

H B

269

# BARTLETT MEMORIAL HOSPITAL

3280 HOSPITAL DRIVE • JUNEAU, ALASKA 99801 • TELEPHONE (907) 586-2811

October 11, 1990

Senator Jim Duncan, Chair  
Health Care Cost Containment Task Force  
Alaska State Senate  
Box V  
Juneau, AK 99811

Subject: Utilization Review Legislation

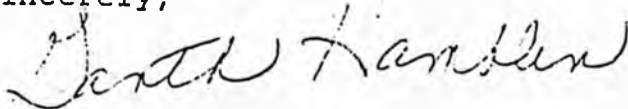
Dear Senator Duncan:

As the task force continues its work to understand and impact some of the factors that influence the cost of health care in Alaska, we would urge that you continue to consider the issue of utilization review standards. In the last legislative session a bill (SB 550) was introduced to try and address at least some of the important issues. We are supportive of the concepts in this legislation and feel that establishing utilization review standards will:

- 1) Improve communication and cooperation between providers and utilization review agents.
- 2) Assure that reasonable standards are adhered to in conducting utilization reviews.
- 3) Promote the delivery of quality, cost effective health care.

We thank you for your consideration of this along with other important matters. Please contact us if you have questions or need additional information.

Sincerely,



Garth M. Hamblin  
Controller

GMH/mem

cc: Task Force Members  
Ray Gillespie

- Bartlett Mem. Hosp. -

ALASKA STATE

# HOSPITAL & NURSING HOME

ASSOCIATION

March 20, 1991

Senator Arlis Sturgulewski, Chair  
Committee on Health & Social  
Services

Alaska State Senate  
Legislative Building  
Juneau, AK 99801

Re: Utilization Review Legislation

Dear Senator Sturgulewski:

The Association would like to see legislation introduced to license and regulate utilization review organizations.

As you know, the major reason for this legislation is to protect patients by making sure the "quality" of care is not jeopardized because of cost containment efforts by insurers and utilization review organizations.

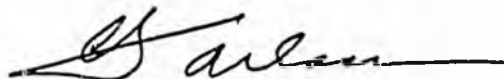
Alaska hospitals do not feel the legislation need be cumbersome, or punitive, rather that it should assure physicians and hospitals that the individuals doing the review are qualified, that all private UR organizations reviewing patient care in Alaska are registered with the state, that the hours of availability and the response to inquiries are timely, that there is an appeals mechanism and that specialty physician review is available under appropriate circumstances.

Ideally this would be done on a volunteer basis, but that appears doubtful.

Enclosed is a summary of state "private utilization review" statutes as of October, 1990.

We appreciate the opportunity to work with you on this issue.

Sincerely



Harlan R. Knudson  
President/CEO

cc: ASHNSHA Executive/Legislative Committees  
Mr. Ray Gillespie  
Mr. Rick Urion

SUMMARY OF STATE PUR STATUTES

OCTOBER 1990

State	AR	FL	GA	KY	ME	MD	MS	NJ***	NC*	PA**	SC	VA
Implement Date	1/1/90	10/1/90	1/1/91	1/1/91	9/30/89	11/1/90	7/1/90		1/1/91	4/15/90	5/1/90	7/1/90
Application & Renewal Fees	X 2 years	X 1 year	X 2 years	X 2 years	X	X 2 years	X 2 years		X 1 year		X 2 years	X 2 years
UR Plans-description of review stds & procedures	X	X	X	X	X	X	X		X		X	X
Mechanism for Appeals & Reconsideration	X	X	X	X	X	X	X		X		X	X
Specialty Physician Review		X	X	X			X		X			
Type & Qualifications of Personnel	X	X	X	X		X	X		X		X	X
Hours of Availability	X	X		X	X	X	X		X		X	X
Provide List of Payers	X			X		X	X					
Complaint Mechanism			X	X	X						X	

- \* Much more specific than other laws being drafted or having been passed.
- \*\* Auto insurance law allows insurers to use UR companies, including PROS, to review medical claims; separate PUR bill failed to pass.
- \*\*\* Health department interprets part of its current statutory to cover UR companies.

RESPONSIBLE AGENCY

Arkansas	Board of Health	Mississippi	Department of Health
Florida	Dept. of Health & Rehab. Services	New Jersey	Department of Health
Georgia	Commissioner of Insurance	North Carolina	Department of Insurance
Kentucky	Cabinet for Human Resources/Health Dept.	Pennsylvania	Department of Insurance
Maine	Bureau of Insurance	South Carolina	Department of Insurance
Maryland	Dept. of Health & Metal Hygiene	Virginia	State Corporation Commission

STATUS

Arkansas	Draft Regulations Complete	Mississippi	Final Regulations Pending
Florida	Implementation Delayed	New Jersey	Proposed
Georgia	Not Implemented/Lack of Financing	North Carolina	Final Regulations Pending
Kentucky	Drafting Regulations	Pennsylvania	Drafting Regulations
Maine	Proposed Regulations	South Carolina	Regulations Proposed
Maryland	Final Regulations Published	Virginia	Drafting Regulations

# Alaska State Legislature

FAIRBANKS

1098 LAKEVIEW TERRACE  
FAIRBANKS, ALASKA 99701  
(907) 456-6473

JUNEAU

P.O. BOX V  
STATE CAPITOL  
JUNEAU, ALASKA 99811  
(907) 465-3466

REPRESENTATIVE  
MARK BOYER

HOUSE FINANCE COMMITTEE



## House of Representatives

### MEMORANDUM

DATE: April 14, 1991

TO: Representative Pat Carney, Co-chair  
Representative Georgianna Lincoln, Co-chair  
House HESS Committee

FROM: Representative Mark Boyer *MB*

RE: Scheduling of HB 269 - Utilization Review

I would like to respectfully request that you schedule HB 269, providing for the licensing and regulation of private health care review agents, at your earliest convenience. The bill is commonly referred to as the utilization review legislation.

The Senate Health, Education and Social Services Committee has introduced an identical bill, SB 239. A similar bill, SB 550, was introduced at the end of the legislative session last year. This legislation has the support of the Alaska State Hospital and Nursing Home Association.

The main reason for HB 269 is to protect patients from increasing health costs and to make sure that the quality of care is not hampered by cost containment measures by insurers and utilization review organizations. As a natural outgrowth of cost containment and other pressure on our health care system, more reliance will be placed upon utilization review practices and many providers are concerned that in the absence of uniform standards and licensing that patients with legitimate health care needs may not receive them.

The bill would provide for the licensing and regulation of private health care review agents. A health care review agent would not be allowed to perform a utilization review in Alaska without a license. Utilization review (UR) refers to the determination of medical necessity of services prior to or during receipt of the services. It does not include reviews after the services have been rendered.

Under this legislation, the Department of Commerce and Economic Development (DCED) would periodically provide a list of licensed private review agents to all hospitals and to any other individuals or organizations requesting the list.

*Sponsor statement*



A private review agent cannot disclose or publish individual medical records or other confidential information. However, they may provide patient information to a third party that they are under contract with or with which they are affiliated.

The section of the bill requiring the DCED to adopt regulations governing licensing requirements would take effect the day after the bill is signed into law. All other sections of the bill take effect 90 days after the bill is signed.

Twenty-six states are expected to look at utilization review legislation this year. Ten states have enacted legislation regulating the practice of private utilization review agents. Typically the legislation requires companies conducting utilization review to obtain a certification either from the State Department of Health or the Commissioner of Insurance. Generally, in order to be certified, a utilization review firm must submit certain information to show:

- 1) the criteria and procedures used in evaluating hospital and medical care;
- 2) the type and qualifications of personnel performing utilization review;
- 3) procedures and policies ensuring that a private review agent is reasonably accessible to patients and providers during normal business hours;
- 4) submit policies and procedures ensuring the applicable state and federal laws protecting confidentiality are followed; and
- 5) procedures that ensure providers may seek reconsideration of adverse decisions.

As a member of the Health Care Cost Containment Task Force I am deeply committed to reducing the steep incline in the cost of health care for Alaskans. I am also committed to providing greater access to basic care for all Alaskans. Sometimes these goals appear contradictory. But the bottom line remains, we must work to make sure that our health safety net catches as many Alaskans as possible at the best rate for the state and consumers at a reimbursement rate that continues to adequately compensate providers. HB 269 is a piece of this safety net.

If you have additional questions and comments please contact me or my staff person, Alexis Miller, at 465-3467. Thanks for your early scheduling of HB 269.



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**LAKESIDE**  
RECOVERY CENTERS, INC.  
JUNEAU

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April 18, 1991

Representative Pat Carney  
Co-Chair House H.E.S.S.  
Pouch V  
Juneau, AK. 99811

Dear Pat,

It is with regrets that I will be unable to testify at your committee's hearing on House Bill 269. By way of background, I administrate the local Lakeside Recovery Outpatient Drug and Alcohol Clinic here in Juneau. Lakeside is a private for profit regional based corporation which has its' corporate offices in Bothell, Washington. We have four outpatient clinics in the state of Alaska and have provided services to the chemically dependent population in this state for eight years. The locations of these four centers are Fairbanks, Anchorage, Juneau, and Ketchikan. The regulation of utilization review has been and continues to be an important issue for treatment providers, such as Lakeside, to be concerned about.

Many people in need of alcohol and drug treatment are now being denied access to the proper level of care and sometimes any treatment at all because of inappropriate decisions by utilization review programs. There are currently no statutes or regulations that govern the operations of utilization review programs by insurance companies and health care companies. As a result, there are many national and regional corporations conducting private reviews, most applying different criteria for coverage. Most criteria do not reflect the professional norms for delivery of care. Among the growing list of problems for patients and providers generated by private utilization review entities are the following;

1. Most companies call their standards of care proprietary and will not share them with either the patient or provider until after the patient has commenced treatment and is denied coverage.
2. Review entities invent continuums of care that exclude customary and statutorily defined modalities, such as requiring patients fail at one modality before receiving the medically prescribed treatment.
3. The reviewing agent often utilizes personnel without training or qualifications in the illnesses about which they make critical decisions on access to care, level of care and length of stay.

4. The review agent may be inaccessible for days yet will deny care retroactively.

The corporation feels strongly about the enactment of legislation to regulate utilization review by requiring review agents to develop a plan to be filed in this state that discloses standards, criteria, and procedures to be used in managing health care plans. The legislation in House Bill 269 seems the responsible thing to do to protect the consumer in letting them know what they have purchased. It also would go on to ensure that the quality of chemical dependency treatment continues in this state.

Once again, it is with regrets that I will not be able to be at the committee hearings over the next couple of weeks. I will be out of town until May 5, 1991. At that time, I will call to see if I can be of any assistance in regards to clarifying any of the above issues.

Respectfully submitted,

Judi Bixby, Administrator  
Lakeside Recovery Center, Juneau

JB:ym

cc: Senator Arliss Sturgulewski  
Senate H.E.S.S. Chair

TESTIMONY BY GORDON E. EVANS  
ON BEHALF OF HEALTH INSURANCE ASSOCIATION OF AMERICA  
BEFORE HOUSE LABOR AND COMMERCE COMMITTEE  
ON HOUSE BILL 269  
April 22, 1991

My name is Gordon Evans and I represent the Health Insurance Association of America ("HIAA"), which is a national, voluntary trade association of 300 private health insurance companies which provide health insurance for over 95 million Americans. Blue Cross and Blue Shield are not HIAA members.

HIAA is very concerned with some of the provisions contained in HB 269, and we would hope that the bill could be referred to the Health Resources and Access Task Force proposed by HJR 5 and SCR 10 for further study over the interim.

The cost of health care has risen at a rate that is matched by no other item represented in our economy. The rate of growth consistently outstrips the other items in the CPI and is soon going to exceed 15 per cent of value of all goods and items produced in the U.S. Studies performed by the Rand Corporation researchers conclude that many medical services performed are not medically necessary. Studies conducted by Dartmouth University researchers conclude that a physician's practice pattern has more to do with surgical rates than appropriateness of care and medical necessity.

Utilization review is a method being used by both the private and public sectors to rein in the costs of inappropriate medical usage. These plans require that before the patient is admitted to the hospital and/or undergoes a surgical procedure, approval must be given by the utilization review firm.

Utilization review is a sound and reasonable approach for assuring that only medically necessary quality care is rendered in the most appropriate and cost effective setting.

Utilization review provides a balance to the health care provider's incentive problem by requiring the physician, hospital or other provider to justify the medical treatment or procedures they wish to perform. Traditionally, health care providers were not questioned about their services, so it is not surprising that some may be upset if they cannot medically justify their services -- resulting in the services not being approved.

Voluntary guidelines regarding utilization review procedures have been jointly developed by the American Hospital Association, American Medical Association, HIAA, the Blue Cross and Blue Shield Association, and the American Managed Care and Review Association, known as AMCRA. AMCRA represents the utilization review companies. The guidelines were developed as a reference for discussion and not for the purposes of legislation

or regulation. However, their very existence indicates that the provider, payer, and utilization review communities can agree on how utilization review can be approached without the need for legislation.

In addition, the Utilization Review Accreditation Commission (URAC) has developed accreditation standards for utilization review firms. Both the guidelines and the URAC standards have been shared with staff of the bill's sponsor. We urge the committee to use these documents as a discussion reference over the interim.

Alaska residents and policyholders have the right to be certain that the medical care they receive is medically appropriate and cost effective. Utilization review permits Alaskans to know this. HIAA is most willing to work with the committee and staff during the interim to help determine what is the best way to assure Alaskans of quality health care that is cost effective, while also assuring them that their health care dollar is being spent only on medically necessary care.

Thank you for the opportunity to present HIAA's views.

\*\*\*\*\*  
 \* DELIVER TO: LHSCHES \*  
 \* ORIGINAL \*  
 \* SENT: 04/22/91 TIME: 10:00 \*  
 \* FROM: LIOCLAI \*  
 \* SUBJECT: 91-04-124;FS;VARIOUS HB'S;4-22 \*  
 \* PRINT DATE: 04/22/91 TIME: 10:00 \*  
 \*\*\*\*\*

SUBJECT LINE TO READ: TC NO.; PL\FS;SHORT SUBJECT;DATE

TC NO: 91-04-124  
 DATE: 04-22-91  
 SPONSOR: H HESS  
 SUBJECT: HB 156,269,165,161  
 MODERATOR: LANI  
 SITE: ANCHORAGE

FINAL STATS

\*\*\*\*\*  
 TO TESTIFY  
 NAMES\ REPRESENTING ADDRESS PHONE BILL NO.  
 1. THEDA PETTMAN 111 W 9TH,99501 276-0528 HB 156  
 2. LYNN ~~RODD~~ BOX 196604,99519 261-3078 HB 269  
*AK women's Resource CTR*  
*Rodda - Providence Hospital*

3. DARRYL LOGAN 4300 B ST,#202 562-2812 HB 269 *opposed*  
 4. NANCY SCHEETZ-FREYMILLER 100 W 13TH99501 279-9581 HB 156  
*Exec. Dir of AWAIC*

\*\*\*\*\*  
 TO OBSERVE:  
 NAME\ REPRESENTING ADDRESS PHONE BILL NO.  
 1. MS. G KRUPPER 2530 DE BARR 258-7575  
 \*\*\*\*\*

TESTIFIED: 4  
 UNABLE: 0  
 OBSERVED: 1  
 TOTAL: 5

STARTING TIME: 8:00 ENDING TIME:

CS FOR HOUSE BILL NO. 269 ( )  
IN THE LEGISLATURE OF THE STATE OF ALASKA  
SEVENTEENTH LEGISLATURE - FIRST SESSION

BY

Offered:  
Referred:

Sponsor(s): REPRESENTATIVES BOYER, Navarre

A BILL

FOR AN ACT ENTITLED

1 "An Act providing for the licensing and regulation of private health care review agents;  
2 and providing for an effective date."

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

4 \* Section 1. AS 08.01.010 is amended by adding a new paragraph to read:

5 (33) regulation of private review agents under AS 08.85.

6 \* Sec. 2. AS 08 is amended by adding a new chapter to read:

7 CHAPTER 85. PRIVATE REVIEW AGENTS.

8 Sec. 08.85.010. PURPOSE. The purpose of this chapter is to

9 (1) promote the delivery of quality health care in a cost-effective and efficient  
10 manner;

11 (2) foster greater coordination between those paying for health care services and  
12 health care providers in the conduct of utilization review activities;

13 (3) assure protection for patients, state employers, and health care providers by  
14 ensuring that private health care review agents are qualified to perform utilization review

1 activities and to make informed decisions on the appropriateness of medical care; and

2 (4) ensure that private review agents maintain the confidentiality of medical  
3 records in accordance with applicable state and federal laws.

4 Sec. 08.85.020. LICENSE REQUIRED. (a) A person who is affiliated with, under  
5 contract to, or acting on behalf of a health care insurer or a person doing business in the state,  
6 whether or not for profit, may not perform a utilization review in this state unless a private  
7 review agent license is held by the person, the person's employer, or another for whom the  
8 person is providing those services under contract. This section does not apply to a person  
9 affiliated with a hospital.

10 (b) The department shall issue a license to an applicant that meets the requirements of  
11 this chapter and regulations adopted under this chapter.

12 (c) A license issued under this chapter is not transferable and expires biennially on a date  
13 determined by the department.

14 Sec. 08.85.030. APPLICATION FOR LICENSE. (a) An applicant for a private review  
15 agent license shall submit an application to the department and pay an application fee set by  
16 regulation. The application must be on a form approved by the department.

17 (b) An applicant is entitled to a license if the applicant submits and the department  
18 approves a utilization review plan that will be provided to patients and providers that includes

19 (1) the review standards, criteria, and procedures to be used in evaluating hospital  
20 or outpatient care that has been proposed or is being or has been delivered;

21 (2) those circumstances under which utilization review may be delegated to a  
22 hospital utilization review program;

23 (3) the provisions by which patients or providers may seek prompt reconsideration  
24 or appeal of adverse decisions by the private review agent and the time period in which the  
25 private review agent must respond to the request for reconsideration or appeal;

26 (4) the number, type, and qualifications of the personnel employed by or under  
27 contract with the private review agent to perform the utilization review including

28 (A) the requirement that a private review agent have available the services  
29 of sufficient numbers of registered nurses, supported and supervised by physicians trained  
30 in the appropriate specialty area, to carry out its utilization review activities, or to have  
31 appropriate numbers of physicians trained in the appropriate specialties for which

1 utilization review is being conducted; and

2 (B) a requirement that only a physician trained in a relevant specialty or  
3 subspecialty be permitted to make a final determination that care rendered, being  
4 rendered, or to be rendered in that specialty or subspecialty is medically inappropriate;

5 (5) the procedures and policies to ensure that a representative of the private  
6 review agent is reasonably accessible to patients and providers at least five days a week during  
7 normal business hours in this state and that payment will not be denied for treatment rendered  
8 that is found to be medically appropriate;

9 (6) the requirement that, except in exceptional circumstances, a determination that  
10 care rendered, being rendered, or to be rendered is medically inappropriate may not be made until  
11 an appropriately qualified review physician has conferred with the patient's attending physician  
12 and reviewed pertinent information concerning the medical care delivered or proposed;

13 (7) the requirement that a determination that care rendered, being rendered, or to  
14 be rendered is medically inappropriate must include the written evaluation and findings of the  
15 reviewing physician;

16 (8) the procedures and policies to ensure that all applicable state and federal laws  
17 to protect the confidentiality of individual medical records are followed;

18 (9) prohibitions against a private review agent entering a hospital to interview a  
19 patient unless the attending physician is advised of the interview with reasonable advance notice,  
20 and the attending physician or the physician's designee is allowed to attend the interview;

21 (10) a prohibition against an incentive payment provision or plan contained in a  
22 private review agent's contract with an entity paying for health care services under which the  
23 agent's compensation is based on controlling the amount charged for services, duration of  
24 services, or setting in which services are rendered and a prohibition against the agent receiving  
25 the incentive payment;

26 (11) a copy of the written material intended to be sent to patients and providers  
27 to inform them of the requirements of the utilization review plan;

28 (12) a list of the health care insurers for which the private review agent is  
29 performing utilization review in the state and a brief description of the services it is providing  
30 for each client, including an affirmation that a payment incentive provision or plan designed to  
31 control the amount, duration, or setting in which services are rendered does not exist with respect

1 to each client;

2 (13) evidence of liability insurance carried by the private review agent to cover  
3 potential liability from its activities under this chapter in an amount, type, nature, and carrier  
4 satisfactory to the department;

5 (14) provisions that, in the absence of fraud, prohibit retrospective denial of  
6 payment for treatment, except in cases of policy limitations or exclusions, after it has been  
7 initially approved by the private review agent;

8 (15) other information the department determines to be appropriate.

9 Sec. 08.85.040. RENEWAL OF LICENSE. (a) The department shall renew the license  
10 of a private review agent holding a license under AS 08.85.020 if, before the license expires, the  
11 agent

12 (1) files an application for renewal, including the information required under  
13 AS 08.85.030(b), and submits the appropriate renewal fee; and

14 (2) meets the qualifications for issuance of a license under AS 08.85.020(b).

15 (b) An application for renewal of a private review agent license must include a list of  
16 all complaints made to the agent by patients or providers and a brief description of how the  
17 complaints were resolved, including the nature of the complaint, the review process, and the time  
18 between the filing of the complaint and its resolution.

19 Sec. 08.85.050. DENIAL OF LICENSE OR RENEWAL APPLICATION. (a) Before  
20 denying an application for a private review agent license or for renewal of a license, the  
21 department shall provide the applicant with reasonable time to supply additional documentation  
22 establishing that the applicant is entitled to a license or to renewal of a license.

23 (b) An applicant who is denied a license or renewal of a license shall be afforded the  
24 opportunity for a hearing. The hearing shall be conducted by the department. The hearing shall  
25 be held in accordance with AS 44.62.330 - 44.62.630.

26 Sec. 08.85.060. REVOCATION OF LICENSE. (a) The department may revoke a  
27 license if the holder fails to comply with a utilization review plan filed by the holder under  
28 AS 08.85.030(b) or otherwise violates a provision of this chapter or a regulation adopted under  
29 this chapter.

30 (b) Before revoking a license under this section, the department shall provide the license  
31 holder with reasonable time to supply additional information demonstrating the holder's

1 compliance with the requirements of this chapter.

2 (c) A license holder whose license is proposed for revocation by the department shall be  
3 afforded the opportunity for a hearing. The hearing shall be held in accordance with  
4 AS 44.62.330 - 44.62.630.

5 Sec. 08.85.070. COMPLAINTS AGAINST LICENSE HOLDER. (a) A patient or  
6 provider may file a complaint with the department alleging that a private review agent is not in  
7 compliance with this chapter or the regulations adopted under this chapter or with other  
8 applicable federal or state law. The complaint may request that the department revoke the license  
9 of the agent or require that the agent demonstrate to the department proof of compliance.

10 (b) Proceedings under this section shall be conducted in accordance with AS 44.62.330 -  
11 44.62.630.

12 (c) If the department fails to render a decision on a complaint brought by a patient or  
13 provider within 90 days, the patient or provider shall have the right to bring suit in the superior  
14 court to compel the department to take an action specified in (a) of this section.

15 (d) This section may not be construed to deprive a patient, a provider, a private review  
16 agent, or a health care insurer of a right available under other provisions of law.

17 Sec. 08.85.080. REGULATIONS. The department shall adopt regulations to implement  
18 the provisions of this chapter, including regulations

19 (1) establishing license application and renewal fees in an amount sufficient to  
20 pay for the costs to the department of administering this chapter;

21 (2) establishing rules of procedure consistent with AS 44.62.330 - 44.62.630.

22 Sec. 08.85.090. EXEMPTION. A private review agent that operates solely under contract  
23 with the federal government or an agency of the federal government for utilization review of  
24 patients eligible for health related services under 42 U.S.C. 1395 - 1395ccc (Subchapter XVIII  
25 of the Social Security Act), 42 U.S.C. 1396 - 1396s (Subchapter XIX of the Social Security Act),  
26 and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) is exempt  
27 from the licensing requirements of this chapter.

28 Sec. 08.85.100. LIST OF PRIVATE REVIEW AGENTS. The department shall  
29 periodically provide a list of licensed private review agents and the expiration date for their  
30 licenses to all hospital utilization review programs and to other individuals or organizations  
31 requesting the list. The department may charge a reasonable fee for providing the list.

1           Sec. 08.85.110. PATIENT CONFIDENTIALITY AND RECORDS. (a) A private review  
2 agent may not disclose or publish individual medical records or other confidential information  
3 obtained in the performance of activities as a private review agent, except that an agent may  
4 provide patient information to a third party to which the agent is under contract or with which  
5 it is affiliated.

6           (b) A person seeking payment of a reimbursement for hospital or medical services may  
7 not invoke the privilege of confidentiality arising from a physician-patient relationship to  
8 withhold pertinent information from review of those services by a private review agent.

9           (c) Notwithstanding the provisions of this chapter or another law, a patient is entitled to  
10 inspect and copy records developed or maintained by a private review agent pertaining to the  
11 health care rendered, being rendered, or proposed to be rendered to the patient.

12           (d) This chapter may not be construed to allow a private review agent to take actions that  
13 violate a state or federal statute or regulation concerning confidentiality of patient records.

14           Sec. 08.85.150. DEFINITIONS. In this chapter,

15           (1) "department" means the Department of Commerce and Economic  
16 Development;

17           (2) "health care insurer" means a person in the business of making payments for  
18 the medical care of others, and includes an insurance company, a nonprofit health service plan,  
19 a health maintenance organization, a preferred provider organization, an employee assistance  
20 program, and a health insurance service organization;

21           (3) "private review agent" means a person who performs a utilization review and  
22 who is affiliated with, under contract to, or acting on behalf of a person doing business in the  
23 state, whether or not for profit, or of a health care insurer, but who is not affiliated with a  
24 hospital;

25           (4) "provider" means a health care provider as defined in AS 18.23.070;

26           (5) "utilization review" means a system for reviewing the appropriate and efficient  
27 allocation of hospital and outpatient resources and services given, being given, or proposed to  
28 be given to a patient or group of patients, including the approval or denial, or recommendation  
29 of approval or denial, of payment for hospital or medical services;

30           (6) "utilization review plan" means a description of the criteria, procedures, and  
31 standards governing utilization review activities performed by a private review agent.

1 \* Sec. 3. AS 44.62.330(a) is amended by adding a new paragraph to read:

2 (57) Department of Commerce and Economic Development concerning the  
3 licensing and regulation of private review agents under AS 08.85.

4 \* Sec. 4. AS 08.85.080 and 08.85.150, enacted by sec. 2 of this Act, take effect immediately under  
5 AS 01.10.070(c).

FISCAL NOTE

STATE OF ALASKA  
1991 LEGISLATIVE SESSION

BILL NO. CSHB 269(HES)

Revision Date: \_\_\_\_\_ Department Affected: Commerce & Economic Dev.  
 Title: Providing for the licensing and BRU: Occupational Licensing.  
reg. of private health care review agents. Component: Administration  
 Sponsor: Reps. Bover & Navarre  
 Requestor: House HES COMPONENT SERIAL NO. 

0	3	5	6
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Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY 92	FY 93	FY 94	FY 95	FY 96	FY 97
PERSONAL SERVICES	65.9	65.9	65.9	65.9	65.9	65.9
TRAVEL	2.0	2.0	2.0	2.0	2.0	2.0
CONTRACTUAL	6.0	6.0	6.0	6.0	6.0	6.0
SUPPLIES	2.0	2.0	2.0	2.0	2.0	2.0
EQUIPMENT	10.2					
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
<b>TOTAL OPERATING</b>	<b>86.1</b>	<b>75.9</b>	<b>75.9</b>	<b>75.9</b>	<b>75.9</b>	<b>75.9</b>

CAPITAL						
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REVENUE	***	***	***	***	***	***
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FUNDING: (Thousands of Dollars)

GENERAL FUND						
FEDERAL FUNDS						
OTHER GF/PR	86.1	75.9	75.9	75.9	75.9	75.9
<b>TOTAL</b>	<b>86.1</b>	<b>75.9</b>	<b>75.9</b>	<b>75.9</b>	<b>75.9</b>	<b>75.9</b>

POSITIONS:

FULL-TIME	1	1	1	1	1	1
PART-TIME	1	1	1	1	1	1
TEMPORARY	0	0	0	0	0	0

Estimate of current year impact: None

ANALYSIS: (Attach a separate page if necessary.)

The bill establishes a licensing program for private health care review agents that perform utilization review services. (Continued on attached)

Prepared By: Jennifer Strickler, Admin. Officer Phone: 465-2144

Division: Occupational Licensing Date: May 2, 1991

Approved by Commissioner: Glenn A. Olds

Agency: Commerce and Economic Development Date: 5-2-91

Distribution (by preparer): Legislative Finance, Legislative Sponsor, Requestor, OMB, & Impacted Agency(ies).

CONTINUATION OF FISCAL NOTE ANALYSIS - CSHB 269(HES)

The bill authorizes the department to administer the licensing program for private health care review agents. Section 08.85.030 requires applicants to submit a utilization review plan consisting of fifteen (15) items listed in this section of the bill. Since each utilization review plan must be thoroughly reviewed to ensure compliance with Section 08.85.030, and to meet the enforcement timeline required by Section 08.85.070; this fiscal note requests funding authorization for the following:

Personal Services \$65.9

- 1 - Occupational Licensing Examiner I, Range 12A  
GGU, 12 months (PFT), (\$39.0); and
- 1 - Investigator III, Range 18A, GGU  
6 months (PPT), (\$26.9).

Travel \$ 2.0

This funding provides travel for the Investigator III to conduct investigations where necessary in preparation for the administrative proceedings described in Section 08.85.070.

Contractual Services \$ 6.0

This funding will provide for printing, advertising, communications, and other contractual costs.

Supplies \$ 2.0

This funding will provide daily operating supplies for the two positions shown above.

Equipment (one time costs) \$10.2

This funding will provide one-time equipment costs for the two positions shown above.

TOTAL: \$ 86.1

\*\*\*Revenues

Revenues will be generated from licensing fees, however, until we have some idea of the number of individuals that would be affected by this legislation, we cannot estimate the amount of revenues that will be generated. It is the intent of the department however, that licensing fees will be set to cover the costs of the program to the extent possible.

**FISCAL NOTE**

**STATE OF ALASKA**  
**1991 LEGISLATIVE SESSION**

BILL NO. HB 269

Revision Date: \_\_\_\_\_ Department Affected: Commerce & Economic Dev.  
 Title: Providing for the licensing and reg. of private health care review agents BRU: Occupational Licensing  
 Component: Administration

Sponsor: Reps. Boyer & Navarre

Requestor: House HES COMPONENT SERIAL NO. 

0	3	5	6
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**Expenditures/Revenues: (Thousands of Dollars)**

OPERATING	FY 92	FY 93	FY 94	FY 95	FY 96	FY 97
PERSONAL SERVICES	86.8	86.8	86.8	86.8	86.8	86.8
TRAVEL	2.0	2.0	2.0	2.0	2.0	2.0
CONTRACTUAL	6.0	6.0	6.0	6.0	6.0	6.0
SUPPLIES	2.0	2.0	2.0	2.0	2.0	2.0
EQUIPMENT	10.2					
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
<b>TOTAL OPERATING</b>	<b>107.0</b>	<b>96.8</b>	<b>96.8</b>	<b>96.8</b>	<b>96.8</b>	<b>96.8</b>

CAPITAL						
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REVENUE	**	**	**	**	**	**
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**FUNDING: (Thousands of Dollars)**

GENERAL FUND						
FEDERAL FUNDS						
OTHER GF/PR	107.0	96.8	96.8	96.8	96.8	96.8
<b>TOTAL</b>	<b>107.0</b>	<b>96.8</b>	<b>96.8</b>	<b>96.8</b>	<b>96.8</b>	<b>96.8</b>

**POSITIONS:**

FULL-TIME	1	1	1	1	1	1
PART-TIME	1	1	1	1	1	1
TEMPORARY	0	0	0	0	0	0

Estimate of current year impact: None

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

The bill establishes a licensing program for private health care review agents that perform utilization review services. (Continued on attached)

Prepared By: Jennifer Strickler, Admin. Officer Phone: 465-2144

Division: Occupational Licensing Date: April 22, 1991

Approved by Commissioner: Glenn A. Olds

Agency: Commerce and Economic Development Date: 4-25-91

Distribution (by preparer): Legislative Finance, Legislative Sponsor, Requestor, OMB, & Impacted Agency(ies).

CONTINUATION OF FISCAL NOTE ANALYSIS - HB 269

Although the bill authorizes the department to administer the licensing program for private health care review agents, Section 08.85.030 places the burden of determining acceptable standards upon the department, to be addressed by regulations. Since the bill gives the department broad authority to establish acceptable guidelines, it will be necessary for the department to obtain a position that is qualified to: 1) understand and establish the necessary standards; 2) review each utilization review plan submitted; and 3) coordinate enforcement activity to meet the timelines specified in Section 08.85.070. This fiscal note therefore consists of the following:

Personal Services \$86.8

- 1 - Program Coordinator, Range 19A, GGU, 12 months (PFT), (\$59.9); and
- 1 - Investigator III, Range 18A, GGU 6 months (PPT), (\$26.9).

Travel \$ 2.0

This funding provides travel for the Investigator III to conduct investigations where necessary in preparation for the administrative proceedings described in Section 08.85.070.

Contractual Services \$ 6.0

This funding will provide for printing, advertising, communications, and other contractual costs.

Supplies \$ 2.0

This funding will provide daily operating supplies for the two positions shown above.

Equipment (one time costs) \$10.2

This funding will provide one-time equipment costs for the two positions shown above.

**TOTAL:** \$ 107.0

\*\*Revenues

Revenues will be generated from licensing fees, however, until we have some idea of the number of individuals that would be affected by this legislation, we cannot estimate the amount of revenues that will be generated. It is the intent of the department however, that licensing fees will be set to cover the costs of the program to the extent possible.

**HOUSE COMMITTEE REPORT**

(7)

Date Referred: April 10, 1991

FURTHER REFERRALS:

Labor & Commerce  
Finance

Date of Committee Action: 05/03/91

The HEALTH, EDUCATION AND SOCIAL SERVICES Committee considered:

HB 269

HOUSE BILL NO. 269

PRIVATE HEALTH CARE REVIEW AGENTS

"An Act providing for the licensing and regulation of private health care review agents; and providing for an effective date."

- RECOMMENDATIONS: [ ] the same title  
 be replaced with CS HB 269 (HES) [ ] a new title  
 have attached amendments(s)  
 do pass  
 do not pass  
 no recommendations  
 individual recommendations  
 additional referral to the \_\_\_\_\_ Committee

ADOPTS: \_\_\_\_\_ letter of Intent

ATTACHES NEW FISCAL NOTE(S): \_\_\_\_\_ (Dept)

APPROVES PREVIOUS: \_\_\_\_\_ (Dept/Date)

fiscal impact \_\_\_\_\_

fiscal note(s) \_\_\_\_\_

zero fiscal note \_\_\_\_\_

zero fiscal note(s) \_\_\_\_\_

SIGNING DO PASS	DP	OTHER RECOMMENDATIONS	DNP	NR	AM
		<i>Steve Davis</i>		<input checked="" type="checkbox"/>	
		<i>Y. M. Lee</i>		<input checked="" type="checkbox"/>	
		<i>Betty Davis</i>		<input checked="" type="checkbox"/>	
		<i>J. C. Souza</i>	<input checked="" type="checkbox"/>		

*[Signature]*  
CHAIRMAN'S SIGNATURE



# Alaska State Legislature

## House of Representatives

COMMITTEE ON HEALTH, EDUCATION  
AND SOCIAL SERVICES

DATE: April 22, 1991

PLACE: Capitol Room 106

### SUBJECT OF MEETING:

WITNESS REGISTER FOR:

- \*HB 156 Confidentiality/Dom. Vio. Counsel
- \*HB 269 Private Health Care Review Agents
- \*HB 165 Extend Board of Nursing
- \*HB 161 Extend State medical Board

NAME	REPRESENTING	BUSINESS/PERSONAL MAILING ADDRESS	ZIP	(H) PHONE	(W) PHONE	DO YOU WANT TO TESTIFY?		WHAT SUBJECT/ WHICH BILL?
						Y	N	
✓ Haaland Krudson	Hosp/ Nursing Home ASSN	319 South 2 St	99501		5-1790	<input checked="" type="radio"/>	<input type="radio"/>	HB 269
✓ Gordon Evans	HIAA	318 4th St., Juneau	99801		586-3210	<input checked="" type="radio"/>	<input type="radio"/>	HB 269
✓ Ann Boudreau <sup>Boudreau</sup>	DCED occ LIC	P.O. Box D Juneau	99811		465-2538	<input checked="" type="radio"/>	<input type="radio"/>	HB 269, 165
✓ Reed Stoops	ACTWT	Box 1211 Juneau	99802		463 3223	<input checked="" type="radio"/>	<input type="radio"/>	HB 269
						<input type="radio"/>	<input type="radio"/>	
						<input type="radio"/>	<input type="radio"/>	
						<input type="radio"/>	<input type="radio"/>	
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						<input type="radio"/>	<input type="radio"/>	
						<input type="radio"/>	<input type="radio"/>	



**ON**  


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**STATE HEALTH**  


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**INSURANCE**  


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**ISSUES**

**ISSUE: MANAGED CARE**  
(as of April 1990)

**BACKGROUND:** The high cost of health care is a major problem for the United States. All who pay – employers, individuals, and government – are burdened by continual increases in health expenditures. Moreover, escalation of health costs greatly complicates the task of finding ways to provide coverage for the large number of Americans who are without either public or private health insurance.

Although cost escalation has many causes, research shows that one key problem is that patients receive much care that is not appropriate for their condition. Some get care that is more intense and expensive than necessary. Others receive care that is not beneficial and may even be harmful. Eliminating such inefficiencies – which may account for 25 percent or more of medical expenditures – is clearly a critical objective, both as a way of reducing costs and improving quality of care.

Payers of health care are aware of such inefficiencies and are demanding more accountability and better performance from those who make health care decisions in order to assure that patients receive good value for money spent. Increasingly, managed care is recognized as the best mechanism for carrying out such improvements. The key objective of managed care is to assure that patients receive appropriate care, that is, high quality care efficiently provided in the least costly setting.

**DEFINITION:** Because it is still evolving, managed care embraces a variety of existing and developing structures. It may be defined as systems that integrate the financing and delivery of appropriate health care services to covered individuals by means of the following basic elements:

- o Arrangements with selected providers to furnish a comprehensive set of health care services to members;
- o Explicit standards for the selection of health care providers;
- o Formal programs for ongoing quality assurance and utilization review; and
- o Significant financial incentives for members to use providers and procedures associated with the plan.

Managed care organizational structures are evolving in response to marketplace demands and will continue to do so. Today's structures include health maintenance organizations (HMOs), preferred provider organizations (PPOs), and exclusive provider organizations (EPOs), as well as mixed arrangements that combine elements of HMOs, PPOs and indemnity plans to accommodate employer and operating environment requirements.

Managed care plans arrange with selected providers to furnish health care services to plan members. Explicit criteria are used for the selection of providers, and formal programs for ongoing review of the quality and appropriateness of services are incorporated into the plan.

Health Insurance Association of America

- o Legislation should not establish inappropriate barriers to insurer efforts to establish effective utilization review programs and should require providers to make available, at a reasonable cost, patient records and other information necessary to monitor cost and quality of care. Monitoring medical practice patterns is critical to managing care. If reviewers cannot get access to medical records at reasonable cost, or if excessive restrictions are put in place to limit who does utilization review or what the process will be, managed care plans cannot accomplish the critical task of encouraging providers to become more efficient.
- o Insurers who are negotiating to form provider panels should not be compelled to enroll every provider who wishes to be included. A key mechanism that managed care plans use to constrain costs is to contract only with efficient providers. If plans are required to include on their panels all willing providers, this critical element of control is eliminated.
- o States should not mandate that insurers cover services and categories of care, since doing so often adds to costs and limits the plan's ability to develop cost-effective benefit packages. Research evidence shows that legislation that requires coverage of certain provider categories or particular services generally causes a net increase in costs. The buyers of insurance plans, not state government, should be the ones who decide what services and provider groups should be covered. Legislation mandating coverage of particular provider groups is often simply a reflection of that group's desire to create demand for their own services as a way of enhancing income.

HIAA supports the concept of physician peer review as a method of determining appropriateness of care. In doing peer review, however, it is not appropriate to rely solely on local peer assessment. Studies of differences in patterns of medical practice from area to area within a state demonstrate that the typical method of treatment in one community is often significantly different from that in another community even though the conditions of the patients are essentially identical. The differences, in other words, are not medically justified. Thus, local habit or customary practice is not necessarily the best standard for assessing medical appropriateness or necessity for a given treatment.

The collective judgment of physicians who are experts in a given field and who have done a systematic study of the scientific research must ultimately form the basis for determining what is appropriate care in a given situation. It is for this reason that HIAA supports the development of medical practice guidelines and protocols. When developed, these can form a rigorous, scientifically defensible standard for educating physicians about the best medical practice and for judging the appropriateness of care.

#### **GLOSSARY:**

Below is a list of some of the current managed care structures now available:

**Health Maintenance Organization (HMO):** This was the original managed care arrangement, first emerging as prepaid group practices in the 1930s. The name "health maintenance organization" was coined in the early 1970s, and was given to 1973 federal legislation promoting its development. HMOs provide:

- o An organized system for providing health care in a certain geographic area, as well as responsibility for providing or otherwise assuring delivery of that care;
- o An agreed-on set of basic and supplemental health maintenance and treatment services; and
- o A voluntarily enrolled group of people

In exchange for a set amount of premium or dues, HMOs provide all the agreed-on health services to their enrollees, there are generally no deductibles and no or minimal copayments. The HMO bears the risk if the cost of providing the care exceeds the premium received. There are now several types of HMOs

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- o The staff model, where providers are directly employed by the HMO;
- o The group model, where medical groups contract with the HMO (Kaiser plans are the best-known example of this type);
- o The independent practice association (IPA), where the HMO contracts with physicians in independent practice, or with associations of independent physicians. IPA physicians frequently have arrangements with more than one HMO; and
- o The network model, which contracts with two or more independent group practices.

**Preferred Provider Organization (PPO).** A PPO consists of groups of hospitals and providers that contract with employers, insurers, third-party administrators or other sponsoring groups to provide health care services to covered persons and accept negotiated fee schedules as payment for services rendered. There are different sponsoring arrangements:

- o Hospital-sponsored PPOs, which often include a network of institutions in order to cover a wider geographic area, as well as many of the physicians on their medical staffs;
- o Physician-sponsored PPOs, which are developed by local medical societies, other local professional associations or clinics, or groups of physicians;
- o Third-party payer-sponsored PPOs, which include those initiated by commercial insurers and Blue Cross and Blue Shield plans;
- o Entrepreneur-sponsored PPOs, which create a broker relationship with the entrepreneur acting as an intermediary between the provider and payer of service;
- o Employer- or labor-sponsored PPOs, which contract directly with providers on behalf of their employees or members;
- o Other provider-sponsored PPOs, which are developed by nonhospital and non-physician providers, such as dentists, optometrists, pharmacists, chiropractors and podiatrists, through their professional associations, local groups or clinics.

**Exclusive Provider Organization (EPO).** People belonging to an EPO must receive their care from affiliated providers; services rendered by unaffiliated providers are not reimbursed.

**Point-of-Service Plans.** Also known as open-ended HMOs or PPOs, these plans permit insureds to choose providers outside the plan at any time yet are designed to encourage the use of network providers. If a provider is affiliated with the HMO or PPO, the service is covered (perhaps after a modest copayment). If an out-of-network provider is chosen, reimbursement may be significantly reduced.

A number of managed care techniques are used to assure quality and appropriate care. These include, but are not limited to, quality assurance, utilization review, case management and use of a primary care physician. Although the combination of elements will differ among plans, each managed care plan operates as an organized system where patient services are subject to review and coordination by health professionals.

- o Quality assurance is a process by which a managed care plan monitors and takes action as necessary to assure that quality care is delivered by selected providers. The process measures the extent to which quality has been attained and periodically reevaluates health care to assure that established standards are being met.

- o Utilization review is a system of reviewing the medical necessity and appropriateness of patient services within guidelines developed by physicians. Performed by health care professionals, it is comprised of several processes and may be used for both inpatient and outpatient services. Processes may include preadmission certification, application of practice guidelines, continued stay review, discharge planning, second surgical opinion and retrospective review. Because of the explosion of costs in all aspects of ambulatory care in recent years, programs to require preauthorization of ambulatory procedures are now evolving.
- o Preadmission certification is a process in which a health care professional (such as a registered nurse) evaluates an attending physician's request for a patient's admission to a hospital by using established medical criteria.
- o Continued stay review, also called concurrent review, is a process whereby a review organization continues to examine medical information during a patient's hospital confinement to determine the need for continued hospitalization.
- o Discharge planning is a process in which a health care professional from a review organization works with an attending physician and hospital staff to arrange for appropriate discharge of a patient from the hospital, including a plan for the patient's subsequent care. Its purpose is to determine when patients are ready to go home, perhaps with the support of a nurse or other home health provider, or are able to be transferred to a nursing home.
- o Second surgical opinion programs require patients to seek a second surgeon's opinion if elective surgery is recommended for certain conditions. Elective surgery is defined as that which can be avoided or delayed without undue risk to the patient and which allows sufficient time to seek another opinion.
- o Retrospective review provides for the establishment of a utilization profile of inappropriate care for monitoring trends and addressing excessive use or cost.

Other managed care techniques include case management, which is a process that provides a comprehensive plan of care and rehabilitation for people suffering from severe conditions such as trauma, premature birth or AIDS. Through flexible interpretation of plan provisions, case management coordinates the use of all appropriate types of therapy and equipment in the most appropriate setting. Case management often supports alternatives to institutional care, such as physical therapy and other services delivered in the home, that achieve better patient outcomes at lower cost.

In many managed care plans, a primary care physician serves as the initial screening, testing, treatment and referral source for a patient. This physician oversees health care services rendered to patients by other providers and assumes continuing responsibility for the overall course of treatment.

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Plans provide financial incentives for covered individuals to use providers who deliver appropriate quality care. In some managed care plans, the cost of services is covered only when health care is received from selected providers. Other managed care plans provide individuals more latitude in the choice of providers. Out-of-pocket costs, however, are usually higher when out-of-plan providers are chosen.

Some state legislators are concerned that managed care, including both contracting arrangements with providers and utilization review techniques, could adversely affect the quality of health care. Their concerns have been encouraged by some associations of providers representing hospitals, physicians, dentists, pharmacists and allied health professions. These groups have drafted and advocated state legislative proposals that would restrict or prohibit the operation of managed care programs.

**HIAA POSITION:** HIAA is firmly committed to the expansion of managed care programs and techniques in order to assure high-quality, cost-effective health care. Managed care systems have the means to avoid unnecessary and inappropriate care.

Therefore, HIAA is opposed to legislation or regulations that would impose barriers to the development and implementation of managed care in its current and evolving forms. Legislation or regulation that unduly limits insurers' ability to carry out rigorous utilization review is one such barrier. Legislation that opposes utilization review takes many forms, but generally seeks to put inappropriate restrictions on who can conduct reviews and what can be reviewed.

HIAA is also opposed to legislation that would restrict an insurer's freedom to form networks or contract selectively with providers. Legislation that opposes networking also takes many forms, but generally seeks to put restrictions on the ability to pay providers anything but their usual and customary fees, or to contract with a limited number of providers.

HIAA believes:

- o Insurers should be free to negotiate whatever price they can with providers. One important way to reduce costs is to be able to buy provider services at lower prices, and managed care systems need to have freedom to negotiate lower prices. On the other hand, in some instances plans may wish to offer higher-than-usual fees to especially efficient providers.
- o Insurers should be able to pay providers in ways that create appropriate incentives. If provider reimbursement systems reward high-cost medical practice, it will be very difficult to reduce costs. Managed care systems need to be able to alter reimbursement incentives to reward efficient providers. Severe restrictions on capitation payment, for example, are inappropriate and unwarranted.
- o State laws should not place artificial limits on the amount of consumer cost sharing that can be imposed on PPO plan enrollees who choose to get care from off-panel providers. If a PPO has a panel of providers that can provide needed high-quality services more efficiently than other providers, it is entirely appropriate to require consumers who choose not to use these efficient providers to pay the extra costs. HMOs, which all states allow, do not pay anything when consumers receive care from non-HMO providers.

Utilization review promises to help control health care costs. The medical establishment is fighting back.

# The doctors' new allies

By Janet Novack

THE MEDICAL ESTABLISHMENT is unhappy. With the spread of managed health care programs (*see preceding story*) and other efforts to control spiraling health costs, physicians' freedom to prescribe whatever treatment they deem fit—and to be paid for it—is being constrained.

The medical business isn't taking the challenge lying down. Doctors, hospitals and other health care providers are lobbying the states to regulate the people hired by employers and insurers to screen for unnecessary care. "We expect up to 26 states to take up the issue, and up to 15 of these

to pass a law this year," worries Marguerite Snyder, government affairs director of the American Managed Care & Review Association.

At issue is the so-called utilization review process. Under it, a review nurse looks over the course of treatment a doctor wants to prescribe for a patient. If it doesn't fit set standards for appropriate care, the nurse passes the case on to a doctor who may try to whittle down the physician's proposal. Does the patient really need to go into the hospital at \$775 a day? Can't this procedure be done on an outpatient basis? About four out of five

companies now require workers to get prior approval for a nonemergency hospital stay, up from about 5% in 1984, according to a survey by consultant A. Foster Higgins & Co.

What's wrong with some intelligent question-asking? The doctors claim that too much of the time the questions are unintelligent and time-wasting and that cost-conscious reviewers can be a hazard to patients' health. Unsaid is that they also threaten doctors' wealth.

Dr. John Kelly, director of quality assurance for the American Medical Association, claims that the main reason there has not been "wholesale abuse of patients" by the review process is that doctors have fought long and hard with the reviewers to have care approved. Dr. Robert Becker, founder of Downers Grove, Ill.-based HealthCare Compare Corp., a successful, publicly owned utilization review company (*FORBES, Mar. 21, 1988*), acknowledges that there have been problems with some of the hundreds of review companies. Says Becker: "Doctors have had to wait too long on the phone to talk to poorly trained people."

Overall, however, there is no evidence that utilization review reduces the quality of care. A 1989 Institute of Medicine study found no "documented anecdotes or other information to suggest that prior review programs are jeopardizing patient safety"; the study concluded that "premature or misguided regulation could stifle worthwhile innovations" in utilization review. In any case, with regulation looming, the review industry is developing its own voluntary accreditation standards, which should help weed out poor performers.

Nonetheless, politicians in a score of states, pressed by the medical estab-



ishment, have passed laws that heavily regulate the reviewers. These laws—half of them not yet implemented—will increase reviewers' costs and in some cases interfere with review. Some examples:

- A new Georgia law requires that reviewers base some decisions on local medical practices. That negates a key principle of review, which is to look extra hard at local pockets where, say, patients are kept in the hospital longer than average.
- Virginia has drafted regulations stating that only a board-certified specialist can deny coverage for a procedure performed by another specialist. Thus, for example, a cardiologist could not review a surgeon's decision to do a coronary bypass.
- Maine's rules state that an insurer can't reduce payment for any state-mandated mental health benefit even if a patient refuses to go through the review process. But the threat of reduced insurance coverage is key to getting an employee's cooperation.

Mental health is, in fact, one of the trickiest areas. Costs here are growing so fast that many companies now monitor mental health care more intensively than other care, requiring, for example, prior review of outpatient mental health services but not other outpatient care. That's bad news for the earning power of psychiatrists. But the American Psychiatric Association is defending its members. It is circulating to its state affiliates a draft state law that would make it illegal to apply different review procedures to mental health care.

Where are the lawyers in all this? Licking their chops. A recent California court decision implies that the utilization review firm may be held liable if, for example, a patient is released from the hospital early because of pressure from reviewers and some harm results. In fact, warns Richard Hinden, a health care lawyer at Chicago's Altheimer & Gray, an employer might also be held liable if it is negligent in picking its utilization review firm.

Perhaps the fear of litigation, despite the rapid growth of utilization review, explains at least partly why health care costs are continuing to rise much faster than the general rate of inflation.

How perseverance earned PepsiCo the enviable position of Mexico's largest consumer products company.

# Pepsi's newest generation

By Claire Poole

SOMETIMES IT JUST PAYS to hang in there. When price controls and peso devaluations persuaded multinationals like Nabisco and Anderson Clayton to cut back their Mexican operations sharply in the wake of Mexico's 1982 economic collapse, PepsiCo elected to build. It is now cashing in on one of the world's most promising economies.

To counteract the peso devaluations, it started exporting wheat, later expanding to taco shells, frozen juices and pineapples—a business now worth \$30 million in sales. In 1984 it added candy and gum to its basic line of soft drinks and chips. And this past fall it spent \$320 million to buy nearly 80% of Empresas Gamsa, Mexico's largest cookie company. PepsiCo, based in Purchase, N.Y., is now Mexico's largest consumer products company, with an estimated \$1.2 billion

in sales—larger than Procter & Gamble or Colgate-Palmolive. Its probable pretax profits in Mexico last year: \$140 million.

Now price controls are easing, the peso has strengthened, and the government of President Carlos Salinas de Gortari is taking an enlightened view toward foreign investment. But it will take other multinationals years to catch Pepsi.

Michael Jordan, PepsiCo International's chairman and the man responsible for Pepsi's Mexican strategy, expects PepsiCo to be doing \$2 billion in annual revenues in Mexico by 1995. "Mexico will be one of the boom economies of the 1990s, with more explosive growth than Eastern Europe," says the 54-year-old Jordan, a 16-year PepsiCo veteran who's considered the strategic mind behind Dallas-based Frito-Lay, PepsiCo's



Stocking Sabritas products in a Monterrey store. A network that now supplies 400,000 shops in Mexico.

by

Christine M. Solomon  
Director of State Legislation  
Federation of American Health Systems



# Utilization Review — Managing the Reviewers

**A**lthough the issue of utilization review is not new, growth in the number of private utilization review (PUR) companies has kept pace with rapid expansion in the managed care industry. More and more frequently, hospitals and doctors are confronted with a maze of PUR companies, all clamoring for data and issuing determinations without the aid of standardized guidelines. In an attempt to inject some organization and safeguards into the way utilization review companies operate, state legislatures and other groups have begun to take action, either through the drafting of legislation or the development of guidelines.

#### Four states

Thus far, four states have adopted legislation to address the problem. In the forefront of these activities is Maryland, which in 1988 passed legislation, the major requirements of which include: certification of all review agents; submission to the credentialing body of reviewers' standards and procedures for conducting reviews; process for appeals of denials, and confidentiality of patient records. By addressing their legislation to the review organizations and not the providers, the Maryland law seems to have avoided any preemption through ERISA. The law also requires adoption of uniform standards for some aspects of PUR, including standardizing information forms. Implementation of the law still hinges on the adoption of regulations by the state health department; regulations are expected to be in place by this summer.

The newest PUR legislation was passed in January in South Carolina. The law is similar to the Maryland legislation, requiring registration and certification of PUR companies by the Commissioner of Insurance. Utilization review programs must meet certain requirements, including: notification of adverse decisions within five days; pro-

cedure for consideration of appeal of denials; availability of reviewer by telephone 40 hours a week, during normal working hours, and types and qualifications of review personnel must be furnished to the Commissioner.

In addition to Maryland and South Carolina, legislation has been adopted in Maine and Arkansas, basically requiring certification of companies meeting certain requirements to do business in the state.

A number of other states have either already introduced bills into their legislatures, or such bills are drafted and awaiting introduction. At this writing, these states include Pennsylvania, Georgia, Virginia, Massachusetts, Illinois, Florida and North Carolina. Most of the bills contain aspects of the Maryland law as well as the guidelines adopted for use in Tennessee.

The Tennessee provider groups have been meeting with representatives of the managed care industry, and have developed a set of standards for utilization review agents. These standards address certification of agents, description of the review process used and an appeals process to be used in the event claims are denied. The standards do not address the problem of retroactive denial of claims. It is expected that these standards will be put in place in Tennessee for at least a six-month period, after which time their effectiveness will be evaluated.

#### National level

At the national level, a number of groups are developing guidelines designed to satisfy not only managed care companies but also health care providers. Working together, guidelines were developed and published by the American Medical Association, Blue Cross and Blue Shield Association and the Health Insurance Association of America. Entitled "Guidelines for Health Benefits

Administration," they address both prior authorization and claims submission and review. These guidelines are currently under review for possible revision by the groups involved.

Most recently, a coalition of leading U.S. utilization review companies announced the formation of a national credentialing, organization and development of national voluntary review standards. The newly formed Utilization Review Accreditation Commission (URAC) will encourage voluntary compliance with the national review standards. The standards developed by URAC include guidelines that address such UR areas as: the role of UR organizations; the scope of inpatient UR review and responsibility of those parties involved; the process of notification and appeal of determinations; confidentiality of patient records, and qualifications of review company staff.

One group has developed draft model state legislation. The National Association of Private Psychiatric Hospitals (NAPPH) convened a special task force to draft the model bill, with the objective of "bringing about a means of establishing a level of uniformity and appropriateness in the conduct of utilization review." The model bill's requirements include: certification of review agents; provision for utilization review plan, including cri-

teria used in evaluating care; provision for process for appeals of denials by providers or patients; descriptions of requirements necessary to be a reviewer; use of physician-specialists to make the final determination of whether prescribed care is inappropriate; reasonable access to review agents during normal business hours, and confidentiality of patient records. The model bill also would prohibit reviewers from interviewing patients without approval of the admitting physician; and prohibit payments to reviewers based on number of denials.

#### Trends

A crystal ball is not necessary to see that the trend in health care is toward managed care — not just for medical and dental care, but for psychiatric, alcohol and drug abuse treatment as well. And key to any successful managed care program will be the cost-effective utilization of available services, together with the review of that utilization. Some form of regulation of the reviewers

— whether by legislation or guidelines — is the logical next step. The coming months will bring a clearer picture of just how such regulation will occur.

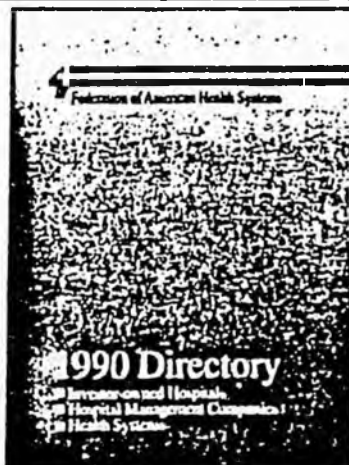
The Federation is working with those national organizations developing voluntary guidelines, as well as monitoring the possible need for state legislation. ■

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*The newly formed  
Utilization Review  
Accreditation Commission  
(URAC) will encourage  
voluntary compliance  
with the national  
review standards.*

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