organization holding a certificate of authority granted under this chapter, shall file with the director all contracts of reinsurance. An agreement between the organization and an insurer is subject to the laws of this state regarding reinsurance. All reinsurance agreements, and modifications to a reinsurance agreement, shall be filed with the director and must be approved by the director. A reinsurance agreement remains in full force and effect for at least 90 days following written notice to the director, by registered mail, of cancellation by either party.

Sec. 21.86.020. Issuance of certificate of authority; approval of changes.

(a) Within 10 days after receipt of an application for a certificate of authority, the director shall forward a copy of the application to the commissioner of health and social services. Within 60 days after the commissioner of health and social services receives the copy of the application, the commissioner shall make a recommendation regarding the granting of the certificate of authority.

(b) The director shall either issue or deny a certificate of authority within 30 days after receipt of the commissioner of health and social services' recommendation. However, the director may extend the time for issuance or

denial of a certificate of authority if additional information is needed in order to make a decision, and notice of the extension is provided to the applicant by the 90th day after the director received the application. A certificate of authority shall be issued if the director determines that the following conditions are met:

(1) the persons responsible for the conduct of the affairs of the applicant are competent and trustworthy;

(2) the applicant will effectively provide or arrange for the provision of basic health care services on a prepaid basis, through insurance or otherwise, except to the extent of reasonable requirements for copayments;

(3) the applicant is financially responsible and may reasonably be expected to meet its obligations to enrollees and prospective enrollees; in determining if this condition is met, the director may consider

(A) the financial soundness of the arrangements for health care services and the schedule of charges used in connection with those services;

(B) the adequacy of working capital;

(C) an agreement with an insurer, a hospital or medical service corporation, a government, or other organization for ensuring the payment of the cost of health care services or providing for automatic applicability of an alternative coverage if the health maintenance organization is discontinued;

(D) an agreement with providers for the provision of health care services; and

(E) a deposit of cash or securities submitted under AS 21.86.140;

(4) the enrollees will be afforded an opportunity to participate in matters of policy and operation as provided in AS 21.86.040;

(5) nothing in the proposed method of operation, as shown by the information submitted under AS 21.86.010 or by independent investigation, is contrary to the public interest;

(6) the information submitted under AS 21.86.010(b)(12) indicates that the applicant will be able to comply with state and federal statutes and regulations regarding the quality of health care.

(c) If a certificate of authority is denied under this section, the applicant may request a hearing under AS 21.86.200.

Sec. 21.86.030. Powers of a health maintenance organization.

(a) A health maintenance organization may

(1) purchase, lease, construct, renovate, operate, or maintain hospitals, other health care facilities, their ancillary equipment, and property reasonably required for its principal office or for purposes necessary in the transaction of the business of the organization;

(2) make loans to a medical group under contract with it in furtherance of its program, or make loans to a corporation or corporations under its control for the purpose of acquiring or constructing medical facilities and hospitals or in furtherance of a program providing health care services to enrollees;

(3) furnish health care services through providers that are under contract with or employed by the health maintenance organization;

(4) contract with a person for the performance, on the organization's behalf, of certain functions such as marketing, enrollment, and administration;

(5) contract with an insurance company licensed in this state, or with a hospital or medical service corporation authorized to do business in this state, for the provision of insurance, indemnity, or reimbursement against the cost of health care services provided by the health maintenance organization;

(6) offer other health care services, in addition to basic health care services.

(b) A health maintenance organization shall file a notice and adequate supporting information with the director before the exercise of a power granted in (a)(1), (2), or (4) of this section. The director may disapprove the exercise of a power only if, in the director's opinion, it would substantially and adversely affect the financial soundness of the health maintenance organization and endange[illegible]ts ability to meet its obligations. If the director does not disapprove the exercise of power within 30 days after the filing of the notice, it is considered approved. The director may adopt regulations exempting from the filing requirement of this section those activities having a minimal effect on the health maintenance organization.

(c) Nothing in this section relieves a health maintenance organization that wishes to exercise the power described in (a)(1) of this section from the requirements of

(1) AS 18.07, regarding obtaining a certificate of need;

(2) AS 18.20, regarding regulation of hospitals; and

(3) other statutes applicable to hospitals or other health care facilities.

Sec. 21.86.040. Governing body; enrollee participation.

(a) The governing body of a health maintenance organization may include providers, or other individuals, or both. At least one-third of the governing body must consist of consumers who are substantially representative of enrollees.

(b) The governing body of a health maintenance organization shall establish a mechanism to afford its enrollees an opportunity to participate in matters of policy and operation through the establishment of advisory panels, by the use of advisory referenda on major policy decisions, or through the use of other mechanisms.

Sec. 21.86.050. Fiduciary responsibility.

(a) A director, officer, employee, or partner of a health maintenance organization who receives, collects, disburses, or invests money in connection with the activities of that organization is responsible for that money in a fiduciary relationship to the organization.

(b) A health maintenance organization shall maintain in force a fidelity bond on employees and officers in an amount not less than $100,000,

or another amount prescribed by the director. The bond must be written with at least a one-year discovery period and, if written with less than a three-year discovery period, must contain a provision that cancellation or termination of the bond, whether by or at the request of the insured or by the underwriter, does not take effect sooner than 90 days after written notice of cancellation or termination has been filed with the director, unless an earlier cancellation or termination date is approved by the director.

Sec. 21.86.060. Provision of services.

(a) A health maintenance organization may provide physician services directly, through physician employees, or may provide the services under arrangements with individual physicians or one or more groups of physicians.

(b) In addition to basic health care services, a health maintenance organization may provide, or arrange for, other health care services on a prepayment or other financial basis.

(c) Health care services may be provided only by appropriately licensed health care providers.

Sec. 21.86.070. Evidence of coverage; charges for health care services.

(a) An enrollee residing in this state is entitled to evidence of coverage. If an enrollee obtains coverage from an insurance policy or from a subscriber contract issued by a hospital or medical service corporation, whether by option or otherwise, the insurer or hospital or medical service corporation shall issue the evidence of coverage; otherwise, the health maintenance organization shall issue the evidence of coverage. Each subsequent change in coverage must be evidenced in a separate document issued to the enrollee.

(b) Except as provided in (d) of this section, evidence of coverage, or an amendment or endorsement to coverage, may not be issued or delivered to a person in this state until a copy of the form of the evidence of coverage, amendment, or endorsement has been filed with and approved by the director. A filing shall be made not less than 30 days before the intended date of delivery or issuance. The form of evidence of coverage, amendment, or endorsement is considered approved 30 days after it was filed, unless it is affirmatively approved or disapproved by an order of the director before the expiration of the 30-day period. If the form of evidence of coverage, amendment, or endorsement is disapproved, the director's order must specify the reasons for disapproval. A hearing shall be granted to a person aggrieved by either an approval or disapproval under this subsection if a written request is made by that person to the director. The hearing shall be granted within 30 days after the receipt of the written request.

(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.

(d) If a form of the evidence of coverage, or an amendment or endorsement to it, is subject to the jurisdiction of the director under AS 21.42.120 and 21.42.130, or under AS 21.87.180, the filing requirements of (b) of this section do not apply. If a form of evidence of coverage, or an amendment or endorsement to it, is subject to AS 21.42.120 and 21.42.130, or to AS 21.87.180, those applicable provisions, as well as (c) of this section, apply to the content of the form of evidence of coverage, amendment, or endorsement.

(e) A schedule of charges for enrollee coverage for health care services, or an amendment or endorsement to it, may not be used until a copy of the schedule has been filed with and approved by the director. A filing shall be made not less than 30 days before its proposed use. The schedule of charges, amendment, or endorsement is considered approved 30 days after it was filed unless it was affirmatively approved or disapproved by an order of the director before the expiration of the 30-day period. If a schedule of charges, amendment, or endorsement is disapproved, the director's order must specify the reasons for disapproval. A hearing shall be granted to a person aggrieved by either an approval or disapproval under this subsection if a written request is made by that person to the director. The hearing shall be granted within 30 days after receipt of the written request.

(f) A schedule of charges, or an amendment or endorsement to it, shall be established according to sound actuarial principles for various categories of enrollees, but charges applicable to an enrollee may not be individually determined based on that enrollee's health status. The charges may not be excessive, inadequate, nor unfairly discriminatory. Certification by an actuary who is a member in good standing of the American Academy of Actuaries or another person who is considered qualified by the director, as to the appropriateness of the application of the charges, based on reasonable assumptions, must accompany each filing under (e) of this section, along with adequate supporting information.

(g) The director may require that additional relevant material considered necessary by the director be submitted in order to determine the acceptability of a filing made under either (b) or (e) of this section.

Sec. 21.86.080. Annual statement; additional reports.

(a) A health maintenance organization shall file an annual statement with the director under AS 21.09.200 and shall provide a copy to the commissioner of health and social services. The annual statement shall be verified by at least two principal officers of the organization. The director may require additional reports that are reasonably necessary and appropriate in order for the director or the commissioner of health and social services to carry out the duties prescribed by this chapter.

(b) The director may require a health maintenance organization to file quarterly financial statements. If quarterly financial statements are required, the statements must follow for a given quarter the reporting specified in the quarterly financial statement blank form and instructions most recently approved by the National Association or Insurance Commissioners.

(c) A filing under this section is subject to AS 21.09.200 and 21.09.205.

Sec. 21.86.087. Insurance report.

(a) The director shall require reporting of and shall compile information necessary to evaluate the effect of the measures enacted in chapter 26, SLA 1997 on the availability and cost of insurance in the state.

(b) Information described in (a) of this section shall be provided by all insurers doing business in this state in the format specified by the director and must include factual information stating premiums, claims, losses, expenses, and solvency of the company as a whole. Information shall be compiled by the division in a way that protects the identity of individual insureds.

(c) The director shall adopt regulations to implement and interpret this section, including requiring insurers doing business in the state to provide information necessary for the division to carry out its responsibilities under (a) and (b) of this section. If there are indications of market disruption, the director may waive all or part of the reporting requirements in this section.

(d) Beginning June 1, 2000, the information compiled under (a) of this section shall be reported annually to the governor and the judiciary committees of both houses of the legislature.

(e) The division may consult with the Alaska Judicial Council when determining what information to require to be reported under (a) - (c) of this section and when implementing the compilation required under (a) of this section.

Sec. 21.86.090. Information to enrollees.
A health maintenance organization shall promptly notify its enrollees of a material change in its operation that would directly affect the enrollees.

Sec. 21.86.100. Complaint system; report.

(a) A health maintenance organization shall establish and maintain a complaint system to provide reasonable procedures for the resolution of written complaints initiated by its enrollees. A complaint system must provide a procedure for forwarding to the commissioner of health and social

services a duplicate copy of a complaint relating to patient care or facility operation.

(b) A health maintenance organization shall annually, on or before March 1, submit to the director, in a form prescribed by the director, a report covering the preceding calendar year. The health maintenance organization shall provide a copy of this report to the commissioner of health and social services. The report submitted under this subsection must include

(1) a description of the procedures used in its complaint system;

(2) the total number of complaints handled through its complaint system and a compilation of the causes underlying the complaints filed; and

(3) the number, amount, and disposition of malpractice claims made by an enrollee that were settled during the year by the health maintenance organization; information concerning malpractice claims shall be held confidential by the director and by the commissioner of health and social services, and is not subject to public disclosure.

(c) The director or the commissioner of health and social services may, at any time during normal business hours, examine the complaint system in any place of business of the health maintenance organization in order to determine compliance with this section.

Sec. 21.86.110. Recovery of health care costs.
If a health maintenance organization determines that an enrollee has received health care services that the enrollee is not entitled to receive under the terms of the health maintenance agreement, the organization may not recover an amount above the actual cost of providing the health care service. This section does not apply if the enrollee gave or withheld information to the health maintenance organization with the intent to mislead or misinform the organization as to the enrollee's right to receive the health care services.

Sec. 21.86.120. Return of agreement.
A person who enters into a health maintenance agreement may return the agreement to the health maintenance organization or the agent from whom it was purchased within 10 days of the delivery of the agreement to the person if the person is not satisfied for any reason. Upon return of the agreement, the health maintenance organization shall promptly refund the fee paid for the agreement. Notice of the substance of this section must be printed on the face of the agreement.

Sec. 21.86.130. Investments.
With the exception of investments made under AS 21.86.030, a health maintenance organization's money may only be invested as allowed by AS 21.21 for the investment of legal reserves of a life insurer.

Sec. 21.86.140. Protection against insolvency.

(a) Except as otherwise provided in this section, a health maintenance organization shall deposit with the director, or with an organization or trustee acceptable to the director through which a custodial or controlled account is used, cash, securities, or a combination of these or other means acceptable to the director in the manner and amount required by this section.

(b) Except as provided in (d) and (e) of this section, the deposit amount for a health maintenance organization that begins operation after June 8, 1990 is the greater of 10 percent of its estimated expenditures for health care services for its first year of operation, twice its estimated average monthly uncovered expenditures for its first year of operation, or $250,000. Except as provided in (d) and (e) of this section, at the beginning of each succeeding year of operation, the organization shall deposit with the director, or organization or trustee, cash, securities, or a combination of these or other means acceptable to the director in an amount equal to four percent of its estimated annual uncovered expenditures for that year. Each year's estimate, after the first year of operation, shall reasonably reflect the prior year's operating experience and delivery arrangements.

(c) Except as provided in (d) and (e) of this section, a health maintenance organization that is in operation on June 8, 1990 shall, on the first day of its fiscal year beginning six months or more after June 8, 1990, make a deposit equal to the greater of one percent of the preceding 12 months' uncovered expenditures or $250,000. The organization shall, at the beginning of its second fiscal year after June 8, 1990, deposit an amount equal to two percent of the organization's estimated annual uncovered expenditures for that year. At the beginning of its third fiscal year, the organization shall deposit an amount equal to three percent of its estimated annual uncovered expenditures for that year. At the beginning of the fourth fiscal year and subsequent years, the organization shall deposit an amount equal to four percent of its estimated annual uncovered expenditures for that year. Each year's estimate, after the first year of operation, must reasonably reflect the prior year's operating experience and delivery arrangements.

(d) The director may waive the deposit requirements in (b) and (c) of this section if the director is satisfied that

(1) the organization has sufficient net worth and an adequate history of generating net income to assure its financial viability for the next year;

(2) the organization's performance and obligations are guaranteed by another organization that has sufficient net worth and an adequate history of generating net income; or

(3) the assets of the organization, or its contracts with insurers, hospital or medical service corporations, governments, or other organizations, are reasonably sufficient to assure the performance of its obligations.

(e) The annual deposit requirements of (b) and (c) of this section do not apply if

(1) a health maintenance organization has achieved a net worth, not including land, buildings, and equipment, of at least $1,000,000 or has

achieved a net worth, including land, buildings, and equipment, of at least $5,000,000;

(2) the total amount of the health maintenance organization's accumulated deposit is equal to 25 percent of its estimated annual uncovered expenditures for the next calendar year, or is equal to the capital and surplus requirements for the formation for admittance of a health insurer in this state, whichever is less;

(3) a health maintenance organization has a guaranteeing organization that

(A) does not sponsor any other health maintenance organization; and

(B) has been in operation for at least

(i) five years and has a net worth, not including land, buildings, and equipment, of at least $1,000,000; or

(ii) 10 years and has a net worth, including land, buildings, and equipment, of at least $5,000,000; or

(4) a health maintenance organization has a guaranteeing organization that sponsors more than one health maintenance organization and that

(A) has been in operation for at least

(i) five years and has a net worth that is at least that required by (3) (B) (i) of this subsection multiplied by a number equal to the number of organizations sponsored; or

(ii) 10 years and has a net worth that is at least that required by (3) (B) (ii) of this subsection multiplied by a number equal to the number of organizations sponsored; or

(B) has, for each organization sponsored, a net worth at least equal to the capital and surplus requirement for a health insurer.

(f) All deposit income belongs to the depositing health maintenance organization, and shall be paid to it as it becomes available. A health maintenance organization that has made a deposit of securities may withdraw that deposit, or any part of it, after making a substitute deposit of cash, securities, or a combination of these or other means of equal amount and value. Substitution of securities must have prior approval by the director.

(g) In a year in which an annual deposit is not required of a health maintenance organization under this section, at the organization's request the director shall reduce the required, previously accumulated deposit by $100,000 for each $250,000 of net worth in excess of the amount that allows the organization not to make the annual deposit. If the amount of an organization's net worth is reduced to less than the amount that allowed a reduction in accumulated deposit, the organization shall immediately redeposit $100,000 for each $250,000 of reduction in net worth, except that the total deposit need not exceed the maximum required under this section.

(h) A health maintenance organization that obtains a certificate of authority shall have and maintain a capital account of at least $100,000 in addition to deposit requirements under this section. The capital account must equal at least $100,000 after deducting accrued liabilities, and must be in

the form of cash, securities, or a combination of these or other means acceptable to the director.

Sec. 21.86.150. Prohibited practices.

(a) A health maintenance organization or a representative of a health maintenance organization may not cause or knowingly permit a person to provide, on behalf of the health maintenance organization, health care services that the person is not licensed to provide.

(b) A health maintenance organization, or a representative of a health maintenance organization, may not cause or knowingly permit the use of advertising that is untrue or misleading, solicitation that is untrue or misleading, or a form of evidence of coverage that is deceptive. For purposes of this chapter,

(1) a statement or item of information is considered to be untrue if it does not conform to fact in any respect that is or might be significant to an enrollee of, or person considering enrollment with, a health maintenance organization;

(2) a statement or item of information is considered to be misleading, whether or not it is untrue, if, in the total context in which the statement is made or the item of information is communicated, the statement or item of information might be understood by a reasonable person, not possessing special knowledge regarding health care coverage, as indicating a benefit or advantage or the absence of an exclusion, limitation, or disadvantage of possible significance to an enrollee of, or person considering enrollment in, a health maintenance organization if the benefit or advantage or absence of limitation, exclusion, or disadvantage does not exist;

(3) an evidence of coverage is considered to be deceptive if the evidence of coverage taken as a whole, and with consideration given to typography and format, as well as to language, might cause a reasonable person, not possessing special knowledge regarding health maintenance organizations or an evidence of coverage, to expect benefits, services, charges, or other advantages that the evidence of coverage does not provide or that the health maintenance organization issuing the evidence of coverage does not regularly make available for an enrollee covered under the evidence of coverage.

(c) AS 21.36 applies to health maintenance organizations and to an evidence of coverage except to the extent that the director determines that the nature of health maintenance organizations and the evidence of coverage renders that chapter clearly inappropriate.

(d) A health maintenance organization may not cancel or refuse to review an enrollee, except for

(1) reasons stated in the organization's regulations applicable to all enrollees;

(2) failure to pay the charge for the enrollee's coverage; or

(3) other reasons adopted by the director by regulation.

(e) Unless it is licensed as an insurer, a health maintenance organization may not refer to itself as an insurer or use a name deceptively similar to the name or description of an insurance or surety corporation doing business in the state.

(f) A person may not use the phrase "health maintenance organization" or "HMO" in the course of the person's operations unless the person possesses a valid certificate of authority issued under this chapter.

(g) A health maintenance organization that offers, renews, issues for delivery, or delivers in this state a health care insurance plan in the group market that does not impose a preexisting condition exclusion with respect to a particular coverage option under the plan may impose an affiliation period for that coverage option only if the affiliation period

(1) is applied uniformly without regard to a health status factor;

(2) does not exceed two months for new enrollees and three months for late enrollees;

(3) begins on the enrollment date; and

(4) runs concurrently with any waiting period under the plan.

(h) A health maintenance organization may use a method other than a preexisting condition exclusion or an affiliation period to lessen the risk of adverse selection only with prior written approval of the director.

Sec. 21.86.160. Regulation of agents.

(a) The director may adopt regulations necessary to provide for the licensing of health maintenance organization agents.

(b) The director may, by regulation, exempt certain classes of persons from the requirement of obtaining an agent license if

(1) the function the class performs does not require special competence or trustworthiness, or the regulatory surveillance made possible by licensing; or

(2) other existing safeguards make regulation through licensing unnecessary.

Sec. 21.86.170. Powers of insurers and of hospital or medical service corporations.

(a) An insurer licensed in this state, or a hospital or medical service corporation authorized to do business in this state, may, either directly or through a subsidiary or affiliate, organize and operate a health maintenance organization under the provisions of this chapter. Two or more insurance companies, hospitals or medical service corporations, or subsidiaries or affiliates of them, may jointly organize and operate a health maintenance organization. The business of insurance is considered to include providing health care by a health maintenance organization owned or operated by an insurer or subsidiary of an insurer.

(b) An insurer or hospital or medical service corporation may contract with a health maintenance organization to provide insurance or similar protection against the cost of care provided through a health maintenance

organization and to provide coverage in the event of the failure of the health maintenance organization to meet its obligations. The enrollees of a health maintenance organization constitute a permissible group under this title. Under a contract authorized by this subsection, the insurer or hospital or medical service corporation may make benefit payments to health maintenance organizations for health care services rendered by providers.

Sec. 21.86.180. Examinations.

(a) The director shall examine the affairs and transactions of a health maintenance organization in the same manner as prescribed for an insurer in AS 21.06.140 - 21.06.180.

(b) As often as is reasonably necessary for the protection of the interests of the people of the state, but at least once every three years, the director shall require submission of an independent review of the quality of care provided by a health maintenance organization either directly or indirectly through contract, agreement, or other arrangement for provisions of health care services to enrollees of the health maintenance organization. The review required under this subsection shall be done by a review organization approved by the Department of Health and Social Services and shall be done under regulations adopted by that department. The health maintenance organization shall pay the cost of the review.

Sec. 21.86.190. Suspension or revocation of certificate of authority.

(a) After compliance with AS 21.86.200, the director may suspend or revoke a certificate of authority issued to a health maintenance organization under this chapter if

(1) the health maintenance organization is operating significantly in contravention of its basic organizational document or in a manner contrary to that described in other information submitted under AS 21.86.010 or 21.86.020;

(2) the health maintenance organization issues an evidence of coverage, or uses a schedule of charges for health care services, that does not comply with the requirements of AS 21.86.070;

(3) the health maintenance organization does not provide or arrange for the provision of basic health care services;

(4) the health maintenance organization is not in compliance with state and federal statutes and regulations as required under AS 21.86.010(b)(12), or is unable to fulfill its obligations to furnish health care services;

(5) the health maintenance organization is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees;

(6) the health maintenance organization has failed to implement a mechanism affording the enrollees an opportunity to participate in matters of policy and operation under AS 21.86.040;

(7) the health maintenance organization has failed to implement the complaint system required by AS 21.86.100 in a reasonable manner to resolve valid complaints;

(8) the health maintenance organization, or any person on its behalf, has advertised or merchandised its services in an untrue, misrepresentative, misleading, deceptive, or unfair manner;

(9) the continued operation of the health maintenance organization would be hazardous to its enrollees;

(10) the health maintenance organization has otherwise failed substantially to comply with this chapter.

(b) If the certificate of authority of a health maintenance organization is suspended, the health maintenance organization may not, during the period of the suspension, enroll additional enrollees except newborn children or other newly acquired dependents of existing enrollees, and may not engage in advertising or solicitation. The director may, by written order, specify limitations in the operation of the organization during the period of suspension as the director finds to be in the best interests of enrollees.

(c) If the certificate of authority of a health maintenance organization is revoked, the organization shall, immediately following the effective date of the order of revocation, proceed to wind up its affairs, and may not conduct further business except that essential to the orderly conclusion of the affairs of the organization. The organization may not engage in further advertising or solicitation. The director may, by written order, permit continued operation of the organization as the director finds to be in the best interest of enrollees, so that enrollees will be afforded the greatest practical opportunity to obtain continuing health care coverage.

Sec. 21.86.200. Administrative procedures.

(a) If the director has reason to believe that grounds for the denial, suspension, or revocation of a certificate of authority exist, the director shall notify the applicant or the health maintenance organization in writing, specifically stating the grounds for denial, suspension, or revocation. A person aggrieved by a decision of the director regarding denial, suspension, or revocation of a certificate of authority may request a hearing under AS 21.06.180. If a hearing is requested, it shall be held under the procedures in AS 21.06.170 - 21.06.220, except that AS 21.06.190 does not apply in the case of a hearing regarding denial of a certificate.

(b) After a hearing under (a) of this section, or upon the failure of an applicant or health maintenance organization to appear at such a hearing, the director shall make written findings and issue an order, that shall be mailed to the applicant or health maintenance organization and concurrently provided to the commissioner of health and social services. An appeal of the director's order may be made in the manner provided by AS 21.06.230.

Sec. 21.86.210. Rehabilitation, liquidation, or conservation.

(a) A rehabilitation, liquidation, or conservation of a health maintenance organization is considered to be a rehabilitation, liquidation, or conservation of an insurer, and shall be conducted under AS 21.78. The director may apply to the superior court for an order directing the rehabilitation, liquidation, or conservation of a health maintenance organization upon one or more of the grounds contained in AS 21.78.040, 21.78.050, or 21.78.060, or if, in the director's opinion, the continued operation of the organization would be hazardous to either enrollees or to the people of the state.

(b) Enrollees of a health maintenance organization have the same priority in the event of liquidation or rehabilitation as AS 21.78 provides to policyholders of an insurer. A claim made by a health care provider in a liquidation or rehabilitation that pertains to services provided to an enrollee, has the same priority as an enrollee if the provider agrees not to assert the claim against an enrollee and if any payment fully discharges the obligation of the enrollee.

Sec. 21.86.220. Regulations.
The commissioner of health and social services may adopt regulations necessary to carry out the commissioner's duties under this chapter. The director may adopt regulations necessary to carry out the director's duties under this chapter.

Sec. 21.86.230. Fees.

(a) A health maintenance organization shall pay fees to the director as provided under AS 21.06.250.

(b) A health maintenance organization shall pay to the commissioner of health and social services fees, as established in regulations adopted by the commissioner of health and social services, that relate to the regulatory functions performed by that department under this chapter.

Sec. 21.86.240. Taxation.
A health maintenance organization is taxed as provided under AS 21.09.210(b)(1), and shall file the report required of an authorized insurer under AS 21.09.210(a).

Sec. 21.86.250. Penalties and enforcement.

(a) Instead of, or in addition to, suspending or revoking a certificate of authority, the director may, in an order issued under AS 21.86.200, impose an administrative penalty in an amount not less than $1,000 nor more than $25,000 for each violation of an applicable provision of this chapter or a regulation adopted under this chapter.

(b) The director may issue an order directing a health maintenance organization or a person representing a health maintenance organization to stop engaging in an act or practice that is in violation of this chapter or a regulation adopted under this chapter. Within five days after service of a stop

order under this subsection, the respondent may request, in writing, a hearing on the question of whether the act or practice has occurred in violation of this chapter or a regulation adopted by the director. The hearing shall commence within 10 days after the written request for the hearing has been received by the director unless the respondent requests that the hearing take place at a later date and the director agrees to the later hearing date.

Sec. 21.86.260. Statutory construction and relationship to other law.

(a) Except as provided in AS 21.36, AS 21.42, AS 21.54, AS 21.56 and in this chapter, this title does not apply to a health maintenance organization that obtains a certificate of authority under this chapter. This subsection does not apply to an insurer licensed under AS 21.09 or a hospital or medical service corporation licensed under AS 21.87 except with respect to its health maintenance organization activities authorized by and regulated under this chapter.

(b) Solicitation of enrollees by a health maintenance organization that has obtained a certificate of authority or by its licensed agents or authorized employee representatives, may not be construed to violate a law of this state relating to solicitation or advertising by health care professionals.

(c) A health maintenance organization that obtains a certificate of authority under this chapter is not considered to be practicing medicine, and is exempt from a law of this state relating to the practice of medicine. However, this subsection does not exempt a health care provider from a licensing requirement, or from another law of this state regarding providers.

Sec. 21.86.270. Filings and reports as public documents.

Except for information described in AS 21.86.100(b)(3) and except for trade secrets, privileged, confidential commercial, or financial information as determined by the director, all applications, filings, and reports required under this chapter, including annual financial statements that are required under AS 21.86.080, are public documents.

Sec. 21.86.280. Confidentiality of medical information.

Data or information pertaining to the diagnosis, treatment, or health of an enrollee or applicant that is obtained from that person, or from a provider, by a health maintenance organization shall be held in confidence and may not be disclosed except (1) to the extent necessary to carry out the purposes of this chapter; (2) upon the express consent of the enrollee or applicant; (3) under a statute or court order for the production of evidence or discovery; or (4) in the event of a claim or litigation between the person and the health maintenance organization regarding which the data or information is relevant. A health maintenance organization may claim a statutory privilege against disclosure that the provider who furnished the information to the health maintenance organization is entitled to claim.

Sec. 21.86.290. Contract authority for commissioner of health and social services.
In carrying out duties under this chapter, the commissioner of health and social services may contract with qualified persons to make recommendations concerning the determinations required to be made by the commissioner. Recommendations made by a contractor may be accepted in full or in part by the commissioner of health and social services.

Sec. 21.86.300. Acquisition of control or merger of a health maintenance organization.

(a) A person may not acquire control of the voting securities of a domestic health maintenance organization, if, after the consummation of the transaction, that person would, directly or indirectly, or by conversion or by exercise of any right to acquire, be in control of the health maintenance organization, or enter into an agreement to merge or consolidate with, or otherwise to acquire control of, a health maintenance organization.

(b) Subsection (a) of this section does not apply to a person who at the time the offer, request, or invitation is made or the agreement is entered into, or before the acquisition of the securities if no offer or agreement is involved, has filed with the director and has sent to the health maintenance organization, information required by AS 21.22 and the offer, request, invitation, agreement, or acquisition has been approved by the director. Approval by the director under this subsection is governed by AS 21.22.

(c) In this section

(1) "acquire control of " means to make a tender for, make a request or invitation for tenders of, enter into an agreement to exchange securities for, or acquire in the open market or otherwise;

(2) "domestic" means formed under the laws of this state.

Sec. 21.86.310. Dual choice.

(a) An employer in this state, whether public or private, that offers its employees a health benefit plan and employs 25 or more employees during any week of the calendar year, and an employee benefit fund in this state that offers its members any form of health benefit, shall make available to its employees or members the option to enroll in at least one health maintenance organization, holding a valid certificate of authority, that provides health care services in the geographic areas in which substantial numbers of the employees or members reside. If employees of the employer are members of a collective bargaining unit, the option of enrollment in a health maintenance organization shall first be submitted to the bargaining representative of the bargaining unit. If the option is approved by the bargaining representative, the option of enrollment shall then be made to each represented employee.

(b) An employer in this state is not required to pay more for employee health benefits as a result of the application of this section than would be required if this section did not apply to the employer. If an employee chooses

enrollment in a health maintenance organization, the employer is required to pay, on behalf of that employee, only an amount equal to the lesser of

(1) the amount that would have to be paid to an insurer on behalf of its employees for substantially similar health benefits; or

(2) the health maintenance organization's charge for coverage that is approved by the director under AS 21.86.070.

(c) This section does not apply to an employer whose employees or members reside in an area where health care services are not provided by a health maintenance organization.

Sec. 21.86.900. Definitions.
In this chapter,

(1) "affiliation period" means a period of time under a contract with a health maintenance organization

(A) that must expire before coverage becomes effective;

(B) during which the health maintenance organization is not required to provide health care services or benefits; and

(C) for which no premium is charged to the participant or beneficiary for coverage during the period;

(2) "agent" means a person who is appointed by a health maintenance organization and who engages in solicitation of membership in the organization; "agent" does not include a person enrolling health maintenance organization members on behalf of an employer, a union, or other organization to whom a master subscriber contract has been issued, or an employee, who is not an independent contractor, of the health maintenance organization;

(3) "basic health care services" means emergency care, inpatient hospital and physician care, and outpatient medical services, but does not include mental health services or services for alcohol or drug abuse;

(4) "beneficiary" has the meaning given in AS 21.54.500;

(5) "enrollee" means an individual who is enrolled in a health maintenance organization;

(6) "enrollment date" has the meaning given in AS 21.54.500;

(7) "evidence of coverage" means a certificate, agreement, or contract issued to an enrollee, setting out the coverage to which the enrollee is entitled;

(8) "group market" has the meaning given in AS 21.54.500;

(9) "health care services" means services for medical or dental care, or hospitalization, or services incident to the furnishing of that care or hospitalization, and includes services for the purpose of preventing, alleviating, curing, or healing human illness, injury, or physical disability;

(10) "health maintenance organization" means a person that undertakes to provide or arrange for basic health care services to enrollees on a prepaid basis;

(11) "health status factor" has the meaning given in AS 21.54.500;

(12) "participant" has the meaning given in AS 21.54.500;

(13) "person" has the meaning given in AS 01.10.060 and includes a joint venture;

(14) "preexisting condition exclusion" has the meaning given in AS 21.54.500;

(15) "provider" means a physician, hospital, or other person licensed or otherwise authorized in this state to furnish health care services;

(16) "uncovered expenditures" means the costs of health care services that are covered by a health maintenance organization, but for which an enrollee would also be liable if the organization became insolvent.

(17) "waiting period" has the meaning given in AS 21.54.500.

Alaska Chiropractic Society

P.O. Box 111507 • Anchorage, Alaska 99511-1507

January 12, 1998

Senator Dave Donley
State Capitol
Juneau, AK 99801

Dear Senator Donley:

On behalf of Alaska's chiropractic community, I want to thank you for introducing Senate Bill 197.

As you know, SB 197 makes three important changes to current law:

- Clarifies guidelines on access to chiropractic care by allowing patients direct access to a chiropractor of their choice and does not require prior consent of a medical doctor or registered nurse;

- Prohibits HMOs from having "gag" orders which prohibit physicians from discussing alternative treatment options; and

- Requires HMOs to clearly identify treatments that may be denied a patient which will minimize confusion about treatments that are not covered.

As evidenced by thousands of patient signatures on petitions in support of SB 197 and letters submitted under separate cover by Alaska's chiropractic community, this legislation is widely supported throughout Alaska.

On behalf of Alaskans throughout the state who value the benefits of chiropractic and Alaska's chiropractic community, thank you for your leadership and support on this issue.

Sincerely,

Dr. R. H. Banks
President
Alaska Chiropractic Society

Providence Health System in Alaska
Position Points Regarding
Senate Bill No. 197

I. OVERVIEW

The proposed legislative language in Senate Bill Numb:r 197 to limit and/or control selected activities of Health Maintenance Organizations raises several issues:

1. Section 21.86.075 which mandates the provision of chiropractic health care services and limits the HMO's ability to select which providers to include in its contracting panel and define a process upon which services are approved will result in increased health care costs.

2. AS 21.86.150 (g)(4) which prohibits an HMO from offering financial incentives for denying or delaying health care services, needs to be clarified to specify clinical protocols for groups of individuals may be appropriate, but care cannot be denied or delayed on an individual basis.

II. SPECIFIC RESPONSES

A. Chiropractic Services

1. We are not giving testimony today regarding the appropriateness or inappropriateness of mandating chiropractic coverage by HMOs.

2. However, we are very concerned that to limit a Health Plan's ability to (a) define the benefit coverage it will offer, (b) select which providers will be included in its network, and (c) implement utilization management and referral authorization procedures will only lead to increased health care costs.

3. For good or bad, managed care organizations have dramatically reduced health care expenditures in this country. In 1996, health care inflation was only 1.9 percent, down from double digit inflation just a few years ago.

4. Managed care organizations have been able to do this through a variety of means such as (a) price competition - promise volume for discounts, (b) benefit design to encourage health and appropriate utilization, (c) utilization management, and (d) referral authorization based upon predefined clinical protocols.

5. By beginning the erosion of the basic elements that have helped HMOs control the dramatic rise in health care costs will only lead to renewed health care inflation.

6. Currently, the market provides people with a choice. They can select an insurance plan that provides them with open access to all providers and benefits or they can choose a managed care plan with its related limitations. The primary difference is usually cost.

7. If the legislature mandates to the market that HMOs must be more similar to traditional indemnity plans, the only thing we will accomplish is that there is no choice in the market and we will all pay the higher price of choice.

B. Physician Compensation

1. The proposed legislative language that states that an HMO may not permit "financial incentives to be given or offered to a provider for denying or delaying health care services" needs to be clarified.

2. There are multiple methodologies used across the country to reimburse physicians based upon their ability to standardize care and as a group determine what is the best pathway for delivering clinical services. Such as capitation, risk pools, shadow capitation, etc.

3. This language could be misconstrued to say that a group of physicians could not develop and implement clinical protocols for the delivery of health care services to a defined group of people.

4. And, without a mechanism to reimburse physicians for this level of creativity and problem solving, HMOs and other organizations may lose their ability to include physicians in defining clinical protocols.

5. Clinical protocols allow physicians to come to agreement regarding how clinical services should be provided given a certain set of conditions.

6. This methodology has helped dramatically to reduce the variation in clinical practices and also helped to reduce health care costs.

7. Stark II legislation clearly addresses the issue of you have outlined here regarding physician compensation for denying or delaying health care services. The federal government's position is that care may NOT be denied or delayed to an individual. However, physicians may define clinical protocol regarding how they will deliver care to groups of people and insurance companies can reimburse them for this level of participation in solving the problem of health care inflation.

8. We encourage that the House bill number 197 not be passed without eliminating or at least clarifying this language as discussed.

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Senator Gary Wilken
Chair Senate Health & Social Services Committee
State Capital
Juneau, AK

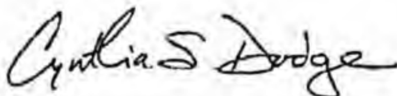
Dear Senator Wilken:

I am writing to you regarding SB 197, which relates to health care provided by health maintenance organizations. Requirements around informing enrollees of their HMO's benefits, limitations and procedures, as well as prohibiting limits on the free speech of health care providers, are important steps toward protecting consumer rights.

As the legislative advocate for the Alaska Psychological Association (AKPA), I want to comment on section 2 of SB 197, which lays out the process that HMO's must adhere to with regard to chiropractic services. This type of "freedom of choice" for the consumer is also a step in the right direction. Psychologists and psychological associates are particularly concerned that patients be allowed to continue to develop relationships with providers upon whom they rely and trust. The patient's ability to freely choose any licensed psychologist or psychological associate to assess and treat their mental health/substance abuse issues is critical for reasons of trust, confidentiality and treatment success. Thus, we would appreciate the opportunity to add language which includes our concerns for ensuring quality of care.

The Alaska Psychological Association thanks you for your efforts regarding this bill.

Sincerely,



Cynthia S. Dodge Ph.D.
Licensed Psychologist
State Advocate for the Alaska Psychological Association

Jan 20 98 05:59p Cynthia S. Dodge 907/258-7733 p.1

NATIONAL ASSOCIATION OF SOCIAL WORKERS
ALASKA CHAPTER

318 4th Street, Juneau AK 99801
586-4438 Fax: 586-4439
naswak@alaska.net

January 19, 1998

Senator Gary Wilkin, Chair
Health Education and Social Services Committee
Alaska Senate
State Capitol
Juneau AK 99801

Re: SB 197

Dear Senator Wilkin:

The National Association of Social Workers Alaska Chapter is watching with interest SB 197, legislation to regulate some of the services and practices of HMO's doing business in Alaska. We believe that the State of Alaska should prepare for the inevitable, and begin the process of regulating managed care health systems.

NASW is very interested in protecting the role of professional social work services in any Alaskan managed care system. Social work has long been a recognized profession in Alaska, with social workers employed in public and private health and mental health care agencies, and in private clinical practice. Nationally, professional social workers provide 50% of all mental health services, and do so at reasonable cost to the consumer. We are interested in exploring the option of including social workers and social work services in legislation protecting specific provider groups operating in HMO's.

I have written to Senator Donley requesting a meeting to discuss possible language that could be included as an addition to Section 2 of the bill. I'd like to discuss the issue with you further during an appointment I've made with you on Tuesday, January 20 at 3:00pm.

Thank you for your attention to this matter, and for your work on behalf of health care consumers in Alaska.

Sincerely,

Angela M. Salerno, Executive Director
NASW Alaska Chapter

PO Box 140351 Anchorage, AK 99514-0351
907-566-3749 (voice) 907-274-7897 (fax)

Alaska Physical Therapy Association

Fax

To:	The Honorable Dave Donley	**From:**	Kathy Volz, PT, President, AkPTA
Fax:	907-465-6595	**Pages:**	1
Phone:		**Date:**	January 20, 1998
Re:	Senate Bill No. 197	**CC:**	Senator Gary Wilkin, Sharon Macklin

x **Urgent** ☐ **For Review** ☐ **Please Comment** ☐ **Please Reply** ☐ **Please Recycle**

Dear Senator Donley,

I have recently been informed of the content of Senate Bill 197 and felt compelled to respond. I would like to thank you for your efforts to protect the rights of free speech of health care providers serving enrollees in a health maintenance organization as well as the rights of the enrollees themselves. As the President of the Alaska Chapter of the American Physical Therapy Association, representing over 180 licensed health care professionals in the state of Alaska, I would urge you to please allow us an opportunity to participate in this piece of legislation .

Health care is an issue affecting each and every citizen in the state and legislation affecting health care regulation should fully reflect this by promoting equity and inclusion of health care providers. I ask that you consider adding a provision to Senate Bill 197 allowing licensed physical therapists to participate in a manner similar to the licensed chiropractors.

Thank you for your serious consideration of this most important issuo.

Kathy Volz, MS, MPT, PT

President, AkPTA

Alaska Nurse Practitioner Association

Alaska Nurse Practitioner Association
237 East Third Avenue
Anchorage, AK 99501

Lynn Hartz, Legislative Representative
phone 907-248-4877
fax 907-561-1257

January 20, 1998

The Honorable Dave Donley
Alaska State Legislature
State Capitol, (MS 3100) Room 204
Juneau, AK 99801-1182

Re. SB 197 Chiropractic Care By HMO

Dear Senator Donley,

As the committee on Health Education and Social Services considers amending state statutes on health maintenance organizations to include chiropractic services, the Alaska Nurse Practitioner Association (ANPA) strongly urges that the Committee amend the proposed language to include Advanced Nurse Practitioners.

Rationale:

- Advanced nurse practitioners (ANPs) are certified and recognized by the State of Alaska as providers of primary health care services.
- Currently, ANPs in independent private practice are serving the Alaskan public in a variety of rural and urban settings.
- Studies show nurse practitioners provide comprehensive, high quality, cost-effective and health effective care.
- **Neglecting to include ANPs in legislation by intent or accident leaves them vulnerable to exclusion by HMOs**. An example already exists in the private sector. The Alaska Physician Network was established for the employees of Providence Hospital as part of a coordinated care option. Independent ANPs are not recognized by the Providence plan and enrollees may now only seek care with their preferred nurse practitioner at considerable financial cost.

We feel it is of the utmost importance to have ANPs included in bills such as SB 197. Only by specifically including nurse practitioners will our patients be assured of continued access to their health care provider of choice. Only by this type of recognition which you as legislators can provide will the people of Alaska continue have choices in their health care.

We appreciate your attention in this matter and look forward to working with you.

Sincerely,

Lynn Hartz, MSN, ANP
ANPA Legislative Representative

cc. Senator Tim Kelly
Senator Gary Wilken

Post-it™ Fax Note 7671

To Senator W. Kern		Date 1/21/98	# of pages ▶ 1
Co./Dept.		From Lynn Hartz	
Phone # 907-452-3421		Co.	
Fax # 907-485-4714		Phone # 907-562-2965	
		Fax # 907 561-1257	

Tue 1/19/98

Fax Transmittal

Providence | Health System

TO: Sheila Paterson

FAX NUMBER: 907 465-4714

FROM: Janet Oates, Director of Marketing & Government/Community Relations

PHONE: 907 261-4946 **FAX NUMBER:** 907 261-3048

DATE: 1/19/98

RE: SB 197

NUMBER OF PAGES: 4

Attached is a copy of the testimony we were anxiously waiting to present to the Committee on Friday morning from the Anchorage LIO. I had asked Quinn McKenna, our Providence Administrator for Managed Care and Alliances in Alaska to speak. But as you know, due to a communication failure, he was not able to address the Committee.

Both Quinn and I will be out of state on Wednesday. If SB 300 is put on the schedule then, **please be sure to contact Quinn who will ready to testify by phone** from our corporate offices in Seattle. His number will be 206 464-3355. If SB 300 is put on the Friday, Jan. 23 schedule, Quinn will be in Anchorage and able to testify from here. His office number here is 261-3134.

Janet Oates

3200 Providence Drive P.O. Box 99519-6604 Anchorage, Alaska 99519-6604 Tel. 907. 562-2211 FAX 907.261-3048

Providence Health System in Alaska
Position Points Regarding
Senate Bill No. 197

I. OVERVIEW

The proposed legislative language in Senate Bill Number 197 to limit and/or control selected activities of Health Maintenance Organizations raises several issues:

1. Section 21.86.075 which mandates the provision of chiropractic health care services and limits the HMO's ability to select which providers to include in its contracting panel and define a process upon which services are approved will result in increased health care costs.

2. AS 21.86.150 (g)(4) which prohibits an HMO from offering financial incentives for denying or delaying health care services, needs to be clarified to specify clinical protocols for groups of individuals may be appropriate, but care cannot be denied or delayed on an individual basis.

II. SPECIFIC RESPONSES

A. Chiropractic Services

1. We are not giving testimony today regarding the appropriateness or inappropriateness of mandating chiropractic coverage by HMOs.

2. However, we are very concerned that to limit a Health Plan's ability to (a) define the benefit coverage it will offer, (b) select which providers will be included in its network, and (c) implement utilization management and referral authorization procedures will only lead to increased health care costs.

3. For good or bad, managed care organizations have dramatically reduced health care expenditures in this country. In 1996, health care inflation was only 1.9 percent, down from double digit inflation just a few years ago.

4. Managed care organizations have been able to do this through a variety of means such as (a) price competition - promise volume for discounts, (b) benefit design to encourage health and appropriate utilization, (c) utilization management, and (d) referral authorization based upon predefined clinical protocols.

5. By beginning the erosion of the basic elements that have helped HMOs control the dramatic rise in health care costs will only lead to renewed health care inflation.

6. Currently, the market provides people with a choice. They can select an insurance plan that provides them with open access to all providers and benefits or they can choose a managed care plan with its related limitations. The primary difference is usually cost.

7. If the legislature mandates to the market that HMOs must be more similar to traditional indemnity plans, the only thing we will accomplish is that there is no choice in the market and we will all pay the higher price of choice.

B. Physician Compensation

1. The proposed legislative language that states that an HMO may not permit "financial incentives to be given or offered to a provider for denying or delaying health care services" needs to be clarified.

2. There are multiple methodologies used across the country to reimburse physicians based upon their ability to standardize care and as a group determine what is the best pathway for delivering clinical services. Such as capitation, risk pools, shadow capitation, etc.

3. This language could be misconstrued to say that a group of physicians could not develop and implement clinical protocols for the delivery of health care services to a defined group of people.

4. And, without a mechanism to reimburse physicians for this level of creativity and problem solving, HMOs and other organizations may lose their ability to include physicians in defining clinical protocols.

5. Clinical protocols allow physicians to come to agreement regarding how clinical services should be provided given a certain set of conditions.

6. This methodology has helped dramatically to reduce the variation in clinical practices and also helped to reduce health care costs.

7. Stark II legislation clearly addresses the issue of you have outlined here regarding physician compensation for denying or delaying health care services. The federal government's position is that care may NOT be denied or delayed to an individual. However, physicians may define clinical protocol regarding how they will deliver care to groups of people and insurance companies can reimburse them for this level of participation in solving the problem of health care inflation.

8. We encourage that the House bill number 197 not be passed without eliminating or at least clarifying this language as discussed.