


ALASKA LEGISLATURE COMMITTEE FILES 1999-2000 8672

9938 HOUSE LABOR & COMMERCE

Mike Tauriainen, P.E., Consulting Engineers, Inc.

35186 Spur Hwy, Soldotna, Alaska 99889 (907) 262-4824 Fax 262-5777 mtpentl@alaska.net

FAX MEMO

Date: 18 February 2000
To: Representative Norm Rokeberg, Chair Fax: 465-2040
Members, House Labor & Commerce Committee
From: Mike Tauriainen 
Subject: HB 207 Licensing of House Inspectors
1 page + Attachment

I am opposed to HB 207 because no compelling reason has been advanced to support licensing house inspectors. Rather, HB 207 would be counterproductive because it would:

1. limit competition,
2. increase the cost of services to consumers,
3. increase cost of state government, and
4. increase regulation.

The proposed law, as written and if passed, initially will be as simple as it will ever be - the law and subsequent regulations will grow more voluminous, more complex, and more onerous. It would seem that with good people, good intentions, and hard work, that the regulatory process would result in fair and simple regulations - but it ain't necessarily so; I've been there, done that and like Brer Rabbit and Tar Baby - sometimes the more you try the worse it gets.

A primary motivation for licensing any occupation seems to be economic protection for select practitioners of that trade. However, the only legitimate reason for the State to license an occupation is to protect public safety, health and property. I am not aware of incompetent or negligent practice that has been alleged that would be best remedied by licensing.

I urge you to oppose these proposed restrictions to Alaska's market economy that would benefit only a few. Attached is testimony I presented to your committee 21 Oct 99.

END OF FAX TEXT

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18 February 2000
Fax

Mike Tauriainen, P.E.
Consulting Engineers, Inc

TESTIMONY ON HB 207

Mike Tauriainen, PE (35186 Spur Hwy. Soldotna, AK 99669) presented the following testimony at the 21 Oct 99 House Commerce Committee Public Hearing in Anchorage.

Background

BS Civil Engineering 1967, MS Arctic Engineering 1972
Consulting Civil Engineering Practice 1978 - Present
Served seven years on State Board of Architects, Engineers and Land Surveyors
Have performed house and commercial building inspections for over 20 years

I am opposed to HB 207. Licensing of house inspectors would assure four things.

1. Reduced competition
2. Increased inspection fees
3. Increased state budget
4. Forever increasing regulations.

The market is a great system for assuring competence and weeding out incompetence. The system is not perfect and never will be. However, people in the housing industry concerned with house inspections (bankers, realtors, etc.) are very capable of determining who is competent or incompetent to perform inspections. Also, several home inspection organizations have entered the market that improve the market by providing education and business practice advice for their members.

Licensing will not prevent incompetence and fraud. As an example, consider the ADEC septic system certified installers program. We have good installers and not good installers; most who stand by their work and a few who cheat; a few who cut too many corners and most who don't, a few frauds but most honest. It's the same in any line of work including the housing inspection trade. Laws and contracts currently provide for holding incompetent and fraudulent people accountable.

Licensing, while setting a minimum standard, impedes raising the standard of performance. A free market slowly but continually raises the bar.

Over the past 20 years many people have entered the market and my firm's share of the market has decreased. That's OK, that's competition; I'm forced to improve my services, and keep my fees lower than if competition was restricted. Right now, without licensing, competent house inspectors abound.

In summary, licensing would result in:

- gate keeping and reduced competition
- slower improvement of services
- higher costs
- more regulation.

The market system is working and doesn't need fixing.

Subject: HB207

Date: Thu, 17 Feb 2000 15:14:34 -0900

From: "General Offices" <mail@paratex-pp.com>

Organization: PARATEX Pied Piper Pest Control

To: <Representative_Norman_Rokeberg@legis.state.ak.us>,
 <Representative_Andrew_Halcro@legis.state.ak.us>,
 <Representative_Lisa_Murkowski@legis.state.ak.us>,
 <Representative_Tom_Brice@legis.state.ak.us>,
 <Representative_Jerry_Sanders@legis.state.ak.us>,
 <Representative_John_Harris@legis.state.ak.us>,
 <Representative_Sharon_Cissna@legis.state.ak.us>

Mr. Chairman & Esteemed Members of the House Labor & Commerce Standing Committee:

I would like to address a seemingly minor matter in regard to the proposed House Bill No. 207. First let me commend you for your show of concern for the population of Alaska in expending this effort to protect them from what could easily be a costly result of unscrupulous home inspectors. It is unfortunate that legislation is sometimes the only way to achieve fairness and honesty in our present society. I have personally examined this market, and feel that there is a place in Alaska for a quality service such as home inspection. However, I am comfortable at this time in my current business interest. That now brings me to my concern.

I am currently the Administrative Manager of a state wide pest control company. Our business by definition involves a measure of "home inspection". This may be to assess a present pest problem or to advise on pest prevention. By way of example, we may be called upon by a householder (or his representative) who is purchasing a home to inspect the property for Carpenter Ant damage and/or activity. My technicians will provide this service, advising on remedial treatments where necessary and perhaps pointing out damage which should be assessed by an engineer or other professional. Since this industry is currently well governed by the Alaska Department of Environmental Conservation, it would seem reasonable that their oversight should be satisfactory to meet the needs you are addressing as it relates to our services.

In other states which have enacted similar legislation in past years, an exemption was added for our industry. I therefore propose the following addendum to Sec 08.57.900 (EXEMPTIONS):

(5) certified as a pesticide applicator pursuant to chapter 90, title 18 of the Alaska Administrative Code and operating within the scope of his certification. (Wording similar to State of New Jersey, January 1998.)

You will be pleased to know that ADEC's enforcement meets or exceeds many of the protections that you are attempting to enact in your legislation. In addition, our company carries far more than the required minimums on insurance & bonding, etc. because we do believe in protecting the people of the State of Alaska. Should you have any questions in regard to my input, you may reach me as below.

Respectfully Submitted

Kenneth J Perry

Kenneth J (Ken) Perry	(907) 344-2538
Administrative Manager	(Fax) 344-9111
PARATEX Pied Piper Pest Control	2440 E 88th Ave., Ste. A
mail@PARATEX-PP.com	Anchorage, AK 99507

RECEIVED
FEB 17 2000

Subject: HB207

Date: Fri, 18 Feb 2000 22:55:42 +0000

From: vmeurlott@mosquiconct.com

To: Representative_Norman_Rokeberg@legis.state.ak.us

Dear Representative Norman Rokeberg and the Labor and Commerce Committee Members:

Thank you for providing the opportunity to participate in the teleconference today. Your efforts to protect the homebuyer are commendable. However, I do not believe that the bill will provide the protection desired. Instead it will raise the cost of inspections and perhaps give a false sense of security to the potential homebuyer. I am a professional civil engineer working for a municipality and also in the private sector outside where there is no authority having jurisdiction. I have performed over a thousand inspections and reports for homebuyers in the Fairbanks area over the last eight years. I am also familiar with the home buying process and inspection practices in other states.

HB 207 should be shelved for the following reasons.

1. It raises the cost of government. Setting up a board to police this area is more difficult and expensive than most people think. There is a wide range of expectations among buyers and sellers in the home market in Alaska just as there is an equally wide range of housing stock. At present you are free to select an inspector or engineer to suit your needs. The problem can be dealt with more effectively by the market and free enterprise. Good inspectors can be found through realtors and lending institutions. Homebuyers can check with the Better Business Bureau and other places to avoid bad inspectors.

2. The program would be difficult to administer. I support the existing voluntary AHFC program for inspection on new residences even though it is flawed for a lack of required consideration of soils and engineering. The AHFC program is a start in the right direction and has raised the quality of home construction in Alaska, but my experience with the program shows that they lack direction in interpretation and enforcement when the "rules" are clear as stated in the most recent addition of the code. The codes change every three years and many "problems" identified in existing construction can be very subjective.

The problem with the majority of the housing stock in Alaska is the lack of enforcement of Building, Electrical, Mechanical and Plumbing Codes in residential construction outside of cities or municipalities. Other states start by adopting and enforcing the codes during the construction process. Work on the cause not the symptom. Inspection of residences inside cities or municipalities where codes are enforced is less problematic. Most of them have been built to reasonable standards and municipal inspectors can be hired to ascertain the condition of the home.

I have accompanied other municipal and private inspectors performing their duties to learn and monitor their methods of inspection and report writing. I also served as the President of the Northern chapter of the International Conference of Building Officials (ICBO) which gave me opportunities to discover the residential housing inspection practices employed by many Building Officials on the western half of the United States. My parents sell real estate in Oregon and I talk with them frequently about the inspection process used there.

In the lower 48 private home inspectors are almost always inspecting housing stock that has been constructed under the watchful eye of a jurisdiction that

enforces the codes. Therefore, the construction is usually safe, sound and sanitary from the outset. The private home inspector in the lower 48 is primarily there to ascertain that the house has been properly maintained and that the appliances function properly. Items on their "check list" include checking for termites and carpenter ants, maintenance of finishes and electrical devices such as smoke detectors and GFCIs. They even serve as "insurance agents" to provide a warranty for the existing appliances for another small fee.

Please contrast the lower 48 with construction in Alaska. We are part of the last frontier. That mentality breeds ingenuity, creativity and use of a wide variety of construction materials/methods not approved by the mainstream. Sometimes this is good, but in many instances the construction is not safe. Often we are confronted with substandard construction with regard to the major components. We deal with expansive soils, permafrost, foundations that are not properly reinforced, improperly constructed foundations of wood and roofs that are not designed or constructed for our snow load on a regular basis. Proper evaluation and design of remedies for these problems and many more we encounter should be performed by an engineer if permanent solution is sought rather than a Band-Aid.

3. The public may be given a false sense of security that "licensed" home inspectors can properly find all the problem areas simply because they have a license. This bill seems to create credentials for those who can pass a test as a substitute for experience and reputation. I am ICBO certified as a Plans Examiner, Building Inspector, Combination Inspector, Electrical Inspector, Fire Inspector, Mechanical Inspector and Plumbing Inspector through the testing process. I have seen many individuals pass the written exam but still be incompetent as an inspector that can properly identify construction problems and specify a practical solution. It is experience and engineering that make the difference.

4. The cost of inspections will go up due to licensure and insurance requirements. Subjective areas will be more likely be contested for settlement under E and O insurance claims simply because they have insurance. Many people coming from the lower 48 think that the homes they are buying are constructed and inspected per code. More emphasis should be places on the education process of buyers and disclosure laws to inform the buyers of homes.

5. Qualifications of the inspector according to the proposed bill includes showing competence in arctic structural and thermal construction techniques. This is most effectively done through the existing AELS registration board. Professional Engineers have demonstrated the competence desired through rigorous testing and completion of coursework in Arctic Engineering which also covers thermal considerations. The scope of work for engineers includes investigation, identification and providing a remedy for the problems most homeowners are most concerned about.

6. Underqualified home inspectors without training in engineering often cannot properly identify problem areas or do not understand the processes/modes of failure for the construction materials used. The result may be a failure to identify a significant structural problems or geologic hazards. This is the primary service the inspector is hired to provide.

7. Underqualified home inspectors without training in engineering often cannot prescribe a complete or cost effective remedy for problems they may identify because to do so involves the services of an engineer. They cannot specify a repair because it is beyond their scope of expertise. Therefore, the unqualified inspector has two difficult choices:

a. Try to provide a service without the proper qualifications.

-or-

b. Insist that the buyer hire an engineer at additional expense.

Neither choice is palatable. Engineering judgment is required to remedy some of the problems in most of the houses under consideration.

In summary: this legislation will raise the cost of home inspections, raise the cost of government to monitor inspectors, encourage less qualified inspectors to perform work beyond their capabilities relying on their insurance to cover their mistakes. Please rely on the existing licenses and registration of engineers to perform the services desired. The homebuyer or public will not be well served by this legislation.

Thank you for your time and work in this area. Please feel free to contact me for clarifications or questions or if I can be of service. I am eager to hear your concerns and will attempt to provide my insight to the process under consideration.

Sincerely,

Vince Meurlott
596 Arvita Court
Fairbanks, AK 99712

Ph: 456-2722

Subject: HB207 for 3:15 Hearing

Date: Fri, 18 Feb 2000 13:45:21 -0900

From: "Charlie Jeannot" <buildfbks@mosquitonet.com>

To: "Representative Murkowski" <Representative_Lisa_Murkowski@legis.state.ak.us>, "Representative Rokeberg" <Representative_Norman_Rokeberg@legis.state.ak.us>, "Representative Sanders" <Representative_Jerry_Sanders@legis.state.ak.us>, "Representative Halcro" <Representative_Andrew_Halcro@legis.state.ak.us>, "Representative Harris" <Representative_John_Harris@legis.state.ak.us>, "Representative Cissna" <Representative_Sharon_Cissna@legis.state.ak.us>, "Representative Brice" <Representative_Tom_Brice@legis.state.ak.us>

Dear Representative Rokeberg,

I am a registered professional engineer (civil) and have conducted many thousand inspections of both new and existing homes in my 16 years as a government and private sector inspector. I was certified by ICBO as an Inspector long before your legislation created AHFC's current inspection program for new construction. I am a firm believer in the adoption and enforcement of codes for new construction and have been a solid backer of the legislation initiated in 1992 which created the ICBO inspection program. However, as I understand HB207, it is your intent to create an entirely new program through the licensure of home inspectors targeting existing homes. I am writing to express my grave concern regarding this bill and the affect it will have on several economic and practical aspects with which I am familiar. I have briefly enumerated some of my concerns below.

Currently most inspections of existing homes affected by this bill are conducted by experienced professional engineers and based upon an intentionally subjective "safe, sound and sanitary" standard. This unwritten standard has served AHFC well for many years and varies somewhat from home to home. Homes built in outlying areas, without the benefit of any former application of code, must be evaluated differently than homes recently constructed within organized municipalities. An under-experienced, "add-water-instant-inspector" (my term) created as a result of passing a written test can inappropriately devalue and permanently "tattoo" a home by means of applying unrealistic standards to an older or unusually constructed home. I have personally spent many hours attempting to defuse the allegations made by an inexperienced, inspector who has attempted to impress the home buyer with his checklist results. Because of the current disclosure laws, once identified, these deficiencies may never go away, and may be not be correctable in a practical manner. This dilemma creates a major hardship for all parties and is likewise difficult for loan underwriters to deal with.

Current licensing provisions governed by the Board of Architects, Engineers and Land Surveyors prohibit non-engineers or architects from designing a fix or repair to the deficiencies identified during an inspection. My experience is that the majority of the inspections involving existing homes require repairs. Even though your bill suggests that these "instant-inspectors" will recommend that experts be retained to address defects, I am confident that they will be pressured to get around this loosely worded language so as to avoid the cost of a second inspection by an engineer. **If**, the "instant-inspector" truly complies with the intent of your bill and current licensing provisions, then the cost of the typical inspection will approximately double.

Unlike the 1992 legislation pertaining to ICBO inspection of new residential construction, which exempts the inspector from liability, HB207 wrongly requires that the inspector have a deep pocket, via minimum insurance requirements. At the same time, it will result in the development of a checklist for which the inspector must bare responsibility. Aside from the fact that it is unusual for the state to mandate of insurance for any particular license holder doing a certain type of work, it is

likewise improper to hold the inspector responsible for items on checklist to be developed by the Board of Home Inspectors. An engineer cannot protect the interests of his client by simply comparing the home to a government generated checklist.

As a licensed, registered, professional engineer, I am already held to a higher standard of responsibility and thereby afforded the option to exercise "engineering judgment" in the formulation of "alternate methods and materials" to accomplish the intent of the Uniform Codes adopted by the State. Likewise, I am also required to evaluate and note additional issues of safety that may not correspond to any checklist. A checklist of any form, will unnecessarily tie the hands of the professional engineer who by his training and code of ethics is already bound to comply with safety provisions. It will also tie his hands with regard to being able to remedy problems discovered in outlying residential properties.

Unlike the application of codes for new construction, subjectivity is an inherent part of inspecting existing homes in outlying areas. A common complaint amidst inexperienced inspectors is that they want a checklist. However, an effort to standardize inspection criteria by means of a prescriptive method will bring the real estate and finance industry to its knees with lists of potentially petty defects. Realtors can tell you that this is not uncommon and I suspect that most of them would never let one of these "add-water-instant-inspectors" into their home. There is no substitute for experience and training, and I fear that the promoters of this bill are making inroads to circumvent this basic principle. My practice is to look at each home individually, based upon the year in which it was constructed and its location. There are many code and non-code related deficiencies that may be applied differently depending upon the conditions at hand. For instance, I cannot in good conscience require a crawl space ground vapor barrier on a home built prior this being a code requirement, when the structure clearly does not have a ground moisture problem. There are endless similar examples.

AHFC has taken a position of support in concept of this bill - "as long as it doesn't compromise affordability." Clearly it does, and the ramifications are many. (1) There is a cost for insurance and the additional liability associated with a prescriptive type of inspection. (2) This bill implies that there will be two inspections, one involving the government sanctioned, "instant-inspector" and the second involving the engineer who must prescribe the necessary repairs. (3) The largest expense will be in the cost of repairs. Under the new provisions, I would estimate the average cost of repairs to approach two to three times that which is typical under current conditions. In summary, the home buyer will pay more for the inspection; the home seller will pay much more for the repairs; the bureaucracy between the lenders, underwriters, realtors and attorneys will likely become staggering and no doubt cost significantly more. As well, the time required to close on a loan will likely be drug out substantially and there will certainly be more litigation involving inexperienced, deep pocketed inspectors.

I find it hard to see where this bill will offer better protection to Alaskan homeowners or buyers. It will create a niche for someone who lacks the experience and credentials to make it in the current market place. However, the additional cost, as well as, the potential for significant delay and the possibility of permanent "tattoos" to the home make this bill quite ominous. If AHFC or others have a problem with the current system, lets talk. But I am not convinced that the self-imposed system operated by the private sector is broke. So I ask, what are we're trying to fix with HB207.

Sincerely,

Charles P. Jeannet, P.E.
599 Arvita Ct
Fairbanks, AK 99712

HB

208

(7)

HOUSE COMMITTEE REPORT

Date Referred to Committee: April 27, 1999

FURTHER REFERRALS:

Date of Committee Action: APRIL 28, 1999

The LABOR AND COMMERCE Committee considered:

HB 208

HOUSE BILL NO. 208

PROFESSIONAL COUNSELORS

"An Act relating to professional counselors; and providing for an effective date."

recommends it be replaced with the following committee substitute _____ the same title a new title

additional referral to _____ Committee
 attached amendment(s)

ADOPTS: _____ Letter of Intent

ATTACHES NEW FISCAL NOTE(S): _____ (Dept)

APPROVES PREVIOUS: _____ (Dept/Date)

fiscal note(s) _____

fiscal note(s) _____

zero fiscal note(s) DCED

zero fiscal note(s) _____

SIGNING WITH RECOMMENDATIONS	DP	DNP	NR	AM
<i>Nan Kelly</i>	✓			
<i>[Signature]</i>	✓			
<i>[Signature]</i>	✓			
<i>[Signature]</i>	✓			
<i>[Signature]</i>	✓			

CHAIR'S SIGNATURE *Nan Kelly*

4-28-99

Interim
716 W. 4th Avenue
Anchorage, AK 99501
Phone: 907-269-0174
Fax: 907-269-0177



Session
State Capitol Bldg., Suite 406
Juneau, AK 99801
Phone: 907-465-3783
Fax: 907-465-2293

REPRESENTATIVE LISA MURKOWSKI
GOVERNMENT HILL • ELMENDORF • EAST ANCHORAGE

**Sponsor Statement
House Bill 208**

"An act relating to professional counselors."

In 1998, the 20th Legislature created statutes establishing a board and license for professional counselors in Alaska. The intent of the statutes was essentially twofold: 1. To create a Board which would oversee activities relating to professional counselors; and 2. To create a requirement of appropriate, quality education and experience for professional counselors seeking licensure. However, key language defining both the authority of the Board and "appropriate, quality education and experience" for professional counselors was inadvertently left out of the original statutes.

In addition to addressing the above omissions, HB 208 also allows for three other housekeeping provisions. Specifically it:

- adds to the list of health professionals allowed to supervise professional counselors;
- adds professional counselors to the Centralized Licensing Statutes section regarding the use of the letters "LPC" after a licensed professional's name; and
- extends the deadline by six months for current, eligible professional counselors to be "grandfathered" in without having to undergo the supervisory and testing requirements currently required for new entrants into the profession.

This bill strengthens the original statutes for both the public and the profession, and consequently enjoys the support of the Board of Licensed Professional Counselors and the American Counseling Association of Alaska.

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

130 Seward Street, Suite 409
Juneau, Alaska 99801-2105

MEMORANDUM

April 20, 1999

SUBJECT: Sectional Summary of Work Order No. 21-LS0828\A. (Professional Counselors)

TO: Representative Lisa Murkowski
Attn: Anne

FROM: Terri Lauterbach
Legislative Counsel *T Lauterbach*

You have requested a sectional summary of the above-described bill.

As a preliminary matter, please note that a sectional summary of a bill should not be considered an authoritative interpretation of the bill and the bill itself is the best statement of its contents.

You have not asked any questions about the legal effects of the bill, so this summary is very brief. If you would like an interpretation of the bill as it may apply to a particular set of circumstances, let me know.

Section 1. Adds counselors to the list of persons who are required to use appropriate letters or a title after the person's name to represent the person's field of practice.

Section 2. Clarifies the board's power to adopt regulations and enforce AS 08.29.

Section 3. Amends the qualifications for counselor licensing.

Section 4. Expands the list of persons who would be suitable supervisors.

Section 5. Changes provisions relating to transitional licensing.

Section 6. Applicability section.

Section 7. Special immediate effective date for sections 2 - 6. Section 1 will take effect 90 days after the bill becomes law.

TML:glc
99-197.glc

STATE OF ALASKA

DEPARTMENT OF COMMERCE AND ECONOMIC DEVELOPMENT

DIVISION OF OCCUPATIONAL LICENSING

TONY KNOWLES, GOVERNOR

P.O. BOX 110806
JUNEAU, ALASKA 99811-0806
PHONE: (907) 465-2534
FAX: (907) 465-2974
TDD: (907) 465-5437

E-mail address:
License@commerce.state.ak.us

March 30, 1999

Ms. Anne Henry
5750 Glacier Hwy D-10
Juneau, AK 99801

Dear Ms. Henry,

Thank you for discussing with me the statute changes proposed by the Board of Professional Counselors. It appears the proposed changes would strengthen the law and I anticipate zero fiscal impact on the Division of Occupational Licensing.

Sincerely,



Catherine Reardon
Director



Homer High School

Kenai Peninsula Borough School District
Richard Farton, Principal
Keith Gebhardt, Assistant Principal
David Cloud, Athletic Director

COUNSELING FAX COVERSHEET

DATE: 4/26/99

TO: Lisa Markowski

FAX # 465 2293
FROM: Samie Bullentine

SUBJECT: HB 208

NUMBER OF PAGES INCLUDING COVER 1

COMMENTS: I am very in favor of
HB 208 we need this legislation
to help counseling in the state

* COUNSELING FAX NUMBER (907) 235-4604 *

600 E. Fairview Avenue, Homer, AK 99603-7661 Phone: (907) 235-8186 Fax: (907) 235-8933
Web Site: www2.kpbsd.k12.ak.us/schools/hhs/main/main.htm



Homer High School

Kenai Peninsula Borough School District
Richard Patton, Principal
Keith Gebhardt, Assistant Principal
David Cloud, Athletic Director

COUNSELING FAX COVERSHEET

DATE: 4/26/99

TO: Lisa Muckowski

FROM: Shawnie Olson
FAX # 465-~~3783~~ 2293

SUBJECT: HB208

NUMBER OF PAGES INCLUDING COVER 1

COMMENTS: I am a counselor very in favor
of HB208. We need people in this state who
are trained to deal with emotional illness in a
counseling capacity.

* **COUNSELING FAX NUMBER (907) 235-4604** *

600 E. Fairview Avenue, Homer, AK 99603-7661 Phone:(907)235-8186 Fax:(907)235-8933
Web Site: www2.kpbsd.k12.ak.us/schools/hhs/main/main.htm



of ALASKA

A Branch of the American Counseling Association

Pamela Watts
3290 Nowell Avenue
Juneau, Alaska 99801
W: (907) 463-7095

April 26, 1999

Representative Lisa Murkowski
Alaska State Capital Building
Juneau, Alaska 99801

Dear Rep. Murkowski:

As Past-President of the American Counseling Association of Alaska, I am writing to ask your support of House Bill 208. Our organization was instrumental in the passage of the Licensed Professional Counselor bill.

- Our intention was that applicants for licensure have two years post-graduate counseling experience to be eligible for licensure,
- Graduate from a regionally accredited university, and
- Have a one-year timeframe within which they could apply for grandparenting licensure.

Since the LPC Board was not appointed by the date originally anticipated, unless the deadline is extended to June 30, 2000 many potential applicants will not be eligible for licensure. In some other states, the grandparenting-in phases spans two or more years.

I believe licensure of professional counselors is critical for consumers of counseling services so they can be assured that a Licensed Professional Counselor has met at least minimum requirements in order to practice. This provides a degree of consumer protection, in addition to having a board that accepts grievances and has the power to revoke licenses if licensees fail to adhere to licensing and ethical standards. As a Client Supervisor and Administrator of a program employing counselors, I can assure you that establishing and maintaining high standards for those who practice in the field of counseling is good for Alaskans. I encourage you to give this legislation high priority and your full support. Thank you for your efforts.

Sincerely,

A handwritten signature in cursive script that reads 'Pamela L. Watts'.

Pamela L. Watts, M.Coun., M.A.C., N.C.C.
Past-President, American Counseling Assn. Of Alaska



NORTON SOUND
HEALTH CORPORATION

P.O. BOX 966
NOME, ALASKA 99762
(907) 443-3311

4/27/99

Representative Lisa Murkowski

Dear Rep. Murkowski,

This is to let you know that I support HB 208.

I am a Counselor in Nome and feel strongly that this bill needs to be passed for many reasons — consumer protection, greater availability of behavioral health services in remote regions, reduced licensure costs to qualified applicants — and there's no fiscal note attached.

Please support HB 208, a basic housekeeping bill.

Thank you,

Joni Christman, MS, LPC, NCC

P.O. Box 1802

Nome, AK 99762

(907) 443-3354

ANNE L. HENRY, M.A., C.H.T.
5750 Glacier Hwy., Bldg. D, Rm. 12, Box 10
Juneau, AK 99801
Telephone: (907) 780-6345

April 26, 1999

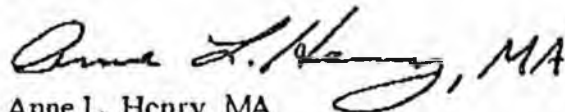
Dear Representative Murkowski:

At the March 25-26, 1999 meeting of the regulatory Board of Licensed Professional Counselors necessary changes to the statutes were discussed. These necessary changes deal with the powers of the Board, the original intent of the statutes to license well qualified professional counselors, and the protection of Alaskan consumers. HB 208 addresses these concerns by making changes to the statutes regarding the Board, and Licensed Professional Counselors.

The Board of Licensed Professional Counselors urges passage of HB 208.

Thank you for your assistance in the passage of this bill.

Sincerely,



Anne L. Henry, MA
LPC Board Chair

Subject: HB 208

Date: Tue, 27 Apr 1999 10:26:46 -0900

From: ffaami@aurora.uaf.edu (Allan Morotti)

To: Anne_Gore@legis.state.ak.us

Dear Anne,

I understand that you are assisting ACA of Alaska and the current LPC Board with rectifying some minor oversights in the original LPC Act. As a member of the LPC Board and a counselor educator (Guidance & Counseling Program--UAF), I strongly support the proposed amendments. Protection of the public is a critical factor when seeking mental health services, these amendments spell out more clearly the original intent of the LPC legislation which was to identify and license appropriately trained counseling professionals in providing mental health services to the Alaska public.

I want to thank you for your work on this issue and Rep. Murkowski for her sponsorship of HB 208. Please contact me at your convenience if I can be of any assistance to you in seeing this matter to fruition.

Sincerely,

Allan Morotti, Ph.D.

LPC Board Member

Subject: HB 208

Date: Tue, 27 Apr 1999 06:40:40 +0000

From: fganger@servcom.com (Frank Ganger, Jr.)

To: Anne_Gore@legis.state.ak.us

The Honorable Rep. Lisa Murkowski,

Please give your support to HB 208, it is a no cost (to the State) bill that will help consumers of counseling services.

Thank you,

Frank Ganger Jr.

Southcentral Counseling Center

Anchorage, AK

562-7900

Subject: RE: ????

Date: Tue, 27 Apr 1999 08:01:29 -0800

From: Florence Pearson <flo@alaska.net>

To: "Anne_Gore@legis.state.ak.us" <Anne_Gore@legis.state.ak.us>

Good Morning,

I am a counselor and support HB208. I was a counselor for 9 years in the Anchorage School District and now have my own consulting/counseling business. I would like to see this bill passed. Thank you. Flo Pearson

-----Original Message-----

From: winktas [SMTP:winktas@alaska.net]
 Sent: Monday, April 26, 1999 9:03 AM
 To: plotsaas@alaska.net; melbob@alaska.net; ffaam1@aurora.alaska.edu; counselor@wytbear.com; aflwk@uaa.alaska.edu; ddonalds@ptialaska.net; wintyre@ptialaska.net; nemo@alaska.net; taffy_wells@cfec.state.ak.us; Mary.Miller@ccsjuneau.com; lgooding@polarnet.com; lmattiso@health.state.ak.us; dihlel@jsd.k12.ak.us; ljhelgeson@aol.com; borealblis@aol.com; kmunson@lifequest.org; neel_julye@msmail.asd.k12.ak.us; JocelynWard@ccsjuneau.com; cclaak@arctic.net; fganger@servcom.com; aman@servcom.com; solso@kpbsd.k12.ak.us; CathrynMFS@aol.com; drichard@rocketmail.com; plwatts@alaska.net; winktas@alaska.net; schindlm@jsd.k12.ak.us; hammaker@mtaonline.net; gorrell@health.state.ak.us; gary_clement@mail.ci.juneau.ak.us; mebozone@juno.com; stabach@alaska.net; jholman@kodiak.alaska.edu; CClarkeAK@aol.com; Karen_Backlund@ajcn.state.ak.us; Rock_Bronyraur@labor.state.ak.us; counsel@polarnet.com; franks@nshcorp.org; FourRiversMH@prodigy.com; lhcphd@ptialaska.net; mallard1@mtaonline.net; chrestman@nshcorp.org; rbutts@teller.bssd.schoolzone.net; afpms@uaa.alaska.edu; karac_bronyraur@labor.state.ak.us; franks@nshcorp.org; janowiec@ptialaska.net; mhaa@alaska.net; 4Bears@alaska.net; mblinsenmeyer@hotmail.com; mccaslak@jsd.k12.ak.us; randi@alaska.net; shellyws@ptialaska.net; lvorachek@kodiak.alaska.edu; lamp@mtaonline.net; taylor@servcom.com; cflegel@hsmail.hbsd.k12.ak.us; mmaxson@stikheen.alaska.ihs.gov; tschenck@ptialaska.net; mcmullen@alaska.net; burbridge_mike@msmail.asd.k12.ak.us; bnrll@aurora.alaska.edu; lillevik@alaska.net; jsimpson@northstar.k12.ak.us; oesting_susan@msmail.asd.k12.ak.us; vprichard@arctic.nsbds.k12.ak.us; cdanitz@educ.state.ak.us; churchl@seapac.net; jensen@seattleu.edu; eat7@alaska.net; pat_knopf@labor.state.ak.us; dona@alaska.net; sandra_mironov@mail.ykhc.org; amoma@customcpu.com; mmaxson@stikheen.alsaka.ihs.gov; tomanos@ptialaska.net; Book@ptialaska.net; dmeans@kodiak.alaska.edu; jvrg@sinbad.net; shellyws@ptialaska.net; randi@alaska.net; mommaluna@yahoo.com; carey@alaskasarctic.com; beachrd@wytbear.com; dunegan@hotmail.com; vademming@mosquitonet.com; counsel@polarnet.com; lgarcia57@hotmail.com; fskrb@uaf.edu; rroberts@brevig.bssd.schoolzone.net; taylor@servcom.com; cenglish@alaska.net; dish@alaska.net; tomanos@ptialaska.net; hartley_robert@msmail.asd.k12.ak.us; annep@alaska.net; cenglish@alaska.net; ALSmith@comregaf.state.ak.us; ipray4u@alaska.net; lomelina@mtaonline.net; candc@alaska.net; alexander_jennifer@msmail.asd.k12.ak.us; burbridge_mike@msmail.asd.k12.ak.us; comeau_car; fawcett_jenny@msmail.asd.k12.ak.us; hubble_teresa@msmail.asd.k12.ak.us; kent_brandy@msmail.asd.k12.ak.us; morgan_betty@msmail.asd.k12.ak.us; ortiz_kathleen@msmail.asd.k12.ak.us; solano_dolores@msmail.asd.k12.ak.us; thorson_gloria@msmail.asd.k12.ak.us; wilson_allison@msmail.asd.k12.ak.us; Zimmer#u#James@msmail.asd.k12.ak.us; mhaa@alaska.net; semerson@health.state.ak.us; flo@alaska.net

Subject: ????

Did anyone send an e-mail or fax to Lisa Murkowski's office? I just talked to her and she has not received anything from anyone but me. So, please send her something right away.

Anne_Gore@legis.state.ak.us
FAX 465-3783

Subject: HB208

Date: Mon, 26 Apr 1999 15:09:48 -0900

From: Lynnette Dihle <dihlel@jsd.k12.ak.us>

To: Anne_Gore@legis.state.ak.us

Dear Anne Gore,

I am a mental health professional/school counselor and I strongly support HB208. Thank you for your work in regard to this bill.

Sincerely,

Lynnette Dihle

Subject: HB208

Date: Mon, 26 Apr 1999 18:16:27 EDT

From: CathrynMFS@aol.com

To: Anne_Gore@legis.state.ak.us

April 26, 1999

Dear Representative Murkowski:

I am a professional counselor writing in support of HB208. It is very important for Alaskans to have a working counselor licensure bill. The initial legislation for this, as you know, was passed last year. But some important details need to be addressed before Alaska's Licensure bill meets the standards set by the rest of the nation. HB208 will fill in the missing peices so that licensure can proceed in a timely and professional manner. Please support this bill and speed its progress through the legislature. I appreciate your time and energy in attending to this.

Sincerely,

Cathryn Simon, N.C.C.
12320 Tracy Rd., Apt. A
Anchorage, AK 99516

Subject: Yes on HB208 "LPC"

Date: Mon, 26 Apr 1999 14:16 -0900

From: "Gary Clement" <Gary_Clement@mail.ci.juneau.ak.us>

To: "Anne_Gore@legis.state.ak.us" <Anne_Gore@legis.state.ak.us>

I am a counselor at CBJ mental health. Passing HB208 will help several of the mental health clinicians here to continue our professional practice and give better service to this agency and its customers.

Thank you for supporting HB208 (Licensed professional counselor).

Gary D. Clement MS, MPA, NCC, CCDC, CRC
Mental Health Clinician
463-7053 work

Subject: HB 208

Date: Mon, 26 Apr 1999 10:56:39 -0800

From: "Debra Lighthart" <Lamp@mtaonline.net>

Reply-To: "Debra Lighthart" <Lamp@pop.mtaonline.net>

To: <Anne_Gore@legis.state.ak.us>

Anne, I am a counselor in Wasilla Ak who was trained specifically for Licensed Professional Counselor. I send you this email in support of HB208. We have been having trouble with our email server. It took me 4 tries to connect today. Again I am in support of HB208. Debra Lighthart, PhD.

Subject: HB 208

Date: Mon, 26 Apr 1999 09:17:18 -0800

From: "Emerson, Steve E" <Steve_Emerson@health.state.ak.us>

To: Anne_Gore@legis.state.ak.us

Hello... this is to voice my support for HB208. As Regional Coordinator for Community Mental Health Services in the Northern Region I witness on a daily basis the shortage of licensed therapists to whom people can turn for services. By approving the passage of HB 208, and ensuring the subsequent LPC licensure for those qualified individuals applying, the State of Alaska would greatly increase the availability of professional therapists and counselors for it's citizens. This would really be of great benefit to those Alaskans living in remote sites, as well as to those in the urban centers. Please consider this bill as a hugely positive step for the state, and for the mental health of it's citizenry. Thanks, Steve Emerson

Subject: HB208

Date: 26 Apr 1999 10:09:28 -0800

From: "Kent_Brandy" <kent_brandy@msmail.asd.k12.ak.us>

To: "Anne Gore" <Anne_Gore@legis.state.ak.us>

Hi Anne,

My name is Brandy Kent. I'm an elementary school counselor in the Anchorage School District. I just want to take the time to let you know I support HB208 and appreciate all your efforts in getting this bill approved. I believe the benefits would be enourmous.....

Thank you. Brandy

Subject: HB 208

Date: Mon, 26 Apr 1999 10:34:11 -0900

From: sojourner <cenglish@alaska.net>

To: Lisa Murkowski <Anne_Gore@legis.state.ak.us>

I am a clinician at Southcentral Counseling Center. I am writing to express my support of HB208. Thank you for supporting this important bill that will help to ensure quality mental health services for the state of Alaska.

Christopher English
3500 E 66th Ave.
Anchorage, AK 99507



LLOYD H. CARY, Ph.D.

265 Binkley Street

PO Box 957

Soldotna, Alaska 99669

Telephone: (907) 262-0608

April 27, 1999

Lisa Murkowski

Attn. Ann Gore

I am writing to you to thank you for your support of HB 208. I believe this is a crucial bill for the advancement of the counseling profession. I am a Clinical Pastoral Counselor licensed by the National Christian Counseling Association. I am not able to get a State of Alaska license. I have been in private practice since July of 1993. I have a Ph.D. in Pastoral Counseling. Not having a state of Alaska license hinders my effectiveness in many areas but primarily with testimony in the court system and in getting third party payments which are an important aspect of support for private practitioners.

I encourage you to strongly continue support of this bill and do all you can to move it along the legislative process. It is primarily a housekeeping bill, with no known opponents. It basically repairs some simple problems.

It also extends the original statutes drive toward consumer protection, by requiring tighter standards for licensees. If it does not pass this session, it simply prolongs the possibility of unqualified counselors continuing to practice unhindered.

If I can assist in any way please contact me.

Sincerely,

Lloyd H. Cary Ph.D
Clinical Pastoral Counselor

Subject: HB-208

Date: Wed, 28 Apr 99 06:05:49 -0700

From: Donaldson <ddonalds@ptialaska.net>

To: "Rep. Rokeberg" <Representative_Norman_Rokeberg@legis.state.ak.us>

Representative Rokeberg,

Thank you for your support of HB-208. I am a potential licenced professional counselor, looking forward to applying for licensure in the near future. I appreciate your efforts to help us get our "housekeeping" bill through the Labor and Commerce Committee, and onto the House floor for a vote.

Sincerely,
Sally Donaldson
Juneau

APR 28 1999



Working for
Alaska's
Mental
Health

APR 28 1999

Mental Health Association in Alaska

aka Alaska Mental Health Association

4045 Lake Otis Parkway, Suite 209 • Anchorage, Alaska 99508 (907) 563-0880
• Fax (907) 563-0881 • Email <mhaa@alaska.net>
Website <<http://www.alaska.net/~mhaa/>>

April 27, 1999

Members of the HOUSE LABOR & COMMERCE COMMITTEE

Re: House Bill 208

Dear Representatives

Rokeberg, Halcro, Harris, Murkowski, Sanders, Brice & Cissna:

I am writing on behalf of the Alaska Mental Health Association to express our strong support for House Bill 208. This bill most certainly support's the Mental Health Association's efforts to secure licensure for professional counselors in Alaska.

Although the major issue of creating a mechanism for licensing professional counselors has been successfully completed in the last legislative session, House Bill 208 is essential in finishing that process. There is broad support for licensing professional counselors. Please move positively on House Bill 208 and lets finish the fine work that has already been completed on this issue.

Sincerely;

Janet McGillivary, M.Ed.
President & CEO

cc: Reading File

FISCAL NOTE

STATE OF ALASKA
1999 LEGISLATIVE SESSION

BILL NO. HB 208

Revision Date/Time (Note if correction) _____ Dept. Affected Commerce & Econ Dev.
 Title An Act relating to professional counselors; and BRU Occupational Licensing
 providing for an effective date. _____ Component Occupational Licensing
 Sponsor Representative Murkowski
 Requester House HESS Component Serial No. 2360

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2000	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0

CAPITAL EXPENDITURES						
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CHANGE IN REVENUES ()	0.0	0.0	0.0	0.0	0.0	0.0
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FUND SOURCE (Thousands of Dollars)

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

Estimate of any current year (FY99) cost: 0.0

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: (Attach a separate page if necessary)
 HB 208 amends requirements for licensing of professional counselors. New funds are not required to implement this bill.

Prepared by Jennifer Strickler, Administrative Manager
 Division Occupational Licensing
 Approved by Commissioner Deborah B. Sedwick
 Agency Commerce & Economic Development

Phone 465-2144
 Date/Time 4/23/99 5:21 PM
 Date 4/30/99

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HB

211

(7)

HOUSE COMMITTEE REPORT

Date Referred to Committee: April 22, 1999

FURTHER REFERRALS:

Judiciary
Finance

Date of Committee Action: March 3, 2000

The LABOR AND COMMERCE Committee considered:

HB 211

HOUSE BILL NO. 211

MANAGED HEALTH CARE INSURANCE

"An Act relating to liability for providing managed care services, to regulation of managed care insurance plans, and to patient rights and prohibited practices under health insurance; and providing for an effective date."

recommends it be replaced with the following committee substitute CSHB 211 (L+C) the same title a new title

additional referral to _____ Committee
 attached amendment(s)

ADOPTS: _____ Letter of Intent

ATTACHES NEW FISCAL NOTE(S): (Dept) _____ APPROVES PREVIOUS: (Dept/Date) _____
 fiscal note(s) _____ fiscal note(s) _____

zero fiscal note(s) DOED 3/7/00 zero fiscal note(s) _____

SIGNING WITH RECOMMENDATIONS	DP	DNP	NR	AM
<i>[Signature]</i>			<input checked="" type="checkbox"/>	
<i>[Signature]</i>			<input checked="" type="checkbox"/>	
<i>[Signature]</i>		<input checked="" type="checkbox"/>		
<i>[Signature]</i>		<input checked="" type="checkbox"/>		
<i>[Signature]</i>	<input checked="" type="checkbox"/>			

CHAIR'S SIGNATURE

[Signature]

3-3-00

FISCAL NOTE

STATE OF ALASKA
2000 LEGISLATIVE SESSION

BILL NO. CSHB 211

Revision Date/Time (Note if correction) 03/06/00 Dept. Affected Community & Economic Development
 Title An Act relating to liability for providing managed care BRU Insurance
services, to regulation of managed care insurance plans . . . Component Insurance
 Sponsor Rokeberg
 Requester (H) L&C Component No. 354

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0

CAPITAL EXPENDITURES						
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CHANGE IN REVENUES ()						
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FUND SOURCE (Thousands of Dollars)

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

Estimate of any current year (FY2000) cost: 0.0

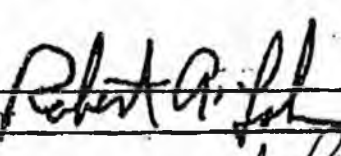
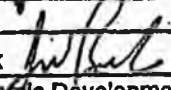
POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: (Attach a separate page if necessary)

Sec. 21.07.020, page 7, lines 8-11 require that a managed care entity provide actuarial support to the director upon request for the increased cost of using a non-network provider. It is estimated that fewer than 15 insurers have provider network provisions in their health insurance contracts. Therefore, it is anticipated that no additional resources will be needed to request and review the increased costs of non-network provider use.

Sec. 21.07.060, page 13, line 17, requires that the director approve "qualified private standard-setting organizations". It is estimated that there are currently fewer than 5 of these organizations. Therefore, it is anticipated that no additional resources will be needed for the director to certify these "qualified private standard-setting organizations". Also, it is anticipated that no additional resource will be needed to develop regulations, should they be needed, to define related party as provided on page 14, lines 20-22 of this section.

Prepared by: Robert A. Loh  Phone 269-7900
 Division Insurance Date/Time 3-7-00 9:28 AM
 Approved by Commissioner Deborah B. Sedwick  Date 3-7-00
 Agency Community & Economic Development

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Mail Stop 3101


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

MEMORANDUM

February 10, 2000

SUBJECT: Managed care - (CSHB 211(L&C))

TO: Representative Norman Rokeberg
Attn: Janet

FROM: Michael F. Ford 
Legislative Counsel

You asked two questions regarding CSHB 211(L&C). First you asked if the last sentence in sec. 21.07.030(a) covers a situation when the insured has other insurance that provides non-network coverage. The answer is yes. Second, you asked if there is a conflict between a managed care plan and a statute, which prevails. While the legislature cannot change the terms of an existing managed care plan, the legislature can dictate the terms of a managed care plan entered into or renewed after the law takes effect. So if there is a conflict between the provisions of a managed care plan and statute, the statute prevails unless the contract was in existence prior to the law taking effect. See AS 21.42.265.

Please contact me if you have further questions.

MFF:pl:glc
00-048.plm

A M E N D M E N T

OFFERED IN THE HOUSE

BY REPRESENTATIVE ROKEBERG

TO: CSHB 211(L&C), Draft Version "I"

- 1 Page 9, line 27:
- 2 Delete "director shall"
- 3 Insert "managed care entity shall provide"

- 4 Page 9, line 28:
- 5 Delete "require"

- 6 Page 9, line 31:
- 7 Delete "provide"

- 8 Page 10, line 2:
- 9 Delete "require by regulation"

- 10 Page 13, line 16:
- 11 Delete "is certified by the director as meeting"
- 12 Insert "meets"

A M E N D M E N T

OFFERED IN THE HOUSE

BY REPRESENTATIVE ROKEBERG

TO: CSHB 211(L&C), Draft Version "I"

1 Page 9, line 4, following "information.":

2 Insert "(a)"

3 Page 9, following line 7:

4 Insert a new subsection to read:

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

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

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

A M E N D M E N T

OFFERED IN THE HOUSE

TO: CSHB 211(L&C), Draft Version "I"

- 1 Page 5, lines 15 - 17:
- 2 Delete all material.

- 3 Page 13, line 20, following ",":
- 4 Insert "and"

- 5 Page 13, line 23:
- 6 Delete "; and"
- 7 Insert "."

- 8 Page 13, line 24, through page 14, line 9:
- 9 Delete all material.

- 10 Reletter the following subsections accordingly.

- 11 Page 14, line 20:
- 12 Delete "as determined under any regulations that the director may prescribe"

- 13 Page 18, following line 8:
- 14 Insert a new bill section to read:
- 15 **** Sec. 4. AS 21.36.125 is amended by adding a new paragraph to read:**
- 16 **(16) violate a provision contained in AS 21.07."**

- 17 Renumber the following bill sections accordingly.

- 1 Page 19, line 7:
- 2 Delete "sec. 6"
- 3 Insert "sec. 7"



Sec. 21.36.125. Unfair claim settlement practices.

A person may not commit or engage in with such frequency as to indicate a practice any of the following acts or practices:

- (1) misrepresent facts or policy provisions relating to coverage of an insurance policy;
- (2) fail to acknowledge and act promptly upon communications regarding a claim arising under an insurance policy;
- (3) fail to adopt and implement reasonable standards for prompt investigation of claims;
- (4) refuse to pay a claim without a reasonable investigation of all of the available information and an explanation of the basis for denial of the claim or for an offer of compromise settlement;
- (5) fail to affirm or deny coverage of claims within a reasonable time of the completion of proof-of-loss statements;
- (6) fail to attempt in good faith to make prompt and equitable settlement of claims in which liability is reasonably clear;
- (7) compel insureds to litigate for recovery of amounts due under insurance policies by offering substantially less than the amounts ultimately recovered in actions brought by those insureds;
- (8) attempt to make an unreasonably low settlement by reference to printed advertising matter accompanying or included in an application;
- (9) attempt to settle a claim on the basis of an application that has been altered without the consent of the insured;
- (10) make a claims payment without including a statement of the coverage under which the payment is made;
- (11) make known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration;
- (12) delay investigation or payment of claims by requiring submission of unnecessary or substantially repetitive claims reports and proof-of-loss forms;
- (13) fail to promptly settle claims under one portion of a policy for the purpose of influencing settlements under other portions of the policy;
- (14) fail to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement;
- (15) offer a form of settlement or pay a judgment in any manner prohibited by AS 21.89.030 .

CS FOR HOUSE BILL NO. 211(L&C)**IN THE LEGISLATURE OF THE STATE OF ALASKA****TWENTY-FIRST LEGISLATURE - SECOND SESSION****BY THE HOUSE LABOR AND COMMERCE COMMITTEE****Offered:****Referred:****Sponsor(s): REPRESENTATIVE ROKEBERG BY REQUEST****A BILL****FOR AN ACT ENTITLED**

1 "An Act relating to liability for providing managed care services, to regulation
2 of managed care insurance plans, and to patient rights and prohibited practices
3 under health insurance; amending Rule 602(b), Alaska Rules of Appellate
4 Procedure; and providing for an effective date."

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

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

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

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

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

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

1 person

2 (1) proximately caused by

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

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

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

9 (c) This section does not create

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

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

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

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

26 (f) In this section,

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

29 (2) "health care treatment decision" means

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

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

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

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

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

* Sec. 3. 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 identifies all health care services to be provided;

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

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

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

(5) 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;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

15 (d) The standard provisions, other than those specifying the exact
16 compensation, of a contract between a health care provider and a managed care entity
17 must be filed and approved by the director before being used.

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

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

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

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

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(4) a provision that any utilization review decision
(A) must be made within 72 hours after receiving the necessary claim for payment or 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 trained in the specialty or subspecialty pertaining to the health care service involved and only after consultation with the covered person's treating 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; this appeal mechanism must provide for a written decision from the managed care entity within 15 working days from the date an appeal is received;

(6) 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;

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

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

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

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

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

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

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

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

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

29 (e) Except as provided in this subsection, a managed care entity that offers a
30 group managed care plan shall permit an enrollee to receive medically necessary or
31 appropriate specialty care, subject to appropriate referral procedures, from any qualified

1 participating health care provider that is available to accept the individual for medical
2 care. This subsection does not apply to specialty care if the managed care entity
3 clearly informs enrollees of the limitations on choice of participating health care
4 providers with respect to medical care. In this subsection,

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

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

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

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

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

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

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

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

30 (2) until the end of the medically necessary treatment for the condition,
31 disease, illness, or injury if the person has a terminal condition, disease, illness, or

1 injury; in this paragraph "terminal" means a life expectancy of less than one year.

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

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

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

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

17 (c) A managed care entity

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

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

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

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

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

31 (2) provide for auditing a sample of decisions by external appeal

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

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

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

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

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

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

23 (4) the external appeal agency shall include among the evidence taken
24 into consideration

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

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

31 (C) the opinion of the individual's treating physician or health

1 care provider;

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

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

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

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

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

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

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

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

21 (6) an external appeal agency shall determine

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

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

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

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

30 (8) the managed care entity involved shall provide the external appeal
31 agency with access to information and to provisions of the plan or health insurance

1 coverage relating to the matter of the externally appealable decision, as determined by
2 the external appeal agency; and

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

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

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

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

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

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

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

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

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

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

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

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

30 (1) means

31 (A) a denial of a claim for benefits that is based in whole or in

1 part on a decision that the item or service is not medically necessary or
2 appropriate or is investigational or experimental, or in which the decision as to
3 whether a benefit is covered involves a medical judgment; or

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

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

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

15 (b) An external appeal agency is qualified to consider appeals of group health
16 plan health care decisions if the agency is certified by the director as meeting the
17 following requirements:

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

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

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

24 (4) the agency meets any other requirements that the director may
25 impose.

26 (c) In determining whether to recertify an external appeal agency, the director
27 shall consider

28 (1) the number of cases reviewed;

29 (2) a summary of the disposition of those cases;

30 (3) the length of time in making determinations on those cases;

31 (4) updated information of what was required to be submitted as a

1 condition of certification for the agency's performance of external appeal activities; and
2 (5) information as may be necessary to assure the independence of the
3 agency from the managed care entities for which external appeal activities are being
4 conducted.

5 (d) For purposes of this section, the director may

6 (1) provide for a process for certification and periodic recertification
7 of qualified private standard-setting organizations that provide for certification of
8 external appeal agencies; and

9 (2) establish by regulation fees for certifying an external appeal agency.

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

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

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

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

19 (4) the peer or entity does not otherwise have a conflict of interest with
20 a related party as determined under any regulations that the director may prescribe.

21 (f) In this section, "related party" means

22 (1) with respect to

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

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

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

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

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

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

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

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

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

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

21 (A) apply medically based eligibility standards;

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

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

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

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

1 nursing care being provided.

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

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

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

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

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

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

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

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

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

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

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

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

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

31 (10) "managed care entity" means an insurer, a hospital or medical

1 service corporation, a health maintenance organization, an employer or employee
2 health care organization, a managed care contractor that operates a group managed care
3 plan, or a person who has a financial interest in health care services provided to an
4 individual;

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

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

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

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

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

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

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

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

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

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

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

30 (16) "religious nonmedical provider" means a person who does not
31 provide medical care, but who provides only religious nonmedical treatment or nursing

1 care for an illness or injury;

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

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

9 * Sec. 4. AS 21.42 is amended by adding a new section to read:

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

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

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

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

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

28 * Sec. 5. AS 21.86.150(j) is repealed.

29 * Sec. 6. The uncodified law of the State of Alaska is amended by adding a new section
30 to read:

31 **INDIRECT COURT RULE AMENDMENT.** AS 21.07.050(h), as enacted by sec. 3

1 of this Act, has the effect of amending Rule 602(b), Alaska Rules of Appellate Procedure, by
2 providing that an appeal from a decision of an external appeal agency must be filed within
3 six months of the decision of the external appeal agency.

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

6 CONDITIONAL EFFECT. AS 21.07.050(h), as enacted by sec. 3 of this Act, takes
7 effect only if sec. 6 of this Act receives the two-thirds majority vote of each house required
8 by art. IV, sec. 15, Constitution of the State of Alaska.

9 * Sec. 8. This Act takes effect July 1, 2000.

1-LS0472\H

Ford

2/9/00

CS FOR HOUSE BILL NO. 211(L&C)**IN THE LEGISLATURE OF THE STATE OF ALASKA****TWENTY-FIRST LEGISLATURE - SECOND SESSION****BY THE HOUSE LABOR AND COMMERCE COMMITTEE**

Offered:

Referred:

Sponsor(s): **REPRESENTATIVE ROKEBERG BY REQUEST****A BILL****FOR AN ACT ENTITLED**

1 "An Act relating to liability for providing managed care services, to regulation
2 of managed care insurance plans, and to patient rights and prohibited practices
3 under health insurance; amending Rule 602(b), Alaska Rules of Appellate
4 Procedure; and providing for an effective date."

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

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

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

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

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

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

1 person

2 (1) proximately caused by

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

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

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

9 (c) This section does not create

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

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

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

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

26 (f) In this section,

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

29 (2) "health care treatment decision" means

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

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

(C) prospective and current review of proposed medical treatment;

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

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

* Sec. 3. 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 identifies all health care services to be provided;

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

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

(4) clearly states the compensation rates for each provider used by the group managed care plan to provide health care services;

(5) 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;

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

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

(B) if, within 30 days following the initial meeting, the parties

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

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

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

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

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

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

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

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

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

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

6 (2) describes the products used by the plan as including all products
7 that are currently offered by the managed care entity; and

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

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

15 (d) The standard provisions, other than those specifying the exact
16 compensation, of a contract between a health care provider and a managed care entity
17 must be filed and approved by the director before being used.

18 **Sec. 21.07.020. Required contract provisions for group managed care**
19 **plans.** (a) A group managed care plan must contain

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

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

25 (3) copayment requirements that are uniform between different types
26 of health care providers;

27 (4) a provision that covered health care services be reasonably available
28 in the community in which a covered person resides; this paragraph is intended to
29 require that a managed care entity contract with a sufficient number of health care
30 providers in each community that it operates in or intends to operate in that allows
31 persons covered by the plan to have access to health care services that fall within the

1 standard of care for that community;

2 (5) a provision that any utilization review decision

3 (A) must be made within 72 hours after receiving the necessary
4 claim for payment or request for preapproval for nonemergency situations; for
5 emergency situations, utilization review decisions for care following emergency
6 services must be made as soon as is practicable but in any event no later than
7 24 hours after receiving the request for preapproval or for coverage
8 determination; and

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

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

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

22 (8) a provision that discloses covered items and services, optional
23 supplemental benefits, and restrictions on nonparticipating provider services;

24 (9) a provision that describes the covered service area, preapproval
25 requirements, and the coverage for clinical trial, experimental, or investigational
26 treatment;

27 (10) a provision describing compensation methods, including
28 assignment of benefits, for health care providers and health care facilities;

29 (11) a provision describing availability of prescription medications or
30 a formulary guide, including specific exclusions; if a formulary guide is made
31 available, the guide must be updated annually; and

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

3 **Sec. 21.07.030. Choice of health care provider.** (a) If a managed care entity
4 offers a group health plan that provides for coverage of health care services only if the
5 services are furnished through a network of health care providers that have entered into
6 a contract with the managed care entity, the managed care entity shall also offer a non-
7 network option to enrollees at initial enrollment, as provided under (c) of this section.
8 This subsection does not apply to an enrollee who is offered non-network coverage
9 through another group health plan or through another managed care entity in the group
10 market.

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

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

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

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

30 (1) "appropriate referral procedures" means procedures for referring
31 patients to other health care providers that comply with ethical guidelines established

1 by the American Medical Association;

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

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

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

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

12 (b) The director by regulation shall establish reasonable standards for the
13 release of information in specified circumstances, including the release of reasonably
14 necessary information to insurance companies and the release of information with the
15 written authorization of the applicant or covered person.

16 **Sec. 21.07.050. External health care appeals.** (a) A managed care entity
17 offering group health insurance coverage shall provide for an external appeal process
18 that meets the requirements of this section in the case of an externally appealable
19 decision for which a timely appeal is made either by the managed care entity or by the
20 enrollee. The director shall adopt regulations to implement this section.

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

25 (c) A managed care entity

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

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

30 (3) shall refund payment of the filing fee under (1) of this subsection
31 if the recommendation of the external appeal agency is to reverse or modify the denial

1 of a claim for benefits that is the subject of the appeal.

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

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

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

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

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

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

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

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

31 (4) the external appeal agency shall include among the evidence taken

1 into consideration

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

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

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

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

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

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

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

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

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

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

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

29 (6) an external appeal agency shall determine

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7 (1) means

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

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

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

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

23 An external appeal agency is qualified to consider appeals of group health
24 plan health care decisions if the agency is certified by the director as meeting the
25 following requirements:

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

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

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

1 (4) the agency meets any other requirements that the director may
2 impose.

3 (c) The director must develop standards for the recertification of external
4 appeal agencies. The standards must include a review of

5 (1) the number of cases reviewed;

6 (2) a summary of the disposition of those cases;

7 (3) the length of time in making determinations on those cases;

8 (4) updated information of what was required to be submitted as a
9 condition of certification for the agency's performance of external appeal activities; and

10 (5) information as may be necessary to assure the independence of the
11 agency from the managed care entities for which external appeal activities are being
12 conducted.

13 (d) For purposes of this section, the director may

14 (1) provide for a process for certification and periodic recertification
15 of qualified private standard-setting organizations that provide for certification of
16 external appeal agencies; and

17 (2) establish by regulation fees for certifying an external appeal agency.

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

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

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

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

27 (4) the peer or entity does not otherwise have a conflict of interest with
28 a related party as determined under any regulations that the director may prescribe.

29 (f) In this section, "related party" means

30 (1) with respect to

31 (A) a group health plan or health insurance coverage offered in

1 connection with a plan, the plan or the insurer offering the coverage; or

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

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

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

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

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

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

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

23 (1) "clinical peer" means a health care provider who is licensed to
24 provide the same or similar health care services and who has similar experience in
25 providing health care services;

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

28 (3) "emergency room services" means health care services provided by
29 a hospital or other emergency facility after the sudden onset of a medical condition
30 that manifests itself by symptoms of sufficient severity, including severe pain, that the
31 absence of immediate medical attention would reasonably be expected by a prudent

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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

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

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

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

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

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

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

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

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

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

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

25 * Sec. 4. AS 21.42 is amended by adding a new section to read:

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

31 (b) A health care insurer may not deny, reduce, or terminate health care

1 payments or deny payment for a health care service because that service is not
2 medically necessary unless that decision is made by an employee or agent of the
3 insurer who is a licensed health care provider trained in that specialty or subspecialty
4 pertaining to that health care service involved and only after consultation with the
5 covered person's treating health care provider.

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

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

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

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

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

19 * Sec. 6. The uncodified law of the State of Alaska is amended by adding a new section
20 to read:

21 **CONDITIONAL EFFECT.** AS 21.07.050(h), as enacted by sec. 3 of this Act, takes
22 effect only if sec. 5 of this Act receives the two-thirds majority vote of each house required
23 by art. IV, sec. 15, Cnstitution of the State of Alaska.

24 * Sec. 7. This Act takes effect July 1, 2000.

FISCAL NOTE

STATE OF ALASKA
1999 LEGISLATIVE SESSION

BILL NO. HB 211

Revision Date/Time (Note if correction) _____ Dept. Affected Commerce & Economic Development
 Title An Act relating to liability for providing managed care BRU Insurance
services, to regulation of managed care insurance plans . . . Component Insurance
 Sponsor Rokeburg
 Requester _____ Component Serial No. 354

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2000	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005
Personal Services	51.0	52.7	54.4	56.2	58.0	59.9
Travel	33.6	44.8	44.8	44.8	44.8	44.8
Contractual	10.0	12.0	12.0	12.0	12.0	12.0
Supplies	1.0	2.0	2.0	2.0	2.0	2.0
Equipment	5.0					
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	100.6	111.5	113.2	115.0	116.8	118.7

CAPITAL EXPENDITURES						
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CHANGE IN REVENUES ()						
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FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts	100.6	111.5	113.2	115.0	116.8	118.7
1037 GF/Mental Health						
Other (Specify Type)						
TOTAL	100.6	111.5	113.2	115.0	116.8	118.7

Estimate of any current year (FY99) cost: 0.0

POSITIONS

Full-time	1	1	1	1	1	1
Part-time						
Temporary						

ANALYSIS: (Attach a separate page if necessary)

Expenditures to implement this bill are based on the addition of one full time Insurance Analyst II who will act as the support for the health care appeals section, plus the nominal associated costs related to the position and to four appeals meetings throughout the year. Travel the first year reflects only three quarterly meetings.

Currently there are no Health Maintenance Organizations (HMO's) in the state. We do not anticipate any HMO's, but if one does decide to open there will be a fiscal impact, which will need to be determined at a later date. These costs are not reflected in this fiscal note.

Prepared by Marianne K. Burke, Director Phone 465-2215
 Division Insurance Date/Time 5/7/99 3:50 PM
 Approved by Commissioner Deborah B. Sedwick Date 5/7/99
 Agency Commerce & Economic Development

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