

SB

1977

SIDE BY SIDE COMPARISON
SB 197 and Work Draft CSSB 197 () Version H
 By Senator Donley

<p>SB 197 Section #1</p> <p>Requires HMOs provide guidelines explaining when treatment may be denied. This prevents the HMO from denying coverage to a patient after treatment has been performed but cost is not covered.</p>	<p>Work Draft CSSB 197() Section #1</p> <p>Section 1, SB 197</p>
<p>SB 197 Section #2</p> <p>Allows patients direct access to chiropractic care with a licensed chiropractor of their choice and does not require prior consent of a gatekeeper. If the patient's condition persists beyond 30 days, the HMO is advised of the condition and recommended treatment. The HMO can then request the patient be examined by a second chiropractor of the HMO's choice. If the treatment recommended by the two chiropractors differs, a third can be selected to recommend treatment. The opinion of the third chiropractor is binding on patient and HMO.</p> <p>N/A</p>	<p>Work Draft CSSB 197() Section #2</p> <p>Same as in SB 197</p> <p>Requires a HMO offer a 'point of service plan' to enrollees that allows access to any health care provider of their choice without prior consent of the HMO. The plan may cost an enrollee a higher deductible or premium.</p>
<p>SB 197 Section #3</p> <p>Bans HMOs from having gag orders which prohibit physicians from discussing alternative treatment options, financial incentives or second opinions with patients. By March, 1997 all but 12 states had enacted legislation or passed rules banning gag clauses.</p>	<p>Work Draft CSSB 197() Section #3</p> <p>Same as section 3, SB 197</p>

Alaska Nurse Practitioner Association

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

Lynn Hartz, Legislative Representative
lhartz@micronet.net
(wk) 907-562-2865 (hm) 907-248-4877
fax 907-561-1257

February 17, 1998

Testimony to the Senate Rules Committee

RE: Draft Amendment to SB 197

Thank-you for the opportunity to address this committee on Senate Bill 197. We were happy to see this legislation as it has some important consumer protection aspects relating to disclosure to the enrollee of what is covered and what will not be covered and protecting the lines of communication between clinician and patient.

The nurse practitioner association I represent had requested that as recognized health care providers we be included in SB 197 in addition to the chiropractors. Last week Senator Donley's staff forwarded a draft amendment (ref. 0-LSO905B7) to us for review and we did respond with a letter of support of that amendment last Friday. Senator Donley's amendment allows HMO enrollees a choice of health care providers who may be outside the HMO network. Over the weekend we found additional language in the HMO statutes that would need to be changed to allow enrollees continued choice in their health care providers inside the HMO network. Since the changes are just to one sentence in the statutes we have included the relevant sections and changes along with the relevant definition of terms.

Sec. 21.86.060. Provision of services.

Current language in brackets. Proposed language bolded.

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

Sec. 21.86.900. Definitions.

In this chapter,

(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;

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

Note that the change in Sec. 21.86.060 (a) does not mandate that the HMO must employ or contract with health care providers who are not physicians, just that they may. It is the view of the ANPA that this change would allow health care consumers choice in their preferred health care provider inside the HMO network as Senator Donley's amendment provides for choice in providers outside the HMO network.

We hope you will consider our proposed amendment before moving this legislation onward.

Thank-you, Lynn Hartz MSN, ANP

~~NOT
CONSIDERED
BY S. RULES~~

operation through the establishment of advisory panels, by the use of advisory referenda on major policy decisions, or through the use of other mechanisms. (§ 1 ch 95 SLA 1990)

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. (§ 1 ch 95 SLA 1990)

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. (§ 1 ch 95 SLA 1990)

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;

A M E N D M E N T

OFFERED IN THE SENATE

BY SENATOR LEMAN

TO: CSSB 197(), Draft Version "H"

1 Page 1, following line 7:

2 Insert a new bill section to read:

3 **"* Section 1.** AS 21.36.090(d) is amended to read:

4 (d) Except to the extent necessary to comply with AS 21.42.365 and
5 AS 21.56, a person may not practice or permit unfair discrimination against a person
6 who provides a service covered under a group health insurance policy that extends
7 coverage on an expense incurred basis, or under a group service or indemnity type
8 contract issued by a health maintenance organization or a nonprofit corporation, if
9 the service is within the scope of the provider's occupational license. In this
10 subsection, "provider" means a state licensed physician, dentist, osteopath, optometrist,
11 chiropractor, nurse midwife, advanced nurse practitioner, naturopath, physical
12 therapist, occupational therapist, psychologist, psychological associate, or licensed
13 clinical social worker, or certified direct-entry midwife."

14 Page 1, line 8:

15 Delete "Section 1."

16 Insert "Sec. 2."

17 Renumber the following bill sections accordingly.

Sec. 21.36.080. Boycott, coercion, and intimidation. A person may not enter into an agreement to commit, or by any concerted action commit, an act of boycott, coercion, or intimidation resulting in or tending to result in unreasonable restraint of, or monopoly in, the business of insurance. (§ 1 ch 120 SLA 1966)

Sec. 21.36.090. Unfair discrimination. (a) A person may not make or permit unfair discrimination between individuals of the same class and equal expectation of life in the rates charged for a contract of life insurance or of life annuity or in the dividends or other benefits payable thereon, or in any other of the terms and conditions of the contract.

(b) A person may not make or permit unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, policy fees, or rates charged for a policy or contract of disability insurance or in the benefits payable, or in any of the terms or conditions of the contract, or in any other manner whatever.

(c) A person may not make or permit arbitrary or unfair discrimination between insureds or property having like insuring or risk characteristics, in the premium or rates charged for a policy or contract of property, casualty, surety, marine, wet marine or transportation insurance, or in the dividends or other benefits payable on the insurance, or in the selection of it, or in any other of the terms and conditions of the insurance.

(d) Except to the extent necessary to comply with AS 21.42.365 and AS 21.56, a person may not practice or permit unfair discrimination against a person who provides a service covered under a group disability policy that extends coverage on an expense incurred basis, or under a group service or indemnity type contract issued by a nonprofit corporation, if the service is within the scope of the provider's occupational license. In this subsection, "provider" means a state licensed physician, dentist, osteopath, optometrist, chiropractor, nurse midwife, advanced nurse practitioner, naturopath, physical therapist, occupational therapist, psychologist, psychological associate, or licensed clinical social worker, or certified direct-entry midwife. (§ 1 ch 120 SLA 1966; am § 5 ch 163 SLA 1976; am § 1 ch 80 SLA 1983; am § 28 ch 2 FSSLA 1987; am § 1 ch 56 SLA 1988; am § 1 ch 150 SLA 1988; am § 139 ch 67 SLA 1992; am § 3 ch 39 SLA 1993; am § 1 ch 51 SLA 1993)

Delayed amendment. — Section 4, ch. 39, SLA 1993, effective July 1, 1998 under § 13, ch. 39, SLA 1993, amends (d) of this section by deleting the reference to AS 21.56.

Effect of amendments. — The 1992 amendment, effective July 1, 1992, added

"psychologist, psychological associate, or licensed clinical social worker" to the end of the section and made related changes.

The first 1993 amendment, effective July 1, 1993, inserted an internal reference in the first sentence in subsection (d).

The second 1993 amendment, effective

0-LS0905H
Ford
2/12/98

CS FOR SENATE BILL NO. 197()

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTIETH LEGISLATURE - SECOND SESSION

BY

**Offered:
Referred:**

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

A BILL

FOR AN ACT ENTITLED

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

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

8 * Section 1. AS 21.86.070(c) is amended to read:

9 (c) An evidence of coverage

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

13 (2) must contain a clear and concise statement [,] if a contract, or a

1 reasonably complete summary [,] if a certificate, of

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

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

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

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

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

13 (F) guidelines explaining when treatment may be denied.

14 * Sec. 2. AS 21.86 is amended by adding new sections to read:

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

26 (b) If the enrollee's chiropractor recommends chiropractic treatment beyond
27 30 days, the chiropractor shall conduct a second examination and transmit the findings
28 to the enrollee's health maintenance organization. The transmitted information must
29 include the enrollee's current status regarding the primary complaint, the progress of
30 a revised treatment plan, and the objectives for continued care.

31 (c) After receiving a 30-day treatment report from a chiropractor under (b) of

1 this section, the enrollee's health maintenance organization may request a review by
2 another chiropractor. The reviewing chiropractor shall conduct a physical examination
3 of the enrollee. The findings of the reviewing chiropractor must be disclosed to the
4 enrollee and the enrollee's chiropractor. Charges for additional chiropractic care
5 recommended by the reviewing chiropractor must be included as covered health care
6 services provided by the health maintenance organization.

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

21 **Sec. 21.86.078. Choice of health care provider.** (a) A health maintenance
22 organization shall offer to every enrollee a point-of-service plan option that would
23 allow a covered person to receive covered services from an out-of-network health care
24 provider without obtaining a referral or prior authorization from the health maintenance
25 organization. The point-of-service plan option may require that an enrollee pay a
26 higher deductible or copayment and higher premium for the plan.

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

1 enrollee who selects that option.

2 * Sec. 3. AS 21.86.150 is amended by adding a new subsection to read:

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

6 (1) the imposition of limits regarding

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

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

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

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

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

**Alaska Nurse
Practitioner Association**

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

Lynn Hartz, Legislative Representative
lhartz@micronet.net
(hm) 907-248-4877
(wk) 907-582-2965
fax 907-561-1257
(wk) 907-343-4623, press 0

February 12, 1998

The Honorable Dave Donley
State Capitol, Room 508
Juneau, AK 99801-1182
Fax 907-465-6595

Dear Senator Donley,

Thank-you for your timely response to our letter re: including Advanced Nurse Practitioners in section 2 of Senate Bill 197. We have reviewed your amendment (ref O-LS0905\B7) to SB197 and feel that it addresses our concerns.

Your bill has important consumer protections in sections 1 and 3 such as banning HMO gag orders and requiring HMOs to identify treatments that may be denied. Based on what we are hearing from around the country, these protections are needed. Hopefully those sections can be added to the House version (HB 219) in the future.

We appreciate your efforts on behalf of the health care consumers of Alaska, both in the consumer protection aspects of SB 197 and assuring consumers continued access to their health care provider of choice.

Sincerely,
Lynn Hartz, MSN, ANP
ANPA Legislative Representative