

ALASKA

According to Regulations of Managed Care Insurance Plans (Title 21, Chapter 7), it appears that there is no regulation or statute in Alaska's legal code that ensures a patient will **not** be held accountable for covered services provided at an in-network facility by an out-of-network provider.

Certain portions of these sections refer to emergency care, specialty care and care received by out-of-network providers. However, they indicate that the covered person may pay a higher deductible, co-payment or premium, if the higher deductible, co-payment or premium is the result of increased costs caused by the use of the non-network provider.

The relevant sections of this chapter are attached and include: Patient and Health Care Provider Protection, Required Contract Provisions for Managed Care Plans, and Choice of Health Care Provider.

According to the article "The Rights of Nonparticipating Providers in a Managed Care World," in most U.S. jurisdictions, there is no explicit statutory prohibition on balance billing, and payors can rarely preclude an out-of-network provider from balance billing a beneficiary. However, most state statutory schemes prohibit balance billing by contracted providers. There is nothing within the Alaska statutes that addresses this issue.

Additionally, there is nothing within these chapters that maintains an insurer must pay an out-of-network provider providing covered services at an in-network facility as if they were in-network.

AS 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 managed care plan must contain a provision that
- (1) provides for a reasonable mechanism to identify all medical care services to be provided by the managed care entity;
 - (2) clearly states or references an attachment that states the health care provider's rate of compensation;
 - (3) clearly states all ways in which the contract between the health care provider and managed care entity may be terminated; a provision that provides for discretionary termination by either party must apply equitably to both parties;
 - (4) provides that, in the event of a dispute between the parties to the contract, a fair, prompt, and mutual dispute resolution process must be used; at a minimum, the process must provide
 - (A) for an initial meeting at which all parties are present or represented by individuals with authority regarding the matters in dispute; the meeting shall be held within 10 working days after the plan receives written notice of the dispute or gives written notice to the provider, unless the parties otherwise agree in writing to a different schedule;
 - (B) that if, within 30 days following the initial meeting, the parties have not resolved the dispute, the dispute shall be submitted to mediation directed by a mediator who is mutually agreeable to the parties and who is not regularly under contract to or employed by either of the parties; each party shall bear its proportionate share of the cost of mediation, including the mediator fees;
 - (C) that if, after a period of 60 days following commencement of mediation, the parties are unable to resolve the dispute, either party may seek other relief allowed by law;
 - (D) that the parties shall agree to negotiate in good faith in the initial meeting and in mediation;
 - (5) states that a health care provider may not be penalized or the health care provider's contract terminated by the managed care entity because the health care provider acts as an advocate for a covered person in seeking appropriate, medically necessary medical care services;
 - (6) protects the ability of a health care provider to communicate openly with a covered person about all appropriate diagnostic testing and treatment options; and
 - (7) defines words in a clear and concise manner.

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

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

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

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

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

AS 21.07.020 Required Contract Provisions for Managed Care Plans

A managed care plan must contain

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

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

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

(4) a provision that any utilization review decision

(A) must be made within 72 hours after receiving the request for preapproval for nonemergency situations; for emergency situations, utilization review decisions for care following emergency services must be made as soon as is practicable but in any event

not 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 medical care service because that service is not medically necessary shall be made by an employee or agent of the managed care entity who is a licensed health care provider;

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

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

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

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

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

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

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

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

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

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

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

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

AS 21.07.030. Choice of Health Care Provider.

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

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

(c) A covered person may make a change to the medical care coverage option provided under this section only during a time period determined by the managed care entity. The time period described in this subsection must occur at least annually and last for at least 15 working days.

(d) If a managed care entity that offers a managed care plan requires or provides for a designation by a covered person of a participating primary care provider, the managed

care entity shall permit the covered person to designate any participating primary care provider that is available to accept the covered person.

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

In this subsection,

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

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

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

However, treatment is required to continue only while the managed care plan remains in effect and

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

(A) the end of the current plan year;

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

(C) through completion of postpartum care, if the covered person is pregnant on the date of termination; or

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

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

AS 21.51.240. Conformity With State Statutes

There may be a provision as follows:

"Conformity with State Statutes: Any provision of this policy which, on its effective date, is in conflict with the statutes of the state in which the insured resides on that date is amended to conform to the minimum requirements of the statutes."