ALASKA LEGISLATURE COMMITTEE FILES 1999-2000 8672

9856 HOUSE JUDICIARY

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

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

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

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

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

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

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

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

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

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

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

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

(16) violate a provision contained in AS 21.07.

*** Sec. 5.** AS 21.42 is amended by adding new sections to read:

Sec 21.42.390. Required health insurance coverage provisions. (a) A health care insurer may not include in a health care insurance plan or contract a provision that restricts a covered person's right to receive full information from the person's health care provider regarding the care or treatment options that the health care provider believes are in the best interests of the person.

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

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

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

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

Sec 21.42.392. Requirements relating to dental care coverage provisions. (a) A health care insurer who provides coverage for dental care may not include in the health care insurance plan or contract a provision that

(1) prohibits a covered person from obtaining dental care services from a dentist of the person's choice, including a specialist;

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

(b) A health care insurance plan or contract that provides coverage for dental services that allows the health care insurer to review a treatment plan or conduct a utilization review must contain a provision that a treatment plan review or utilization review relating to dental care for a covered person receiving treatment in this state must be conducted by a dentist.

(c) A health care insurer may not

(1) directly or indirectly reimburse a covered person at a different rate because of the person's choice of a dentist;

(2) deny coverage, cancel a health care insurance plan or contract, or otherwise take action against a covered person or a dentist because the person has asserted a right described in this section.

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

(e) In this section, "dentist" means a person licensed in this state to practice dentistry.

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

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

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

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

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

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

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
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State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM April 7, 2000

SUBJECT: Managed care - (CSHB 211(JUD))

TO: Representative Pete Kott
Attn: Lesil

FROM: Michael F. Ford
Legislative Counsel

The draft you requested is attached. I have added the new provision regarding "medical necessity" as a new paragraph 2 in Sec. 21.07.020, beginning on page 3, line 25. This provision raises issues regarding other existing provisions in the bill, however. I believe it is necessary to also change Sec. 21.07.020(1), (5)(B) and (6)(B). These are provisions that also involve determinations regarding "medical necessity" and need to be amended to avoid conflicts or duplications. You could simply remove the conflicting provisions, but this may be a change that is too drastic. In short there is no quick fix for this situation. One approach you may consider is to make Sec. 21.07.020(1) contingent on compliance with Sec. 21.07.020(2), and simply remove Sec. 21.07.020(5)(B) and (6)(B), but that still leaves the issue of "utilization review". Utilization review, as defined in Sec. 21.07.250, includes a determination of "medical necessity". You could specifically exclude "medical necessity" from the utilization review process and leave this issue to the independent review organization. Again this may require other adjustments to the bill.

Let me know what you decide.

MFF:glc
00-165.glc

1-LS0472\V
Ford
4/7/00

CS FOR HOUSE BILL NO. 211(JUD)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FIRST LEGISLATURE - SECOND SESSION

BY THE HOUSE JUDICIARY COMMITTEE

Offered:
Referred:

Sponsor(s): REPRESENTATIVE ROKEBERG BY REQUEST

A BILL

FOR AN ACT ENTITLED

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

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

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

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

*** Sec. 2.** AS 21 is amended by adding a new chapter to read:

Chapter 07. Regulation of Managed Care Insurance Plans.

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

(1) provides for a reasonable mechanism to identify all health care services to be provided by the managed care entity;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) a provision that a determination regarding the medical necessity or appropriateness of health care services for an enrollee or the application of managed care plan provisions to an enrollee must be made by medical reviewers from an independent review organization; a determination by a medical reviewer shall be based on the medical reviewer's expert medical judgment, after consideration of relevant medical, scientific, and cost-effective evidence, and medical standards of practice in this state; except as provided in this paragraph, the independent review organization

must ensure that a determination is consistent with the scope of covered benefits as outlined in the managed care plan; a medical reviewer may override the managed care plan's standard of medical necessity or appropriateness of health care services if the standard is determined by the medical reviewer to be unreasonable or inconsistent with sound, evidence-based medical practice;

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

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

(5) a provision that any utilization review decision

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

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

(6) a provision that provides for an internal appeal mechanism for a covered person who disagrees with a utilization review decision made by a managed care entity; except as provided under (7) of this section, this appeal mechanism must provide for a written decision

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

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

(7) a provision that provides for an internal appeal mechanism for a

covered person who disagrees with a utilization review decision made by a managed care entity in any case in which delay would, in the written opinion of the treating provider, jeopardize the covered person's life or materially jeopardize the covered person's health; the managed care entity shall

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

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

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

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

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

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

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

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

Sec. 21.07.030. Choice of health care provider. (a) If a managed care entity offers a group health plan that provides for coverage of health care services only if the services are furnished through a network of health care providers that have entered into a contract with the managed care entity, the managed care entity shall also offer a non-network option to enrollees at initial enrollment, as provided under (c) of this section. The non-network option may require that a covered person pay a higher deductible, copayment, or premium for the plan if the higher deductible, copayment, or premium results from increased costs caused by the use of a non-network provider. The

managed care entity shall provide an actuarial demonstration of the increased costs to the director at the director's request. If the increased costs are not justified, the director shall determine the appropriate costs allowed and determine the appropriate amount of higher deductible, copayment, or premium. This subsection does not apply to an enrollee who is offered non-network coverage through another group health plan or through another managed care entity in the group market.

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

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

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

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

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

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

(f) If a contract between a health care provider and a managed care entity is

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

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

(A) the end of the current plan year;

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

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

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

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

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

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

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

(2) the information is disclosed for research

(A) that is subject to federal law and regulations protecting the

rights and welfare of research participants; or

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

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

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

(5) the disclosure is required by law.

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

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

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

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

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

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

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

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

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

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

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

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

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

(D) the group managed care plan;

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

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

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

(C) practice and treatment guidelines prepared or financed in

whole or in part by government agencies;

(D) government-issued coverage and treatment policies;

(E) generally accepted principles of professional medical practice;

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

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

(H) the community standard of care; and

(I) anomalous utilization patterns;

(5) an external appeal agency shall determine

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

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

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

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

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

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

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

(B) be made in accordance with the medical exigencies of the case involved, but in no event later than 21 working days after the appeal is

filed, or, in the case of an expedited appeal, 72 hours after the time of requesting an external appeal of the managed care entity's decision;

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

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

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

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

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

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

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

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

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

(1) means

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

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

(2) does not include a decision based on specific exclusions or express limitations on the amount, duration, or scope of coverage that do not involve medical

judgment, or a decision regarding whether an individual is a participant, beneficiary, or enrollee under the plan or coverage.

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

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

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

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

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

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

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

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

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

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

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

(1) with respect to

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

(B) individual health insurance coverage, the insurer offering

the coverage, or any plan sponsor, fiduciary, officer, director, or management employee of the plan or issuer;

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

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

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

(5) the covered person; or

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

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

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

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

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

(A) apply medically based eligibility standards;

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

(C) use health care providers in making a decision on an

internal or external appeal; or

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

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

Sec. 21.07.250. Definitions. In this chapter,

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

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

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

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

(B) a serious impairment to bodily functions; or

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

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

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

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

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

(8) "managed care" means a contract given to an individual, family, or group of individuals under which a member is entitled to receive a defined set of

health care benefits in exchange for defined consideration and that requires the member to comply with utilization review guide lines; "managed care" does not include Medicaid coverage under 42 U.S.C. 1396 - 1396p (Social Security Act);

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

(10) "managed care entity" means an insurer, a hospital or medical service corporation, a health maintenance organization, an employer or employee health care organization, a managed care contractor that operates a group managed care plan, or a person who has a financial interest in health care services provided to an individual;

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

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

(B) a serious impairment to bodily functions; or

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

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

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

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

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

(16) "utilization review" means a system of reviewing the medical

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

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

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

(16) violate a provision contained in AS 21.07.

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

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

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

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

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

1-LS0472\S
Ford
4/5/00

CS FOR HOUSE BILL NO. 211( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FIRST LEGISLATURE - SECOND SESSION

BY

Offered:
Referred:

Sponsor(s): REPRESENTATIVE ROKEBERG BY REQUEST

A BILL

FOR AN ACT ENTITLED

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

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

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

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

* **Sec. 2.** AS 21 is amended by adding a new chapter to read:

Chapter 07. Regulation of Managed Care Insurance Plans.

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

(1) provides for a reasonable mechanism to identify all health care services to be provided by the managed care entity;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(4) a provision that any utilization review decision

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(A) the end of the current plan year;

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

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

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

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

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

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

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

(2) the information is disclosed for research

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

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

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

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

(5) the disclosure is required by law.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(D) the group managed care plan;

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

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

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

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

(D) government-issued coverage and treatment policies;

(E) generally accepted principles of professional medical practice;

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

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

(H) the community standard of care; and

(I) anomalous utilization patterns;

(5) an external appeal agency shall determine

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) means

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) with respect to

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

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

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

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

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

(5) the covered person; or

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

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

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

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

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

(A) apply medically based eligibility standards;

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

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

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

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

Sec. 21.07.250. Definitions. In this chapter,

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

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

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

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

(B) a serious impairment to bodily functions; or

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

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

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

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

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

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

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

(10) "managed care entity" means an insurer, a hospital or medical service corporation, a health maintenance organization, an employer or employee health care organization, a managed care contractor that operates a group managed care plan, or a person who has a financial interest in health care services provided to an individual;

(11) "medical emergency" means the sudden onset of a medical

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

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

(B) a serious impairment to bodily functions; or

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

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

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

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

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

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

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

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

(16) violate a provision contained in AS 21.07.

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

INDIRECT COURT RULE AMENDMENT. AS 21.07.050(g), as enacted by sec. 2 of this Act, has the effect of amending Rule 602(b), Alaska Rules of Appellate Procedure, by

providing that an appeal from a decision of an external appeal agency must be filed within six months of the decision of the external appeal agency.

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

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

4/10/00
JUD

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM April 7, 2000

SUBJECT: Managed care - (CSHB 211(JUD))

TO: Representative Pete Kott
Attn: Lesil

FROM: Michael F. Ford
Legislative Counsel

The draft you requested is attached. I have added the new provision regarding "medical necessity" as a new paragraph 2 in Sec. 21.07.020, beginning on page 3, line 25. This provision raises issues regarding other existing provisions in the bill, however. I believe it is necessary to also change Sec. 21.07.020(1), (5)(B) and (6)(B). These are provisions that also involve determinations regarding "medical necessity" and need to be amended to avoid conflicts or duplications. You could simply remove the conflicting provisions, but this may be a change that is too drastic. In short there is no quick fix for this situation. One approach you may consider is to make Sec. 21.07.020(1) contingent on compliance with Sec. 21.07.020(2), and simply remove Sec. 21.07.020(5)(B) and (6)(B), but that still leaves the issue of "utilization review". Utilization review, as defined in Sec. 21.07.250, includes a determination of "medical necessity". You could specifically exclude "medical necessity" from the utilization review process and leave this issue to the independent review organization. Again this may require other adjustments to the bill.

Let me know what you decide.

MFF:glc
00-165.glc

4/10/00 JUD

1-LS0472\V
Ford
4/7/00

adopted 4/10 amended & moved out

CS FOR HOUSE BILL NO. 211(JUD)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FIRST LEGISLATURE - SECOND SESSION

BY THE HOUSE JUDICIARY COMMITTEE

Offered:
Referred:

Sponsor(s): REPRESENTATIVE ROKEBERG BY REQUEST

A BILL

FOR AN ACT ENTITLED

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

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

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

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

*** Sec. 2.** AS 21 is amended by adding a new chapter to read:

Chapter 07. Regulation of Managed Care Insurance Plans.

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

(1) provides for a reasonable mechanism to identify all health care services to be provided by the managed care entity;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) a provision that a determination regarding the medical necessity or appropriateness of health care services for an enrollee or the application of managed care plan provisions to an enrollee must be made by medical reviewers from an independent review organization; a determination by a medical reviewer shall be based on the medical reviewer's expert medical judgment, after consideration of relevant medical, scientific, and cost-effective evidence, and medical standards of practice in this state; except as provided in this paragraph, the independent review organization

must ensure that a determination is consistent with the scope of covered benefits as outlined in the managed care plan; a medical reviewer may override the managed care plan's standard of medical necessity or appropriateness of health care services if the standard is determined by the medical reviewer to be unreasonable or inconsistent with sound, evidence-based medical practice;

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

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

(5) a provision that any utilization review decision

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

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

(6) a provision that provides for an internal appeal mechanism for a covered person who disagrees with a utilization review decision made by a managed care entity; except as provided under (7) of this section, this appeal mechanism must provide for a written decision

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

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

(7) a provision that provides for an internal appeal mechanism for a

covered person who disagrees with a utilization review decision made by a managed care entity in any case in which delay would, in the written opinion of the treating provider, jeopardize the covered person's life or materially jeopardize the covered person's health; the managed care entity shall

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

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

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

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

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

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

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

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

Sec. 21.07.030. Choice of health care provider. (a) If a managed care entity offers a group health plan that provides for coverage of health care services only if the services are furnished through a network of health care providers that have entered into a contract with the managed care entity, the managed care entity shall also offer a non-network option to enrollees at initial enrollment, as provided under (c) of this section. The non-network option may require that a covered person pay a higher deductible, copayment, or premium for the plan if the higher deductible, copayment, or premium results from increased costs caused by the use of a non-network provider. The

managed care entity shall provide an actuarial demonstration of the increased costs to the director at the director's request. If the increased costs are not justified, the director shall determine the appropriate costs allowed and determine the appropriate amount of higher deductible, copayment, or premium. This subsection does not apply to an enrollee who is offered non-network coverage through another group health plan or through another managed care entity in the group market.

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

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

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

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

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

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

(f) If a contract between a health care provider and a managed care entity is

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

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

(A) the end of the current plan year;

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

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

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

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

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

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

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

(2) the information is disclosed for research

(A) that is subject to federal law and regulations protecting the

rights and welfare of research participants; or

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

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

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

(5) the disclosure is required by law.

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

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

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

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

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

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

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

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

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

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

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

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

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

(D) the group managed care plan;

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

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

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

(C) practice and treatment guidelines prepared or financed in

whole or in part by government agencies;

(D) government-issued coverage and treatment policies;

(E) generally accepted principles of professional medical practice;

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

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

(H) the community standard of care; and

(I) anomalous utilization patterns;

(5) an external appeal agency shall determine

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

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

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

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

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

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

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

(B) be made in accordance with the medical exigencies of the case involved, but in no event later than 21 working days after the appeal is

filed, or, in the case of an expedited appeal, 72 hours after the time of requesting an external appeal of the managed care entity's decision;

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

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

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

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

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

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

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

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

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

(1) means

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

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

(2) does not include a decision based on specific exclusions or express limitations on the amount, duration, or scope of coverage that do not involve medical

judgment, or a decision regarding whether an individual is a participant, beneficiary, or enrollee under the plan or coverage.

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

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

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

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

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

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

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

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

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

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

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

(1) with respect to

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

(B) individual health insurance coverage, the insurer offering

the coverage, or any plan sponsor, fiduciary, officer, director, or management employee of the plan or issuer;

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

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

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

(5) the covered person; or

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

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

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

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

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

(A) apply medically based eligibility standards;

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

(C) use health care providers in making a decision on an

internal or external appeal; or

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

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

Sec. 21.07.250. Definitions. In this chapter,

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

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

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

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

(B) a serious impairment to bodily functions; or

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

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

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

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

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

(8) "managed care" means a contract given to an individual, family, or group of individuals under which a member is entitled to receive a defined set of

health care benefits in exchange for defined consideration and that requires the member to comply with utilization review guide lines; "managed care" does not include Medicaid coverage under 42 U.S.C. 1396 - 1396p (Social Security Act);

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

(10) "managed care entity" means an insurer, a hospital or medical service corporation, a health maintenance organization, an employer or employee health care organization, a managed care contractor that operates a group managed care plan, or a person who has a financial interest in health care services provided to an individual;

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

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

(B) a serious impairment to bodily functions; or

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

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

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

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

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

(16) "utilization review" means a system of reviewing the medical

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

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

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

(16) violate a provision contained in AS 21.07.

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

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

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

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

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

ALASKA STATE MEDICAL ASSOCIATION

4107 Laurel Street ·Anchorage, Alaska 99508 ·(907)562-0304 ·(907)561-2063 (fax)

FAX COVER SHEET

Pages (including cover sheet):18

TO: Lisel McGuire 907-465-2819

FROM: Jim Jordan

DATE: April 3, 2000

MESSAGE:

/kms

Insert 1.

21.07.010 (a) (3) from K version p. 3, line 16 and 17 remove and insert as the new (3)

"(3) clearly identifies and describes each health benefit plan for ~~those~~ which ~~enrollees~~ the managed care entity intends to have its participating health care provider ~~agrees to~~ provide services to those enrolled in those health benefit plans;"

Insert 2

On page 4 of N, line 7 after the ";" add the following clause:

"however, if the treating health care provider is a physician than the employee or agent of the managed care entity shall be a licensed physician;"

WORK DRAFT WORK DRAFT WORK DRAFT

1-LS0472\N
Ford
3/30/00

CS FOR HOUSE BILL NO. 211( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FIRST LEGISLATURE - SECOND SESSION

BY

Offered:
Referred:

Sponsor(s): REPRESENTATIVE ROKEBERG BY REQUEST

A BILL

FOR AN ACT ENTITLED

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

keep original title (version K)

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

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

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

* Sec. 2. AS 21 is amended by adding a new chapter to read:

Chapter 07. Regulation of Managed Care Insurance Plans.

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

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

keep version (K) Liability section See 09.65.175

Keep version K chapter 07 See 21.07.010 (3) (4) (5) (1), (6), (7), (8), (9)

New Text Underlined [DELETED TEXT BRACKETED]

See insert 1.

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

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

(A) for an initial meeting at which all parties are present or represented by individuals with authority regarding the matters in dispute; the meeting shall be held within 14 working days after the plan receives written notice of the dispute or gives written notice to the provider, unless the parties otherwise agree in writing to a different schedule;

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

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

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

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

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

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

(b) A contract between a participating health care provider and a managed care

need original version (c) Chapter (7) see 21.07.010 (1),(4),(5),(6),(7) (8),(9)

entity that offers a group managed care plan may not contain a provision that

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

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

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

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

Keep version (K) indemnification language 8 lines 11-14

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

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

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

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

(4) a provision that any utilization review decision

(A) must be made within 72 hours after receiving the request for preapproval for nonemergency situations; for emergency situations, OK

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

(B) to deny, reduce, or terminate a health care benefit or to deny payment for a health care service because that service is not medically necessary shall be made by an employee or agent of the managed care entity who is a licensed health care provider; → See Insert 2.

(5) a provision that provides for an internal appeal mechanism for a covered person who disagrees with a utilization review decision made by a managed care entity; except as provided under (6) of this section, this appeal mechanism must provide for a written decision from the managed care entity within 15 working days after the date written notice of an appeal is received;

(6) a provision that provides for an internal appeal mechanism for a covered person who disagrees with a utilization review decision made by a managed care entity in any case in which delay would, in the ~~written~~ opinion of the treating provider, jeopardize the covered person's life or materially jeopardize the covered person's health; the managed care entity shall decide an appeal described in this paragraph within 72 hours after receiving the appeal;

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

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

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

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

(11) a provision describing availability of prescription medications or a formulary guide, ~~and its structure~~; if a formulary guide is made available, the guide must be updated annually; and

(12) a provision describing available translation or interpreter services.

reason (K) language is better but highlighted language would do.

ok with change.

ok with change

ok

ok

ok with change

ok with change

ok with change

ok

including audiotape or braille information.

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

Keep version (F) 21.07.030 (a)

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

ok

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

ok

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

ok

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

ok

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

ok with change

[redacted]

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

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

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

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

(A) the end of the current plan year;

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

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

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

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

Sec. 21.07.040. Confidentiality of managed care information. (a) Medical and financial information in the possession of a managed care entity regarding an applicant or a current or former person covered by a managed care plan is confidential

and is not subject to public disclosure.

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

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

(2) the information is disclosed for research purposes using

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

(B) anonymous health information in which the confidentiality of participants is protected by coding or encryption of information that would otherwise reveal the identity of the patient;

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

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

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

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

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

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

(2) for auditing a sample of decisions by external appeal agencies to

assure that decisions are not made in a biased manner; and

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

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

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

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

~~(2)~~ (3) the external appeal agency shall include among the evidence taken into consideration

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

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

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

(D) the group managed care plan;

(4) the external appeal agency may also take into consideration the following evidence: but is not limited to

(A) the results of studies that meet professionally recognized

standards of validity and replicability or that have been published in peer-reviewed journals;

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

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

(D) government-issued coverage and treatment policies;

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

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

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

(5) an external appeal agency shall determine

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

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

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

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

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

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

(A) be made orally or in writing and, if it is made orally, shall

be supplied to the parties in writing as soon as possible;

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

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

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

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

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

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

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

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

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

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

(1) means

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

(B) a denial that is based on a failure to meet an applicable

deadline for internal appeal under AS 21.07.020;

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

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

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

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

(2) the agency conducts external appeal activities through a panel of clinical peers; and

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

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

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

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

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

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

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

(1) with respect to

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

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

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

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

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

(5) the covered person; or

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

ok

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

ok

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

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

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

(A) apply medically based eligibility standards;

ok

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

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

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

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

Sec. 21.07.250. Definitions. In this chapter,

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

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

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

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

(B) a serious impairment to bodily functions; or

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

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

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

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

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

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

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

(10) "managed care entity" means an insurer, a hospital or medical service corporation, a health maintenance organization, an employer or employee health care organization, a managed care contractor that operates a group managed care plan, or a person who has a financial interest in health care services provided to an individual;

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

must include "medical necessity" definition / version (C)

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

(B) a serious impairment to bodily functions; or

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

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

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

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

(15) "religious nonmedical provider" means a person who does not

ok ok ok ok

provide medical care, but who provides only religious nonmedical treatment or nursing care for an illness or injury;

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

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

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

(16) violate a provision contained in AS 21.07.

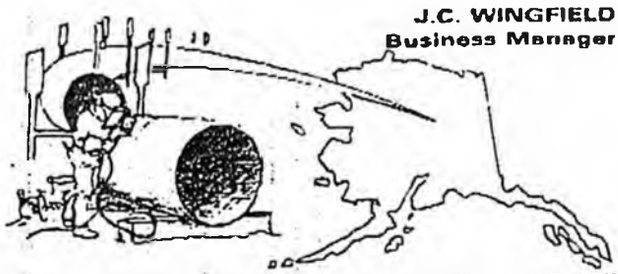
* Sec. 4. The uncodified law of the State of Alaska is amended by adding a new section to read:

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

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

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

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



J.C. WINGFIELD
Business Manager

PLUMBERS & STEAMFITTERS LOCAL UNION NO. 375
3568 Geraghty
(907) 479-6221
Fairbanks
Alaska 99701

SENT BY FAX

DATE 4/3/00 FAX Number 465-2819

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FROM: U.A. Local 375 of the Plumbers & Steamfitters Union
3568 Geraghty Street
Fairbanks, Alaska 99709
Telephone: 907-479-6221

TO: Representative Kott

Route to:

CC:

Comments:

UNITED ASSOCIATION
of Journeymen and Apprentices of the Plumbing and Pipe Fitting Industry of the United States and Canada

Founded 1889

Letters should be confined to one subject.

Martin J. Maddaloni
General President

Michael A. Collins
General Secretary-Treasurer

C. Randal Gardner
Assistant General President

UA Local Union: 375
3568 Geraghty Street, Fairbanks, Alaska 99709

Subject:

March 31, 2000

Representative Pete Kott

We, the trustees of Plumbers & Steamfitters Local 375 H & W Fund, representing approximately 500 Plan Participants, have read and reviewed House Bill #211, sponsored by Representative Norm Rokeberg. Its passing will have a significant and adverse impact on our Participants' health care costs.

If we are faced with the decision to either increase exposure to participant litigation or be denied the ability to control plan costs through effective managed care, we will not be able to afford to continue providing our plan participants with the level of benefits they currently enjoy. Managed care is one method we can use to control the increasing cost of health care.

You should be aware that as Trustees and Plan Sponsors, we are the ones who create the Plan design and the cost containment provisions of the plan- not the insurance company.

Again, House Bill 211, if passed, will be disadvantage to our Plan participants and Plan Fiduciaries. Therefore, we strongly encourage the defeat of House Bill #211.

Sincerly,

J. C. Wingfield

Chairman of The Board of Trustees

TOTAL P.02

Alaska State Legislature

HOUSE OF REPRESENTATIVES

Official Business Faxed to Legal 4/4/00 @ 7:50pm jp

State Capitol
Juneau, AK 99801-1182

MEMORANDUM **TIME SENSITIVE, SEE PARAGRAPH 2**

TO: Mike Ford, Legislative Counsel **FAX: 2029**

FROM: Janet Seitz Janet
Rep. Norman Rokeberg's Office

DATE: April 4, 2000

RE: HB 211 - N version

At the request of Rep. Joe Green, Chair, Subcommittee on HB 211, I am requesting a new work draft CS, blank committee sponsor, as contained in this memorandum. Please use the N version, LS0472/N, Ford, 3/30/00 as your starting point.

Please NOTE that the subcommittee is scheduled to report to the full House Judiciary Committee regarding this matter at the Wednesday, April 5th, meeting, which begins at 1:00 p.m. It would be appreciated if we could have the work draft BEFORE the meeting.

1. **Amendment #1, use LS0472/N.1, Ford, 3/31/00**

2. **Page 2, line 9, after "within" DELETE "14"; INSERT "10"**

3. **Amendment #2, see "Rokeberg A" follows. Use the amendments to Page 3, line 8, and page 3, line 15 as reflected by that amendment. DO NOT incorporate the page 3, line 9, amendment.**

4. **Amendment #3, see "Rokeberg B" follows. Note that the correct line reference is line 26, page 3.**

3. **Amendment #4, see "Rokeberg C" as follows.**

4. **Amendment #5, see "Rokeberg D" as follows.**

1/8

5. Amendment #6, page 5, line 7, after "deductible", DELETE "or"; INSERT ",". Page 5, line 8, after "copayment", DELETE "and"; INSERT "or".

6. Amendment #7, page 11, lines 14-15, conceptual amendment: (2) Unless otherwise agreed to by both parti the agency conducts external appeal activities through a panel of two nical peers; and

7. Page 3, line 2, INSERT new subsection (1) as follows:

   Provides a reasonable mechanism to identify all health care services to be covered by the managed care entity;

   Renumber remaining sections.

8. Page 4, line 11, after "within" DELETE "20"; INSERT "18".

9. Page 4, lines 26-27: DELETE language and replace with:

   A provision describing a mechanism for assignment of benefits for health care providers and payment of benefits.

10. Page 4, line 29, after "guide," DELETE "and its structure" and INSERT "and whether drugs not listed are excluded."

11. Page 5, line 8 after "plan", INSERT conceptual amendment: "subject to the terms of AS 21.54.015." Please verify that the director of insurance has adequate authority to review rates of the managed care entity and request information if the review indicates a problem. Hospital or medical service corporations already have to file with the director under AS 21.87.190 and we desire to reference those who may not file yearly rates.

12. Page 5, line 31 after "health care providers" INSERT: as set forth in the applicable member contract.

    AFTER that new language add: "The non-network option may require that a covered person pay a higher deductible, copayment or a higher premium for the plan."

13. Page 9, line 16: ADD two more subsections as follows:

    (H) community standard of care;
    (I) anomalous utilization patterns.

2/8

If you have any questions, please do not hesitate to contact me at x4954 or Kevin Jardell of Rep. Green's office at x4931. A copy of the work draft should be delivered to both offices.

cc: Kevin Jardell, Rep. Green's Office

3/8

1-LS0472\N.1
Ford
3/31/00

adopted

AMENDMENT

OFFERED IN THE HOUSE BY REPRESENTATIVE ROKEBERG

TO: CSHB 211( ), Draft Version "N"

Page 4, line 11, following "decision":

Insert "(A)"

Page 4, line 12, following "received;":

Insert "and

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

Page 4, line 17, following "shall":

Insert "(A)"

Page 4, line 18, following "appeal;":

Insert "and

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

4/8

Rokeberg A

AMENDMENT # 2

OFFERED IN THE HOUSE By: Rep. Rokeberg

TO: CSHB 201 (), LS0472/N, Ford, 3/30/00

Page 3, line 8

AFTER: "provider to"
DELETE: "purchase or use"
INSERT: "contract for"

RATIONALE: The provider does not purchase or use the product; the patient does. The provider, therefore, contracts for the products.

Page 3, line 9:

AFTER: "entity"

INSERT: unless these products have equal rates of provider compensation.

RATIONALE: Requested by Blue Cross. Allows access to products that provider may want.

Page 3, line 15:

AFTER: "entity"

INSERT: "for the acts of the managed care entity"

RATIONALE: As written, the language would prohibit the standard clauses in which the provider indemnifies the entity for the provider's bad acts and the entity indemnifies the provider for the entity's bad acts. New language would make it clear that contract could not include a provision where the provider would hold the entity harmless for the entity's bad act.

5/8

adopted

Rokeberg B

AMENDMENT 3

OFFERED IN THE HOUSE By: Rokeberg

TO: CSHB 211 (), LS0472/N, Ford, 3/30/00

Page 3, line 25:

AFTER: "referrals"

INSERT: ", if required,"

RATIONALE: Some plans do not require a patient to receive referrals. The current language would mandate that a plan must have a referral system. If a plan does not have a referral system, there should be no mandate to put one in place.

6/8

adopted

Rokeberg C

AMENDMENT # 4

OFFERED IN THE HOUSE BY: ROKEBERG

TO: CSHB 211 (), LS0472/N, Ford, 3/30/00

Page 6, lines 4-5:

DELETE

Reletter subsequent sections

RATIONALE: This clause would mean that every time a provider contract was terminated, the entity would have to notify all covered persons. This is a cost driver as it could result in many letters being sent out to notify all covered persons.

Additionally, the language references "for cause" and putting this in a letter could create liability for the managed care entity.

7/8

Adopted

Rokeberg D

AMENDMENT # 6

OFFERED IN THE HOUSE BY ROKEBERG

TO: CSHB 211 (), LS0427/N

Page 7, lines 5-10 DELETE current language and insert following:

(2) the information is disclosed for research:
(A) that is subject to federal laws and regulations protecting the rights and welfare of research participants; or
(B) using health information that protects the confidentiality of participants by coding or encryption of information that would otherwise identify the patient.

RATIONALE: Code of Federal Regulations specifically outlines the protections required and procedures to protect patients that must be used by institutional Review Boards, researchers, and clinical sites. Other federal laws given general guidance. Thus "federal laws and regulations" is the correction terminology to include all provisions followed by researchers to ensure patient protection.

Information that is coded and encrypted is not truly anonymous - the encryption code or key and be used to identify the patient in situations where the patients is in danger or when the patient's physician believes it is necessary. This amendment in (b) more clearly exempts the type of information that should be exempted, without mis-characterizing it as anonymous.

Page 7, line 14:

AFTER: "person"
INSERT: ";
(5) such disclosure is required by law.

RATIONALE: This would cover such items as court orders to disclose.

8/8

1-LS0472\N.1
Ford
3/31/00

AMENDMENT

OFFERED IN THE HOUSE BY REPRESENTATIVE ROKEBERG

TO: CSHB 211( ), Draft Version "N"

Page 4, line 11, following "decision":

Insert "(A)"

Page 4, line 12, following "received;":

Insert "and

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

Page 4, line 17, following "shall":

Insert "(A)"

Page 4, line 18, following "appeal;":

Insert "and

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

1-LS0472\N.2
Ford
3/31/00

AMENDMENT

OFFERED IN THE HOUSE BY REPRESENTATIVE ROKEBERG

TO: CSHB 211( ), Draft Version "N"

Page 3, following line 18:

Insert a new paragraph to read:

"(1) a provision that defines "medical necessity"; unless the plan sets out a different definition, "medical necessity" shall be defined as meaning those health care services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease, or its symptoms in a manner that is

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

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

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

Renumber the following paragraphs accordingly.

Page 4, line 10:

Delete "(6)"

Insert "(7)"

Rokeberg A

AMENDMENT #_____

OFFERED IN THE HOUSE By: Rep. Rokeberg

TO: CSHB 201 (), LS0472/N, Ford, 3/30/00

Page 3, line 8

AFTER: "provider to"
DELETE: "purchase or use"
INSERT: "contract for"

RATIONALE: The provider does not purchase or use the product; the patient does. The provider, therefore, contracts for the products.

Page 3, line 9:

AFTER: "entity"

INSERT: unless these products have equal rates of provider compensation.

RATIONALE: Requested by Blue Cross. Allows access to products that provider may want.

Page 3, line 15:

AFTER: "entity"

INSERT: "for the acts of the managed care entity"

RATIONALE: As written, the language would prohibit the standard clauses in which the provider indemnifies the entity for the provider's bad acts and the entity indemnifies the provider for the entity's bad acts. New language would make it clear that contract could not include a provision where the provider would hold the entity harmless for the entity's bad act.

Rokeberg B

AMENDMENT _____

OFFERED IN THE HOUSE By: Rokeberg

TO: CSHB 211 (), LS0472/N, Ford, 3/30/00

Page 3, line 25:

AFTER: "referrals"

INSERT: ", if required,"

RATIONALE: Some plans do not require a patient to receive referrals. The current language would mandate that a plan must have a referral system. If a plan does not have a referral system, there should be no mandate to put one in place.