ALASKA LEGISLATURE COMMITTEE FILES 1991-1992 8672
7067 HOUSE LABOR & COMMERCE

Make It Alaskan, Inc. is proud to join Ogden Allied Facility Management of Alaska, Inc., in sponsoring yearly Alaska product trade shows. These trade shows are held each fall in Anchorage, and each spring in Fairbanks. Alaskan manufacturers must be certified in the "Made In Alaska" program to participate, and are encouraged to call **451-7800 in Fairbanks or 279-0618 in Anchorage** for information on the shows,.

The shows are an all out effort to bring Alaskan made products under one roof, and present them to the rest of Alaska. Our goal is to educate Alaskans as to the importance of supporting and purchasing locally manufactured products. We need to become aware of the variety of Alaskan products which are available, and local manufacturers must be given an opportunity to compete with those products that come in from "Outside".

"DISPLAY ALASKA", our name for the trade shows, will take place September 28, 29, & 30, 1990 in Anchorage. A final date at the Carlson Center in Fairbanks for spring 1991 has not yet been set.

Display ALASKA

MADE-IN-ALASKA

Application for Certification

DBD USE ONLY

Authorization Number _____

NAME OF COMPANY

Name _____

Address _____

_____

_____

Phone _____

OWNER

Name _____

Address _____

_____

_____

Phone _____

Product Manufactured _____

Owner _____ _____ Business License # _____

Signature Date

FOR OFFICE USE ONLY

FIELD INSPECTION

Retail ☐ Wholesale ☐ Both ☐

Description of Manufacturing Facility _____

_____

_____

_____

_____

Comments _____

_____

_____

_____

_____

_____

Number of Employees:

Full Time _____ Part Time _____ Seasonal _____

Field Inspector Name: _____

Product(s) appears to meet criteria ☐

Product(s) appears not to meet criteria ☐

Signature _____ Date _____ Organization _____ Phone _____

Affidavit of Eligibility for Remote Manufacturing Sites

This affidavit is to be used **ONLY** at the direction of the department or designated agent.

The affidavit must be signed by the owner, and requires two witnesses.

I, the undersigned, do hereby certify that I manufacture a product (or products) in Alaska, and that this product (or products) satisfies the requirements of the MADE-IN-ALASKA program, as specified by the Department of Commerce and Economic Development, and I request that I be authorized to use the MADE-IN-ALASKA logo to identify the product (or products) specified above. In addition, I take full responsibility for the proper used of said logo in accordance with AS 45.50.170.

Signed _____

Name of Owner Date

Witness _____ Witness _____

Date Date

DIVISION OF BUSINESS DEVELOPMENT USE ONLY

I have reviewed the application and field inspection report. Certification of this product (or products) under the requirements of the MADE-IN-ALASKA Program is ☐ Approved ☐ Denied

Signed _____

Printed Name _____ Title _____

Date _____

The MADE IN ALASKA program is an ongoing effort by the Department of Commerce and Economic Development, Division of Business Development, and Make It Alaskan, Inc. for the purposes of identifying and promoting products manufactured in Alaska. The MADE IN ALASKA trademark, a logo with a mother bear and her cub, named "TOKLAT and MISHKA", is registered with the State of Alaska and cannot be used without written permission of the Department of Economic Development, the trademark holder. Before a product can use the logo, it must meet the necessary criteria and be certified by the commissioner of the department. The logo goes to the product and not to the manufacturer.

Any Alaskan business that manufactures a product in Alaska may apply for certification. To qualify for permission to use the MADE IN ALASKA logo, the applicant must meet all of the following requirements, as appropriate:

1. Maintain the product manufacturing operations within the State of Alaska.
2. Produce a finished, manufactured product that is intended for sale by the producer, either wholesale or retail, in which the majority of value added processes were completed within the state.
3. A finished product, that has been partially manufactured in the state may qualify to use the MADE IN ALASKA logo if the applicant can show proof that no Alaskan facility has the capability to do the work being done outside.
4. The manufactured product must be made from Alaskan raw materials unless the manufacturer can show proof that the raw material does not economically exist within the state.
5. Allow the department or its designated representative to inspect the manufacturing facilities to verify in-state production. Where an inspection is not possible due to the location, an affidavit for remote sites is included in the application. Owner's signature must have two witnesses.
6. Have, or be in the process of obtaining, an Alaskan Business License.

We currently have product inspectors at the following locations in Alaska. Please contact the inspector at your location when you have completed the first portion of the application.

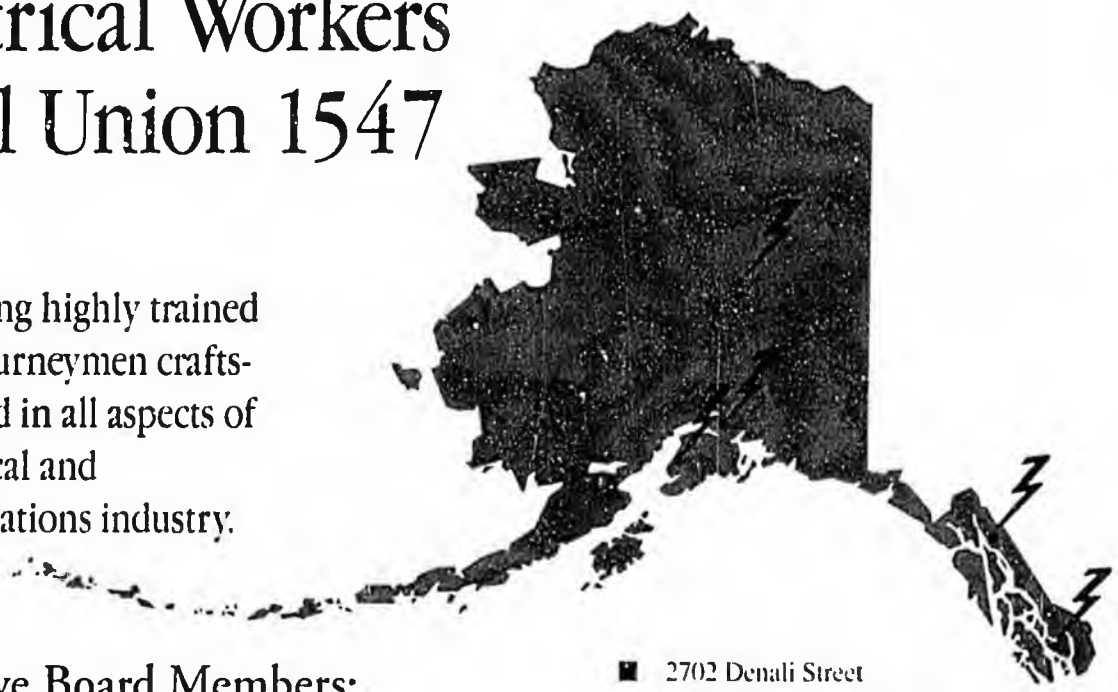
ANCHORAGE Make It Alaskan, Inc. 258-2878
ANCHORAGE Division of Business Development 562-2728
ANCHOR PT Chamber of Commerce 235-8351
BARROW 852-2611
CORDOVA Chamber of Commerce 424-3899
FAIRBANKS Chamber of Commerce 452-1105
HOMER Chamber of Commerce 235-8944
JUNEAU Division of Business Development 465-2017
KENAI Chamber of Commerce 283-7989
KENAI PENINSULA AREA 283-3335
KETCHIKAN Chamber of Commerce 225-3184
KODIAK Chamber of Commerce 486-5557
MOOSE PASS, COOPER LANDING AREA 288-3168
PALMER - WASILLA AREA 376-1060
PETERSBURG Chamber of Commerce 772-3646
SAXMAN .....225-4421 (gift type items, call 586-2108)
SEWARD Chamber of Commerce 224-3046
SITKA Chamber of Commerce 747-8604
SOLDOTNA Chamber of Commerce 262-9814
VALDEZ Chamber of Commerce 835-2330
WILLOW AREA 495-6823 495-6498

Mail the finished application to: **Division of Business Development - 3601 C Street, Suite 724 - Anchorage, Alaska 99503**

There are no fees or license costs to participate in the MADE IN ALASKA PROGRAM. Once certified, you can purchase logo stickers, tags, and labels at your local print shop by giving them your authorization number. You may use the logo in the advertising of your product. This includes letterhead, brochures, business cards, store displays, etc., as well as on any packaging your product comes in. The logo may be any size or combination of colors you choose. The only requirement is that the integrity of the logo be maintained, i.e. the two bears in a rectangular format with MADE IN ALASKA at the bottom.

IT IS IMPORTANT THAT YOU LET US KNOW OF ANY CHANGES THAT OCCUR IN YOUR BUSINESS, I.E. LOCATION, PRODUCT LINE ETC. PLEASE CALL US FOR THIS OR ANY QUESTIONS: MAKE IT ALASKAN, INC. 258-2878

International Brotherhood of Electrical Workers Local Union 1547



Representing highly trained Alaskan journeymen craftsmen skilled in all aspects of the electrical and communications industry.

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Elma M. Williams
Recording Secretary
Knute Anderson, Treasurer
Ronald L. Smith, Unit 101
Carl Crosman, Unit 102
Mike J. Notar, Unit 103
Denny Zeiser, Unit 104
Gary Brooks, Business
Manager/Financial Secretary

- 2702 Denali Street
  Anchorage, Alaska 99503
  (907) 272-6571
- 60 Hall Street
  Fairbanks, Alaska 99701
  (907) 456-4248
- 124 Front Street
  Juneau, Alaska 99801
  (907) 586-3050
- 2204 Tongass Street
  Ketchikan, Alaska 99801
  (907) 225-4020
- 36275 Kenai Spur Highway
  Soldotna, Alaska 99669
  (907) 262-1547

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HB

247

REPRESENTATIVE
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CRAIG, ALASKA 99921
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CHAIRMAN,
COMMUNITY & REGIONAL AFFAIRS COMMITTEE
VICE CHAIRMAN,
TRANSPORTATION COMMITTEE

Alaska State Legislature

WHILE IN JUNEAU
P.O. BOX V
JUNEAU, ALASKA 99811
(907) 465-4925

House of Representatives

Senate CS for CSHB 247 (L&C)

The following changes have been made in the draft Labor and Commerce Committee Substitute:

Section 2 — (D) and (F) were combined to provide that an applicant for licensure is not the subject of an adverse or unresolved complaint, investigation or review procedure.

Section 4 — (B) page 4, lines 3 - 4 "in scope, quality and difficulty" deleted; it now provides that an applicant for licensure by credentials must be licensed in another state, territory or region of the U.S. with licensing requirements at least <u>generally</u> equivalent to those in Alaska at the time of <u>application</u>; deleted "time of licensure in the other state, territory or region".

(C) page 4, line 7 - inserted "while practicing in those jurisdictions" after licensed.

(D) page 4, lines 9-15 - adopted the amendment proposed by the sponsor which specifies that an applicant for credentialing must have been engaged for 5 years in active clinical practice in good standing while (1) licensed in another state, or (2) working for the federal government after having been licensed by a jurisdiction.

(E) and (J) were combined as in section 1.

(H) deleted language that the applicant has not failed the state clinical examination. Was (G) in House Rules CS.

(2)(c) page 5, lines 15-16 - rewrote the subsection providing that the board shall adopt regulations to implement this section, deleting former (c)(2) which required that all paperwork had to provided directly to the board from the institution, agency or jurisdiction.

SECTIONAL ANALYSIS

SCSCSHB 247 (L&C)

Section 1 — Requires the Board of Dental Examiners to require all dentists applying for license or renewal to have a current CPR certification.

Section 2 — Repeals and reenacts AS 08.36.110, adding a new subsection (E), which provides that an applicant for a license shall not have an adverse report relating to criminal or fraudulent activity or malpractice in the national clearinghouse or data bank. Also provides that the applicant is not the subject of an unresolved or adverse complaint, investigation, review procedure or other disciplinary proceeding and is not an impaired practitioner.

Section 3 — Adds a new subsection (e) to AS 08.36.160, Contents of Examination, which provides that a passing score on a clinical exam given by the Western Regional Examining Board in the 5 years preceeding application will constitute a passing school on the Alaskan clinical examination.

Section 4 — Repeals and reenacts AS 08.36.234, Licensure by Credentials, to provide that the Board of Dental Examiners will provide for licensing without examination, except for an examination on the Alaskan dental statutes. An applicant for licensure by credentials must provide certification to the board that the dentist:

1) is a graduate of an accredited dental school;

2) has passed clinical and written examinations in another state or territory and been licensed to practice in that jurisdiction under licensing requirements generally equivalent to this state's requirements;

3) is in good standing with the licensing jurisdiction or federal agency;

4) has been engaged in continuous practice at least 20 hours per week in the previous five years;

5) is not the subject of an adverse or unresolved complaint, investigation, review procedure or proceeding, and has not had a license revoked, suspended or surrendered;

6) has not failed a clinical examination, in the past three years, of the the WREB;

7) has completed 42 hours of continuing education in the 3 years preceeding application;

8) is personally interviewed by the board, pays all fees, authorizes release of records to the Board and certifies that they are not an impaired practitioner;

9) provides that the board can revoke a license for evidence of misinformation or substantial omission, and that the board must adopt regulations to implement this section.

Section 5 Adds a new definition of "impaired practitioner" to AS 08.36.370.

Section 6 Provides for an immediate effective date.

HB

265

[redacted]OUSE COMMITTEE REPO[redacted]

(7)

Date Referred: April 10, 1991 FURTHER REFERRALS: Judiciary

Date of Committee Action: 4-18-91

The LABOR AND COMMERCE Committee considered: HB 265

HOUSE BILL NO. 265 INSTITUTIONAL REAL ESTATE APPRAISERS

"An Act relating to the certification of real estate appraisers; and providing for an effective date."

RECOMMENDATIONS: [ ] the same title
be replaced with _____ [ ] a new title

[ ] have attached amendments(s)
[ ] do pass
[ ] do not pass
[X] 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) _____

[X] zero fiscal note Commerce + Econ Dev. [ ] zero fiscal note(s) _____

SIGNING DO PASS	DP	OTHER RECOMMENDATIONS	DNP	NR	AM
David Donley	✓				
				✓	
				✓	

CHAIRMAN'S SIGNATURE

FISCAL NOTE

STATE OF ALASKA
1991 LEGISLATIVE SESSION

BILL NO. HB 265

Revision Date: _____ Department Affected: Commerce & Economic Dev.

Title: Relating to the certification of real estate appraisers;.... BRU: Occupational Licensing

Component: Administration

Sponsor: Rep. Navarre

Requestor: Rep. Navarre COMPONENT SERIAL NO. 0 3 5 6

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY 92	FY 93	FY 94	FY 95	FY 96	FY 97
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	0	0	0	0	0	0
CAPITAL						
REVENUE	**	**	**	**	**	**

FUNDING: (Thousands of Dollars)

GENERAL FUND						
FEDERAL FUNDS						
OTHER						
TOTAL	0	0	0	0	0	0

POSITIONS:

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

Estimate of current year impact: None

ANALYSIS: (Attach a separate page if necessary.) HB 265 creates a separate licensing category for institutional real estate appraisers. New funds are not required to implement this bill. **Revenue will be generated from application and license fees however, at this time, we are unable to provide an estimate until we have some idea of the numbers of individuals who would be affected by the bill.

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

Division: Occupational Licensing Date: 4-17-91

Approved by Commissioner: Glenn A. Olds

Agency: Commerce and Economic Development Date: 4-18-91

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

Rev 10/90

ALASKA STATE LEGISLATURE
REPRESENTATIVE MIKE NAVARRE

Co-Chair
House Finance Committee
P.O. Box V
Juneau, Alaska 99811
(907) 465-3779

April 15, 1991

M E M O R A N D U M

TO: Representative David Finkelstein, Chair,
All members
House Labor and Commerce Committee

FROM: Representative Mike Navarre Mike

Subject: House Bill 265, "An Act relating to the certification of real estate appraisers; and providing for an effective date."

In 1989, federal requirements were modified by Title XI of the Financial Institutions Reform, Recovery and Enforcement Act (the savings and loan "bailout", or FIRREA). The federal act required that all appraisals dealing with federal funds be performed by state certified or licensed appraisers. Last year the Legislature passed HB 523, which set into place those certification and licensing procedures.

I introduced HB 265 to amend those statutes to provide for another class of real estate appraiser, the "institutional real estate appraiser." The proposal to add this class of appraiser was initiated by the Alaska Real Estate Appraisers Association, and is more or less a "housekeeping" measure.

I respectfully request the committee's favorable consideration of HB 265.

DISTRICT 5
34824 K-Beach Road • Soldotna, Alaska 99669 • (907) 262-7842

Department of Commerce & Economic Development / POSITION PAPER

HB 265: "An Act relating to the certification of real estate appraisers; and providing for an effective date."

HB 265 creates a new certification category for institutional real estate appraisers by amending the real estate appraiser statutes (AS 08.87). The bill requires individuals who are employed full-time by a financial institution to obtain a certificate issued by the Board of Real Estate Appraisers, as proof of satisfying educational and testing requirements in compliance with federal law.

The institutional real estate appraiser certificate is valid only during the period in which the individual is employed full-time by a financial institution in Alaska. Under this category, individuals who perform real estate appraiser services for a financial institution must meet limited qualifications consisting primarily of educational and testing requirements, and not necessarily the experience requirements mandated for general or residential real estate appraisers.

Section 3 of the bill repeals and reenacts AS 08.87.110(e) to clarify the "limited certification" provision by replacing the section with specific language identifying the federal mandates.

Since HB 265 attempts to clarify and bring the real estate appraiser statutes closer into compliance with the federal mandates, the department supports passage of this bill.

Glenn A. Olds, Commissioner

Date: 4-18-91

GAO/JS/dgl9417D
041791a

ALASKA CHAPTER
OF THE

APPRAISAL
INSTITUTE

Post-it™ brand fax transmittal memo 7671 | # of pages ▸ 1

To Rep Navarre	From William Larick
Co.	Co. Appraisal Inst
Dept.	Phone # 243-4181
Fax # 465-2918	Fax # 243-4171

April 18, 1991

The Honorable Mike Navarre
Member of the Alaska State Legislature
3111 "C" Street
Anchorage, Alaska 99501

RE: House Bill 265

Dear Representative Navarre:

The newly organized Alaska Chapter of the Appraisal Institute, which encompasses 180 appraisers, wishes to info m you of our support of House Bill 265.

At our March meeting the proposed framework of this bill was discussed at length and was endorsed by an overwhelming majority. We feel this to be a significant piece of legislation that will positively affect our profession.

We look forward to working with you on this bill.

Sincerely,

William A. Larick, SRA
President, Alaska Chapter
of the Appraisal Institute

WAL/llt

DENALI STATE BANK
119 N. Cushman Street • (907) 456-1400 • FAX (907) 456-2140 • P.O. Box 74568 • Fairbanks, Alaska 99707-4568

April 16, 1991

Representative Navarre
Alaska State Legislature
via Fax #1-465-2278

RE: House Bill 265
"An Act Relating to the Certification of Real Estate Appraisers; and Providing for an Effective Date."

Thank you for introducing HB265 concerning certification of real estate appraisers. This bill has a great influence upon the banking industry in the State of Alaska as we attempt to comply with recent Federal FIERRA laws.

As Chairman of the Legislative Committee of the Alaska Bankers Association, I am pleased to advise you that we support the concept of this bill. However, we continue to be concerned with the departure in terminology that appears to be required in the FIERRA legislation designating "certified" and "licensed" appraisers and procedures. Every effort should be made to find out if the designation of "general", "residential", and "institutional" real estate appraisers terminology in this bill will comply with Federal FIERRA laws prior to the passage of the bill.

Failure to comply with FIERRA may potentially find financial institutions in the State of Alaska being unable to extend mortgage loans until such time as State law comes into compliance with FIERRA. It is better to determine this during the legislative session rather than after the session is over and an opportunity to amend this bill would not occur until January of 1992.

Once again, thank you for your introduction of the bill and with the exception of our concern about terminology, we hope for its speedy passage.

Sincerely,

Gary Roth

Gary Roth
President and Chief Executive Officer

ALASKA MORTGAGE BANKERS ASSOCIATION
P.O. BOX 9-2691 ANCHORAGE, ALASKA 99509-2691

April 16, 1991

Representative Mike Navarre
Alaska State House of Representatives
P. O. Box V
Juneau, Alaska 99811

Re: HB 265

Dear Representative Navarre:

Our Association appreciates your introduction of HB 265. We support passage of the bill, which will correct some technical problems in the present statute.

If we can be of any assistance, please call me at 257-3442.

Sincerely,

Lucille Stietz
Chair, Legislative Committee

Alaska State Legislature

REPRESENTATIVE
MARK BOYER

VICE-CHAIRMAN
HOUSE FINANCE COMMITTEE

FAIRBANKS

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

JUNEAU

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

House of Representatives

MEMORANDUM

DATE: May 3, 1991

TO: Representative David[illegible]nkelstein, Chairman
House Labor and Commerce Committee

FROM: Representative Mark Boyer

RE: Scheduling of HB 269 - Utilization Review

I would like to respectfully request that you schedule CSHB 269 (HESS), 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. CSHB 269 (HESS) passed out of the House HESS Committee on Friday, May 3, with a majority of the committee voting do pass.

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 the legislation 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.

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. CSHB 269 (HESS) 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 CSHB 269 (HESS).

[redacted]OUSE COMMITTEE REPOR[redacted]

(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:
be replaced with CS HB 269 (HES)

[ ] the same title
[ ] 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)

[✓] fiscal impact ______________

[ ] zero fiscal note ______________

APPROVES PREVIOUS: (Dept/Date)

[ ] fiscal note(s) ______________

[ ] zero fiscal note(s) ______________

SIGNING DO PASS	DP	OTHER RECOMMENDATIONS	DNP	NR	AM
		[signature]		✓	
		[signature]		✓	
		[signature]		✓	
		[signature]	✓		

[signature]

CHAIRMAN'S SIGNATURE

7-LS1185\J ✓
Luckhaupt
4/7/92

CS FOR HOUSE BILL NO. 269 ( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

SEVENTEENTH LEGISLATURE - SECOND SESSION

BY

Offered:
Referred:

Sponsor(s): REPRESENTATIVES BOYER, Navarre

A BILL

FOR AN ACT ENTITLED

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

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

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

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

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

CHAPTER 85. PRIVATE REVIEW AGENTS..

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

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

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

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

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

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

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

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

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

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

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

(1) the review standards, criteria, and procedures to be used in evaluating hospital or outpatient care that has been proposed or is being or has been delivered; provided that if the applicant uses a software package or other published standards, criteria, and procedures that are available to the public, the applicant may identify the system and distributor and specifically identify all alterations, additions, or deletions from the published system; an applicant shall immediately report a substantial change in the standards, criteria, and procedures utilized and shall annually report to the department all changes to the standards, criteria, and procedures;

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

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

(4) the number, type, and qualifications of the personnel employed by or under

contract with the private review agent to perform the utilization review; individual biographies or resumes of the personnel are not required unless requested by the department; the plan must include

(A) the requirement that a private review agent have available the services of sufficient numbers of registered nurses or other mental health professionals, as appropriate, supported and supervised by physicians trained in the appropriate specialty area, to carry out its utilization review activities, or to have appropriate numbers of physicians trained in the appropriate specialties for which utilization review is being conducted; and

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

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

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

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

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

(9) prohibitions against a private review agent entering a hospital to interview a patient unless the attending physician is advised of the interview with reasonable advance notice, and the attending physician or the physician's designee is allowed to attend the interview; this paragraph does not apply to a full-time, on-site review agent;

(10) a prohibition against an incentive payment provision or plan contained in a

private review agent's contract with an entity paying for health care services under which the agent's compensation is based on controlling the amount charged for services, duration of services, or setting in which services are rendered and a prohibition against the agent receiving the incentive payment;

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

(12) a list of the health care insurers for which the private review agent is performing utilization review in the state and a brief description of the services it is providing for each client, including an affirmation that a payment incentive provision or plan prohibited under (10) of this subsection does not exist with respect to each client;

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

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

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

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

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

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

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

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

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

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

(b) Before revoking a license under this section, the department shall provide the license holder with reasonable time to supply additional information demonstrating the holder's compliance with the requirements of this chapter.

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

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

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

(c) Within 45 days of receiving a complaint, the department shall notify the patient or provider if the complaint is incomplete or lacks information available to the patient or provider necessary to a decision. The patient or provider shall supply the necessary information before a decision on the complaint.

(d) If the department fails to render a decision on a complaint brought by a patient or provider within 90 days, or within 45 days after an incomplete complaint has been completed by the submission of the necessary information identified in (c) of this section, the patient or provider may bring suit in the superior court to compel the department to take an action specified in (a) of this section.

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

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

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

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

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

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

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

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

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

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

Sec. 08.85.150. DEFINITIONS. In this chapter,

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

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

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

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

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

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

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

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

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

DRAFT

April 7, 1992

CS FOR HOUSE BILL NO. 269 ( )

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

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

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

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

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

CHAPTER 85. PRIVATE REVIEW AGENTS.

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

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

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

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

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

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

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

line 9: address concern that hospitals may go in to UR business, competing with other UR agents that must comply with these requirements. (HAA, page 1)

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

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

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

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

line 18: "provided" changed to "available" (Sponsor change: don't want to require that this information be provided to every patient and provider unless requested)

(1) the review standards, criteria, and procedures to be used in evaluating hospital or outpatient care that has been proposed or is being or has been delivered; provided that if the applicant uses a software package or other published standards, criteria, and procedures that are available to the public, the applicant may identify the system and distributor and specifically identify all alterations, additions, or deletions from the published system; an applicant shall immediately report a substantial change in the standards, criteria, and procedures utilized and shall annually report to the department all changes to the standards, criteria, and procedures;

lines 20-25: allow applicant to simply supply name and distributor of publicly available software or other published standards, criteria and procedures, if the applicant uses a purchased system. If an in-house system, they would need to fully disclose criteria, etc. (Aetna, page 9, HAA, page 1)

Also, would allow for annual updates, if criteria change. Substantial changes should be reported immediately. (HAA, page 1)

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

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

(4) the number, type, and qualifications of the personnel employed by or under

contract with the private review agent to perform the utilization review; individual biographies or resumes of the personnel are not required unless requested by the department; the plan must include

(A) the requirement that a private review agent have available the services of sufficient numbers of registered nurses or other mental health professionals, as appropriate, supported and supervised by physicians trained in the appropriate specialty area, to carry out its utilization review activities, or to have appropriate numbers of physicians trained in the appropriate specialties for which utilization review is being conducted; and

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

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

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

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

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

(9) prohibitions against a private review agent entering a hospital to interview a patient unless the attending physician is advised of the interview with reasonable advance notice, and the attending physician or the physician's designee is allowed to attend the interview; this paragraph does not apply to a full-time, on-site review agent;

(10) a prohibition against an incentive payment provision or plan contained in a

lines 1-3: language clarifying that summary information would be sufficient - not interested in individual biographies of all staff. (HAA, page 2)

line 5-6: provide for mental health professionals. (HAA, page 3)

line 10: According to Leg. Legal, more specific wording for "relevant" is not needed. It should be handled in regs. (Aetna, page 11)

line 15: According to Leg. Legal, it is clear that "in this state" refers to business hours in Alaska. It provides for flexibility in interpreting "normal business hours". (HAA, page 4)

lines 17-18: Requiring "attending physician" to be reasonably available to confer with UR physician. (HAA, page 5)

lines 29-30: Exempting full-time, on-site review agents, such as at Providence. (Aetna, page 12)

private review agent's contract with an entity paying for health care services under which the agent's compensation is based on controlling the amount charged for services, duration of services, or setting in which services are rendered and a prohibition against the agent receiving the incentive payment;

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

(12) a list of the health care insurers for which the private review agent is performing utilization review in the state and a brief description of the services it is providing for each client, including an affirmation that a payment incentive provision or plan prohibited under (10) of this subsection does not exist with respect to each client;

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

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

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

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

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

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

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

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

line 5: Changes "sent" to "available". Corresponds to change on page 2, line 18.

lines 9-10: Statute reference instead of restating language. (HAA, page 7)

lines 14-15: Changed "fraud" to "fraudulent information or material misrepresentation" to avoid the greater burden of proof implied by fraud. (Aetna, page 13)

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

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

(b) Before revoking a license under this section, the department shall provide the license holder with reasonable time to supply additional information demonstrating the holder's compliance with the requirements of this chapter.

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

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

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

(c) Within 45 days of receiving a complaint, the department shall notify the patient or provider if the complaint is incomplete or lacks information available to the patient or provider necessary to a decision. The patient or provider shall supply the necessary information before a decision on the complaint.

(d) If the department fails to render a decision on a complaint brought by a patient or provider within 90 days, or within 45 days after an incomplete complaint has been completed by the submission of the necessary information identified in (c) of this section, the patient or provider may bring suit in the superior court to compel the department to take an action specified in (a) of this section.

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

lines 21-28: Clarifying that "a complaint" must have provided all necessary information before a suit can be filed. (Aetna, page 13 & 14)

Sec. 08.85.080. REGULATIONS. The department shall adopt regulations toimplement the provisions of this chapter, including regulations

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

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

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

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

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

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

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

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

Sec. 08.85.150. DEFINITIONS. In this chapter,

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

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

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

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

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

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

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

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

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

7-LS1185\J.1
Luckhaupt
04/08/92

AMENDMENT

OFFERED IN THE HOUSE

TO: CSHB 269( ) (DRAFT DATED 4/07/92)

Page 1, line 1:

Delete "licensing and"

Page 1, lines 4 - 8:

Delete all material and insert:

"* **Section 1.** AS 18.20 is amended by adding new sections to read:

ARTICLE 5. PRIVATE REVIEW AGENTS.

Sec. 18.20.400. PURPOSE. The purpose of AS 18.20.400 - 18.20.490 is to"

Page 1, line 13:

Delete "state employers"

Insert "employers in the state"

Page 1, line 14:

Delete "are qualified to perform"

Insert "meet certain minimum standards in the performance of"

Page 2, line 1:

Delete "to make"

Insert "in making"

Page 2, line 4:

Delete "Sec. 08.85.020. LICENSE"

Insert "Sec. 18.20.410. REGISTRATION"

Page 2, line 6, following "unless" through line 8, following "contract.":

Delete all material.

Insert "the person has

(1) registered as a private review agent on a form provided by the department;

(2) provided the department a list of all health care insurers for which the person is providing utilization review services in this state and a brief description of the services provided to the insurer;

(3) filed with the department an affirmation that

(A) a payment incentive provision or plan prohibited under AS 18.20.420 is not being utilized;

(B) the person has a utilization review plan that complies with the requirements of AS 18.20.420 that is available to patients and providers;

(C) the person will ensure confidentiality of patient information or records under AS 18.20 °0;

(D) provided the department with evidence acceptable to the department of liability insurance carried by the private review agent to cover potential liability from its activities under AS 18.20.400 - 18.20.490 in an amount, type, nature, and carrier satisfactory to the department.

(b) The department may set by regulation a fee for the registration of private review agents and other fees the department finds necessary to implement AS 18.20.400 - 18.20.490.

(c)"

Page 2, line 10, through "approves" on line 18:

Delete all material and insert:

"Sec. 18.20.420. UTILIZATION REVIEW PLAN. A private review agent registered under AS 18.20.410 shall have"

Page 2, line 23, following "system;" through line 25:

Delete all material.

Page 3, line 2:

Delete "unless requested by the department"

Page 4, lines 5 - 13:

Delete all material.

Renumber the following paragraphs accordingly.

Page 4, line 18, through page 5, line 29:

Delete all material and insert:

"Sec. 18.20.430. CRIMINAL AND CIVIL PENALTIES; SUSPENSION AND REVOCATION OF REGISTRATION: INJUNCTIONS. (a) A person who knowingly violates a provision of AS 18.20.400 - 18.20.490 is guilty of a class B misdemeanor.

(b) Notwithstanding (a) of this section, after a hearing the department may revoke or suspend the registration of a person and may fine a person up to $5,000 who knowingly violates a provision of AS 18.20.400 - 18.20.490, a regulation of the department adopted under AS 18.20.400 - 18.20.490, or an order of the department issued under AS 18.20.400 - 18.20.490.

(c) The department may bring an action in the superior court to enjoin a violation of AS 18.20.400 - 18.20.490, to enforce compliance with a regulation adopted under AS 18.20.400 - 18.20.490, or to enforce an order issued under AS 18.20.400 - 18.20.490. Evidence of a single act is sufficient to justify an injunction without evidence of a general course of conduct."

Reletter the following subsection accordingly

Page 6, line 1:

Delete "Sec. 08.85.080."

Insert "Sec. 18.20.440."

After "regulations":

Insert "under AS 44.62 (Administrative Procedure Act)"

Page 6, line 2, following "of" through line 5:

Delete all material.

Insert "AS 18.20.400 - 18.20.490."

Page 6, line 6:

Delete "Sec. 08.85.090."

Insert "Sec. 18.20.450."

Page 6, line 11:

Delete "licensing requirements of this chapter"

Insert "requirements of AS 18.20.400 - 18.20.490"

Page 6, line 12:

Delete "Sec. 08.85.100."

Insert "Sec. 18.20.460."

Page 6, lines 13 - 14:

Delete "periodically provide a list of licensed private review agents and the expiration date for their licenses"

Insert "provide a list of private review agents on request"

Page 6, line 16:

Delete "Sec. 08.85.110."

Insert "Sec. 18.20.470."

Page 6, line 24:

Delete "this chapter"

Insert "AS 18.20.400 - 18.20.490"

Page 6, line 27:

Delete "This chapter"

Insert "AS 18.20.400 - 18.20.490"

Page 6, line 29:

Delete "Sec. 08.85.150."

Insert "Sec. 18.20.490."

Delete "this chapter"

Insert "AS 18.20.400 - 18.20.490"

Page 7, line 16:

Delete "* Sec. 3."

Insert "* Sec. 2."

Page 7, line 18:

Delete "licensing and"

Delete "AS 08.85"

Insert "AS 18.20.400 - 18.20.490"

Page 7, line 19:

Delete "* Sec. 4. AS 08.85.080 and 08.85.150, enacted by sec. 2"

Insert "* Sec. 3. AS 18.20.450 and 18.20.490, enacted by sec. 1"

Page 7, following line 20:

Insert a new bill section to read:

"* Sec. 4. Except for AS 18.20.450 and 18.20.490, enacted by sec. 1 of this Act, this Act takes effect January 1, 1993."

HB 269

AMENDMENTS
by Boyer

Amendment #1

Page 4, line 10:
after "client;" add:
"an applicant shall annually report to the department all changes to the list of health care insurers;"

Amendment #2

Page 4, line 25:
after "providers" add:
"during the most recent licensing period"

Amendment #3

Page 5, line 4:
after "revoke" add:
", suspend, or place on probation"

Department of Commerce & Economic Development / POSITION PAPER

CSHB 269: "Licensing and regulation of private health care review agents."

There is a need to hold down costs for employers providing a health care plan if those costs are being driven upward by unnecessary procedures and exaggerated hospital stays or after care. There is also a need to protect patients from being subjected to unnecessary procedures or medication.

Insurance companies have increasingly turned to utilization review firms to determine whether care procedures are or were warranted in individual cases. They also approve the length of hospital stay.

This bill seeks to provide assurance that these review firms and their employees possess the needed skills and education to accurately assess the procedures.

The bill requires the applicant to file a review plan but does not specify the basis on which the department may reject the plan.

The bill does not establish what is acceptable as guidelines for a standard review. Therefore, most of the review is discretionary.

Sec. 08.85.030(b)(4)(A): "Sufficient number of nurses" and "appropriate numbers of physicians" is too vague. If the bill is trying to establish speedy handling or availability, perhaps it needs to state hours and days (including week-ends) someone is available.

Sec. 08.85.030(b)(6): "The requirement that except in exceptional circumstances" needs to be clarified.

Needs language requiring licensees to notify department when they are adding or dropping an insurer.

Sec. 08.85.030(b)(13): Needs to add to be set by regulations after "department,"

Sec. 08.85.040. RENEWAL OF LICENSE. (a)(1) files an application for renewal, provides evidence of current liability insurance, any change of the review plan [including the information] required under AS 08.85.030(b), and submits the appropriate renewal fee and . . . .

Sec. 08.85.040(b): An application for renewal of a private review license must include a list of all complaints made to the agent by patients or providers during the most recent licensing period and a brief description . . . .

Sec. 08.85.060. REVOCATION OF LICENSE. (a) The department may revoke, suspend, or place on probation a license . . . .

Sec. 08.85.070. COMPLAINTS AGAINST LICENSE HOLDER. (c) 90 days is probably not a reasonable time to investigate, hold hearing and render a decision.

In summary, we do not oppose the bill, but have numerous concerns about the vagueness with which it is written.

In our opinion, too much of the review is discretionary.

Glenn A. Olds, Commissioner

Dated: 5-9-91

9561D
050891a

DIVISION OF LEGAL SERVICES

LEGISLATIVE AFFAIRS AGENCY
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MEMORANDUM February 21, 1992

SUBJECT: Sectional Summary - CSHB 269(HES)

TO: Representative Mark Boyer
Attn: Fawn Helms

FROM: Jerry Luckhaupt
Legislative Counsel

You have requested a sectional summary of CSHB 269(HES), an Act providing for the licensing of private health care review agents. Be advised that a sectional summary is not an authoritative interpretation of the bill. The bill itself is the best statement of its contents.

Section 1 of the bill applies AS 08.01 to the regulation of private review agents.

Section 2 of the bill is the statutory meat of the bill. It adds a new chapter to AS 08.

AS 08.85.010 provides a purpose clause.

AS 08.85.020 requires that a person who seeks to perform a utilization review (which is a system to review the appropriate medical care to be given a patient, see AS 08.85.150(5)), on behalf of a health care insurer must be licensed.

AS 08.85.030 provides the application procedures for a license.

AS 08.85.040 provides for renewal of licenses.

AS 08.85.050 provides procedures for denial of a license.

AS 08.85.060 provides for revocation of licenses.

AS 08.85.070 provides for complaints against licensees.

AS 08.85.080 requires the Department of Commerce and Economic Development to adopt regulations to implement AS 08.85.

AS 08.85.090 exempts from the requirements of AS 08.85 employees or contractors of the federal government.

AS 08.85.100 requires the department to publish a list of licensed private review agents.

AS 08.85.110 provides that medical records obtained by a private review agent are confidential.

AS 08.85.150 provides definitions.

Section 3 of the bill requires the department to comply with the contested case provisions of the APA (AS 44.62.330 - 44.62.630) when regulating private review agents.

Section 4 of the bill provides an effective date.

GPL:pl
92-123.plm

Alaska State Legislature

Legislative Research Agency

P.O. Box Y
Juneau, AK 99811-3100
Phone: (907) 465-3991
Fax: (907) 463-3351

June 3, 1991

MEMORANDUM

TO: Representative Mark Boyer

FROM. Christine M. Cheff
Legislative Analyst

RE: Utilization Review Statutes in Other States
Research Request 91.270

You asked for a comparison of licensing and certification laws for private health care review agents in the states of Arkansas, Maine, Maryland, and South Carolina, and for information about the implementation of those laws.[1] Additionally, you asked for a sample of utilization review bills from those pending in the states of Florida, Georgia, Illinois, Massachusetts, North Carolina and Pennsylvania.

Utilization review (UR) is a service conducted primarily by or for an insurer to determine whether the cost associated with providing health care services to a patient should be paid by the insurer.[2] It is the private review agent who makes that determination. Hospital services such as pre-admission, second surgical opinions, medical necessity, length-of-stay, and the medical service delivery site can be included in utilization review. The UR process usually involves reviewing a patient's medical records or examination of the patient and can take place before, during or after a hospital stay or the receipt of health care service.

According to insurers, the purpose of UR is to control costs while assuring that the quality of health care is maintained.[3] Health care providers generally support those objectives but have some concerns about the way in

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[1]In this memo, private health care review agents will be referred to as "review agents" or "agents," and "certificate" is synonymous with license.

[2]The Annotated Code of Maryland 1990 [Section 19-1301(b)] defines utilization review as "a system for reviewing the appropriate and efficient allocation of hospital resources and services given or proposed to be given to a patient or group of patients" (see Attachment A).

[3]The Iowa Division of Insurance, *Presentation to the Fiscal Committee (of the Legislative Council)*, July 18, 1990.

which UR is conducted. They believe that the procedures and criteria used to make UR decisions should be available to patients and providers and that determinations to deny medical services should be made by or in consultation with a physician qualified in the area of medicine related to a prescribed course of treatment. Because there are no regulations to ensure that these or other areas of concern are addressed by private review agents, many health care providers favor the passage of laws requiring that only certified or licensed agents be allowed to conduct UR activities.[4]

COMPARISON OF CERTIFICATION/LICENSING LAWS

Maryland was one of the first states (1988) to adopt a certification law for "nonhospital-affiliated" agents who perform utilization review (UR) for business entities or "third party" providers or hospital administrators (Attachment A).[5] Serving as a model for the laws adopted in Arkansas, Maine and South Carolina (Attachments B-D), the Maryland law is intended to:

a. promote delivery of quality, cost-effective health care;

b. foster greater coordination between payors and providers of UR;

c. ensure that private review agents are qualified to perform UR and to make medical care decisions; and

d. ensure confidentiality of medical records.

To obtain a certificate to engage in UR, an agent must apply to the state agency designated by statute to grant the certificate or license.[6]

The following table presents general information about statutory provisions concerning certification or licensure in the four states whose laws we reviewed. It is followed by more detailed information about application requirements, fees and the denial/revocation process.

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[4]Bill Analysis, House Bill 2503, 87th General Assembly, State of Illinois, 1991 and 1992 (see Attachment H).

[5]Arkansas law (Section 20-9-907) further requires that "every health insurance plan/insurer proposing to issue or deliver a health insurance policy or contract or administer a health benefit program which provides for the coverage of hospital and medical benefits and the UR of those benefits shall:" have a certificate or "contract with a certificated private review agent. . ." (see Attachment B).

[6]The application, annual, and renewal fees are established by statute in Maine and South Carolina, by regulation in Arkansas and Maryland.

STATE	GRANTING AGENCY	LICENSE OR CERTIFICATE	TERM	APPL. FEE	WAIVERS* GRANTED TO
ARKANSAS	Board of Health	Certificate	2 yrs	$1,500	Agents under contract to the federal government, home health agencies, preferred providers, clinics, private offices, pharmacists.
MAINE	Bureau of Insurance	License	1 yr	$400	Insurers, nonprofits, HMOs, preferred providers.
MARYLAND	Secretary of Health & Mental Hygiene	Certificate	2 yrs	$1,500	Agents under contact to the federal government.
SOUTH CAROLINA	Insurance Commissioner	Certificate	2 yrs	$400	Insurers & HMOs licensed or regulated by Department of Insurance.

*Private review agents who meet these criteria are not required to obtain a certificate or license to perform utilization review.

Minimum Application Requirements

An applicant for a UR certificate or license must submit the following information to the designated granting authority.

1. A utilization review plan which includes:

   a. a description of review standards and procedures used for evaluation of hospital care;

   b. the circumstances under which UR would be delegated to a hospital UR program (Maryland only);

   c. the process by which patients, physicians, and hospitals appeal an adverse decision.

2. The type and qualifications of personnel who will perform UR.

3. Procedures and policies to ensure accessibility to the review agent by patients and providers during normal in-state business hours, five days per week.

4. Copies of materials used to inform patients and providers of UR plan requirements.

5. A guarantee of confidentiality of individual medical records reviewed during the UR process.

6. A list of third-party payors for whom the agent is performing UR in the state.

Denial/Revocation of Certificate or License

A certificate or license application will be denied if it does not meet the statutory requirements outlined above, or if it violates applicable regulations. Once issued, certificates and licenses are subject to periodic review at the discretion of the issuing agency.[7] Failure to comply with defined standards and procedures, applicable regulations, or ordered corrective actions can result in the imposition of a fine, or suspension or revocation of the certificate.

Fines are imposed through different processes. Authorization for the imposition of a civil penalty not to exceed $1,000 is given to the Superintendent of the Bureau of Insurance in Maine and the Chief Insurance Commissioner in South Carolina. "Violation of provisions of law or regulations is a misdemeanor with a fine on conviction of not more than $1,000" in Arkansas and Maryland. After the first conviction, "each day a violation is continued is a separate offense."

Appeal of Application Denial or Certificate/License Revocation

All of the laws we reviewed include a provision allowing the applicant or certificate holder a reasonable amount of time to supply required compliance information before an application is denied or a certificate is revoked. An applicant or certificate holder may request a hearing before the granting authority and must be notified 30 days in advance of the scheduled hearing date. Additionally, in Arkansas and Maryland hearing decisions can be appealed to the courts.

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[7]Maine (Section 277A) and South Carolina (Section 38-70-40) statutes also specify the use of telephone audits to determine compliance with the requirement that agents are "reasonably accessible."

Other Statutory Provisions

There are certain unique statutory provisions in each of the states whose laws we reviewed. The following is a list of those worth noting.

MAINE - The Bureau of Insurance must "compile and maintain a current listing of persons, partnerships or corporations" licensed under statute (Section 2771). It is the only state of those reviewed which has no statutory prohibition against transferring a certificate or license.

MARYLAND - The Secretary of Health and Mental Hygiene is required to periodically provide a list of certified private review agents and their certificate renewal dates to the Chamber of Commerce, the hospital association, hospital UR programs, and other businesses or labor organizations requesting the list (Section 19-1309).

A 1990 amendment to Maryland law provides guidelines to be followed by agents reviewing services for the treatment of alcoholism, drug abuse, or mental illness. In particular it requires that determinations for denial or reduction in coverage of these services must be made by "a physician, or a panel of other appropriate health care providers with at least 1 physician" whose qualifications meet statutory definitions (Attachment E).

SOUTH CAROLINA - Private review agents conducting UR in the state of South Carolina on the effective date of the law were allowed 90 days to submit applications for certification. The Insurance Commissioner then had six months from receipt of the application to act. During the transition period, agents were allowed to continue UR activities "subject to the jurisdiction of the commissioner." [Section 38-70-20(A)]

IMPLEMENTATION OF CERTIFICATION/LICENSURE LAWS

The Arkansas, Maine, Maryland and South Carolina laws requiring certification or licensure of private utilization agents were passed between 1988 and 1990, and implemented during the fiscal year beginning July 1, 1990. The number of certificates or licenses issued ranges from 12 in Maine to 85 in South Carolina. Alison Bane, contract examiner for the Maine Bureau of Insurance, said her department's biggest problem is determining the number of UR agents operating in the state. They have received 15 applications since the February 9, 1991 implementation deadline. Representatives of each state's certificate granting agency believe that compliance with the law will be voluntary, however they are also relying on the hospitals to report violations. Copies of the Maine and South Carolina application packages are attached (Attachments F and G).

Only a few applications for certification have been denied by the South Carolina Department of Insurance. Those denials were for failure of the applicant to submit all required information. According to Tim Baker, director

of the Utilization Review section, the number is low because applicants are forewarned they will be charged an additional $400 fee to re-apply. He receives a substantial number of phone calls from agents requesting prefiling guidance.

Despite an estimated 60 to 70 complaints concerning review agents received each month (almost 95 percent from physicians), Mr. Baker's office has not acted to suspend or revoke any certificates. Approximately one-half of the private agents doing business in South Carolina are companies located west of the Mississippi and most problems are necessarily resolved through telephone negotiation. Mr. Baker believes it's important to meet with review agents and providers to work at solving the problems, but his is a one-person operation without the resources to do so. Staff and budget limitations have also restricted his ability to conduct the periodic reviews and audits of certificate holders mandated by statute. According to Mr. Baker, legislators and regulators underestimated the number of private review agents that would operate in the state, the number of complaints that would be received, and the amount of time required for implementation of the laws.

Maryland's certification law is a "money maker" but "not effective" according to Bill Darrill, deputy director of the Office of Licensing and Certification. He says original legislation proposed by the Maryland Hospital Association was an attempt to create a standardized utilization review formula for hospitals to follow. It included a provision that the UR plan submitted with applications for certification would be made available to providers and patients.[8] But through lobbying efforts on the part of private review agents that provision was deleted. Denise Matricciani, director of Legislative Services at the Maryland Hospital Association was involved with drafting the original bill. According to her, review agents contended that UR standards and criteria are proprietary information and release to the public would provide an advantage to their competitors. But the effort to amend statutes for inclusion of a provision to make UR plans available to patients and providers is still underway. Legislators will be working on a new bill during this summer's interim. Ms. Matricciani also said there have been reports by some hospitals that review agents are being more cooperative about providing information concerning UR standards.

PENDING LEGISLATION

Copies of pending legislation for the certification of private UR agents in Illinois and Massachusetts are attached.

The Illinois Hospital Association supports House Bill 2503 to create "the Patient Protection in Utilization Review Act." The bill includes a provision

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[8]The same provision as included in your House Bill 269 [Sec. 08.85.030(b)].

for making UR procedures and criteria available to patients and providers. It would also grant reciprocity to UR agents who are "certified, licensed, or otherwise authorized to conduct utilization review under the laws of another state . . ." if they are in substantial agreement with the Illinois law. (Attachment H)

Three UR bills were introduced in Massachusetts--one each from the hospital association, medical society, and psychiatric association. The House Health Care Committee is attempting to redraft a bill which will meet the concerns of all health care providers. Two of the issues which the bill will address are:

- a requirement that a qualified physician be involved in any determination to deny claims for third-party reimbursement of services provided or to be provided to a patient, and

- a requirement that private review agents carry liability insurance (Attachment I).[9]

ADDITIONAL INFORMATION

We have enclosed additional information which might also be of interest to you.

The American Managed Care and Review Association (AMCRA) is a trade association located in Washington, DC which supports current efforts to establish a national standard for UR agents under the Utilization Review Accreditation Commission (URAC). Director of State Affairs Stephen Lamb says AMCRA believes "the accreditation process is far superior to establishing an expensive state regulatory structure." A copy of URAC standards and some background information is attached (Attachment J).

Model state utilization review bills drafted by the American Medical Association are also attached (Attachment K).

I hope this information will be useful. Please do not hesitate to call if we can be of assistance on this or any other matter.

Attachments

[9]As provided in your House Bill 269 [Section 08.85.030(b)(13)].

Ray Gillespie
Gillespie & Associates
Lobbying & Governmental Affairs

10390 Mendenhall Loop Road
Juneau, Alaska 99801
Telephone: (907) 463-3375
Fax: (907) 463-5522

MEMORANDUM

TO: Representative David Finkelstein

FROM: Ray Gillespie

RE: CSHB 269

DATE: February 10, 1992

As per your request, this is a brief outline of problems experienced in current utilization review processes and a corresponding solution to these problems contained in Committee Substitute for House Bill No. 269.

PROBLEM	SOLUTION-CSHB 269
1. Lack of Training, knowledge and qualifications of review agents.	Requires sufficient number of nurses, supported and supervisors by physicians trained in appropriate specialty area.
	Disclosure of numbers, type and qualification of personnel employed by review agent. (08.85.030(b)(4))
2. Secret and undisclosed criteria and procedures used in evaluating care.	Disclosure to providers, as part of licensing application, All review standards, criteria and procedures. (08.85.030(b)(1)
3. Unavailability of review agents to patients and providers.	Requires Review agents to be reasonably accessible to patients and providers at least 5 days a week during normal business hours in this State. (08.85.030(b)(5))

4.	Lack of confidentiality of medical records.	Requires compliance with all State and Federal laws to protect confidentiality. (08.85.030(b)(8))
5.	Inability to seek reconsideration of adverse decisions.	Disclosure of provision by which patients and providers may seek reconsideration, the time period for action on reconsideration. (08.85.030(b)(3))
6.	Unavailability of physicians trained in specialties to discuss appropriateness of care with the patient's attending physician.	Requirement that only a physician trained in relevant specialty or sub-specialty make a final determination that care is medically inappropriate. (08.85.030(b)(5))
7.	Denial of claims after pre-authorization and/or concurrent authorization.	Prohibits retrospective denial except in exceptional case, such as fraud. (08.85.030(b)(14))

A review plan meeting these requirements must be submitted as part of the application for a private review agent license. The plan must also prohibit any financial incentive provision or plan under which the review agent's compensation is based on controlling the amount charged for services.

If you have further questions, please contact me. I hope an early hearing can be scheduled in the Labor and Commerce Committee.

ALASKA STATE

HOSPITAL & NURSING HOME

ASSOCIATION

February 24, 1992

Representative David Finkelstein, Chair
Labor & Commerce Committee
Alaska House of Representatives
P.O. Box V
Juneau, AK 99811

Re: Support HB 269,
Medical Utilization Review

Dear Representative Finkelstein:

Thank you very much for holding the special committee meeting 1:00 p.m. Wednesday, February 26, to review HB 269. A physician and hospital representative will ask your help in getting our friends in the insurance industry to "simplify" a very slow, costly process to secure authorization from an insurance company to proceed with a medical procedure.

Over 24 State Legislatures have enacted legislation similar to HB 269. The insurance industry opposes HB 269, offering no solution to assure that:

1. Individuals doing review for insurance companies are qualified, and that medical review criteria is reasonable.

2. UR agents are registered with the state, and therefore have some accountability.

3. That insurance company UR offices are open during Alaska business hours and that response is timely.

4. That there is an appeals mechanism with properly trained physicians available to review medical decisions.

We are hopeful your schedule will allow you to attend this important hearing 1:00 p.m. Wednesday.

If we can answer questions before then, please call.

Sincerely,

Harlan R. Knudson
President/CEO

319 SEWARD STREET #11 • JUNEAU, AK 99801 • (907) 586-1790 • FAX (907) 463-3573

In general, the terms used in the UR chart can be defined as follows:

Definition of Categories:

1. ***Application and Renewal Fees*** Private utilization review (UR) firms and/or agents are required to apply and pay fees for certification by the state.

2. ***Appeals and Reconsideration Process*** UR firms must have policies and procedures in place to allow patients and providers the opportunity to appeal an adverse decision.

3. ***Specialty Physician Review on Appeal*** A physician trained in the relevant specialty or subspecialty must make the final determination (on appeal) that care rendered or to be rendered was or may be medically inappropriate.

4. ***Type and Qualifications of Personnel*** UR firms must provide to the state a written description of the types and qualifications of personnel performing the reviews.

5. ***Hours of Availability*** Private UR agents must be accessible to patients and providers a minimum of five working days a week during normal business. (Some states prohibit denials of payment during a period when the review agent is not available).

6. ***Complaint Mechanism*** The law establishes a complaint mechanism that allows an aggrieved patient or provider to file a complaint with the state alleging that a private UR agent is not in compliance with the UR law and/or regulations.

7. ***Confidentiality*** UR firms practicing in the state must maintain strict confidentiality of their medical records, and follow all applicable state laws regarding confidentiality.

8. ***Fine for Violation of Act*** The law stipulates that a violation of any provisions of the Act will result in a fine.

9. ***UR Plans -- Description of Review Standards and Procedures*** UR firms must file a plan with the state that includes a description of the review standards and procedures to be used in evaluating proposed or delivered health care services.

10. ***Disclose Criteria*** In addition to review standards and procedures, a UR plan must disclose specific review criteria.

11. ***Provide List of Payors*** UR firms must provide to the state a list of third party payors for whom the private review agent is performing utilization review in the state.

12. ***No Financial Incentives*** Prohibits UR agents or personnel from receiving compensation based on the amount of adverse determinations, reductions or limitations on lengths of stay, etc.

From: Alaska State Hospital & Nursing Home Assn.
Harlan Knudson - 586-1790, Juneau , 2-25-92

As of August, 1991 24 State Legislatures had bills introduced and hearings held (Source, American Hospital Assn) on utilization review. The majority of these bills regulate the operation of U.R. firms.

22 states have laws regulating UR agencies. Below are state criteria for regulation as of October, 1990.

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 & Mental 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

Attached is (a hard to read) Summary of 19 state UR laws as of December, 1991. Source National Association of Private Psychiatric Hospitals.

STATE UTILIZATION REVIEW LAWS -- DECEMBER 1991

State	AR	CT	FL	GA	HI	KY	LA	ME	MD	MN*	MO	MS	MT	NC	ND	OK	SC	TX	VA
Implement Date	9/1/89	10/1/90	10/1/90	11/1/91	1/1/92	1/1/91	1/1/92	6/30/90	11/1/90	?	?	7/1/90	?	1/1/92	,1991	1/1/90	6/1/91	9/1/91	7/1/91
Application Renewal Fees	x 2 yrs	x 2 yrs	x 1 yr	x 2 yrs	X	x 2 yrs	x 2 yrs	x 1 yr	x 2 yrs	NA	X	x 1 yrs	X	x 1 yr	x 2 yrs	x 2 yrs	x 2 yrs	x 2 yrs	x 1 yrs
Appeals and reconsideration process	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
geriatric physician/health provider Review on appeal	X	X	X	X	X	X	X	–	X	–	X	X	X	X	X	–	–	X	–
Type and qualifications of personnel	X	X	X	X	X	X	X	X	X	–	X	X	X	X	X	X	X	X	X
Hours of Availability	X	X	X	X	X	X	X	X	X	–	X	X	X	X	X	X	X	X	X
Complaint Mechanism	–	–	–	X	X	X	–	X	–	X	X	–	–	–	X	X	X	X	X
Confidentiality	X	X	–	X	X	X	X	X	X	–	X	X	X	X	X	X	X	X	X
Fine for Violation of Act	X	X	X	–	X	X	X	–	–	–	X	X	–	–	X	X	X	X	–
JR Plans - Description of review standards and procedures	X	–	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Disclose criteria	–	–	–	X	X	X	–	–	X**	–	–	X	X	–	X	–	–	X	–
Provide list of payors	X	–	–	–	–	X	–	–	X	–	X	X	–	–	X	X	–	–	–
No Financial Incentives	–	X	X***	X	–	–	–	–	X**	–	–	–	–	%	X	–	–	X	–

National Association of Private Psychiatric Hospitals – 1991

*Applies only to UR of chemical dependency claims.
**Applies only to mental health and substance abuse UR.
***Must disclose any incentives in contracts.

A POSITION PAPER SUPPORTING
SENATE BILL 239
HOUSE BILL 269
LICENSING UTILIZATION REVIEW AGENTS

DEVELOPMENT OF UTILIZATION REVIEW AGENTS:
Utilization review organizations originated in response to U.S. corporations frustrated with the rising cost of health care. Private businesses and insurance companies reacted to corporate pressure to reduce or contain health care costs by creating utilization review companies or subsidiaries. Corporations then hired these new firms or subsidiaries to develop programs and review claims for payment.

POSITIVE RESULTS OF NEW FIRMS:
U.S. corporations and utilization review firms claim success at reducing health care costs. They indicate that cost reductions are in excess of costs expended for utilization review firm's services. Hospital admissions for procedures that normally can be done on an outpatient basis are decreased. Length of stay for hospital cases is reduced. There is increased attention on outcomes analysis, justifying inpatient care for certain types of patients. Hospitals have now designated specific staff to facilitate the review process which has increased the cooperation with utilization review firms.

NEGATIVE RESULTS:
There is inadequate accountability by utilization review firms. Problems arise from authority being separated from responsibility. Utilization review firms have no responsibility by law for the effects of denied treatment. The providing hospital and physician, whose advice is often ignored are responsible. For example:

- Cases where a reviewer, not a physician, makes the decision whether an admission to the hospital is appropriate.
- Cases where reviewers demand hospital discharge of patients too early in the treatment process.
- Cases where a patient leaves the hospital against medical advice, when a reviewer indicates treatment will not be covered by his/her insurance company.
- Denial by reviewers of recommended ancillary services and diagnostic evaluations for patients.

Hospitals and providers worry about the level of expertise of the reviewers. Utilization review firms often have small, inadequate staff accessible via few telephone lines. There are currently no requirements for specific training or clinical experience in Alaska for individuals conducting utilization review. Nurses, and in some cases clerks, are evaluating medical cases without the physician s involvement. Physicians have their treatment decisions challenged or reversed by clerks with no medical training.

HIAA

ON

STATE HEALTH

INSURANCE

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

1025 Connecticut Avenue N.W., Washington, DC 20036 = 202-223-7780 = FAX 202-223-7897

CORRECTION

THIS DOCUMENT
HAS BEEN REPHOTOGRAPHED
TO ASSURE LEGIBILITY

A POSITION PAPER SUPPORTING
SENATE BILL 239
HOUSE BILL 269
LICENSING UTILIZATION REVIEW AGENTS

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Utilization review organizations originated in response to U.S. corporations frustrated with the rising cost of health care. Private businesses and insurance companies reacted to corporate pressure to reduce or contain health care costs by creating utilization review companies or subsidiaries. Corporations then hired these new firms or subsidiaries to develop programs and review claims for payment.

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Hospitals and providers worry about the level of expertise of the reviewers. Utilization review firms often have small, inadequate staff accessible via few telephone lines. There are currently no requirements for specific training or clinical experience in Alaska for individuals conducting utilization review. Nurses, and in some cases clerks, are evaluating medical cases without the physician's involvement. Physicians have their treatment decisions challenged or reversed by clerks with no medical training.

Currently it is impossible to determine the basis for utilization review decisions. Utilization review firms are not required to inform providers of the criteria used to make clinical determinations. Since providers do not have this basic information it is impossible to know if criteria is being applied consistently.

Providers are increasingly concerned about the apparent game playing which occurs with some reviewing agents: cases when reviewers refuse to communicate with hospital utilization staff; case where physicians are paged out of surgery to answer routine inquiries; or cases where reviewers make excessive requests for data, or limit access for hospital and physicians trying to resolve disputes.

CHARACTERISTICS OF LEGISLATION:

Ten states have enacted legislation regulating the practice of utilization review agents. Senate Bill 239 and House Bill 269 requires companies conducting utilization review to obtain certification from the division of occupational licensing. Utilization review agents must submit information describing:

- Review criteria and procedures to be used in evaluating hospital and medical care.
- The type and qualifications of personnel performing utilization review.
- Policies and procedures ensuring that applicable state and federal laws protecting confidentiality of individual medical records are followed.
- Procedures by which insurers, patients and providers may seek reconsideration of adverse decisions.

Included is the requirement that each agent submit a statement affirming availability of a physician licensed in the applicable specialty area, when the review staff questions the medical necessity or appropriateness of care. The patient's attending physician or health care provider must be able to discuss the case with an identified health care provider trained in a related specialty.

This bill seeks to provide assurance that these review firms and their employees possess the needed skills and education to accurately and fairly assess the recommended health care procedures. There is also a need to protect patients from unwarranted and arbitrary denial of, or interference with necessary and legitimate health care services.

HIAA

ON

STATE HEALTH

INSURANCE

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

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- 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

- 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 nonphysician 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 inapproppriate 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.

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:

- 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.
- 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.
- 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.

STATE UTILIZATION REVIEW LAWS
MAY 1990

So far this year, six states -- Georgia, Kentucky, Maryland, Mississippi, South Carolina, and Virginia -- have enacted legislation regulating the practices of private utilization review agents. In addition, Arkansas, Maine, New Jersey, Maryland, and North Carolina had utilization review laws on the books prior to 1990.

The bills enacted in 1990 all require companies conducting utilization review in their state to obtain certification from either the State Department of Health or the Commissioner of Insurance. Generally, in order to be certified by a state, a utilization review firm must submit information describing:

- review criteria and procedures to be used in evaluating hospital and medical care
- the type and qualifications of personnel performing UR
- procedures and policies ensuring that a private review agent is "reasonably accessible" to patients and providers during normal business hours
- policies and procedures ensuring that applicable state and federal laws protecting confidentiality of individual medical records are followed
- procedures by which insureds, patients or providers may seek reconsideration of adverse decisions

In addition, several of the laws require that, in the event a utilization review agent is questioning the medical necessity or appropriateness of care, the attending physician or health care provider must be able to discuss the case with an identified health care provider (or physician) trained in a related specialty.

Utilization review legislation has also been introduced this year in Florida, Massachussetts, Missouri, and Kansas. While the first three states are still considering their bills, the Kansas legislation died when the session ended in April.

Pennsylvania, Nevada, New York, Illinois, Ohio and Alaska are among the states that are reportedly considering the introduction of utilization review legislation.

15-Oct-91

OVERVIEW OF STATE LEGISLATION FOR UTILIZATION REVIEW

STATES WITH HOSPITALS	BILL (Y/N)	STATUS OF REGS	CRITERIA TO BE AVAIL?	PHYSICIAN INVOLVEMENT: DENIAL	PHYSICIAN INVOLVEMENT: SUPERVIS.	TIMING STIPULATED IN BILL/REG: DECISION	TIMING STIPULATED IN BILL/REG: RECONSID	TIMING STIPULATED IN BILL/REG: EXPED APPEAL	INCENTIVES PROHIBITED	COMMENTS
ALABAMA	N									Draft bill available
ALASKA	N									
ARIZONA	N									
ARKANSAS	Y	Compl	NO		X	X(a)				(a) If decision is not to certify
CALIFORNIA	N									
COLORADO	N									
FLORIDA	Y	In proc	NO							Questions re:legisl. intent (exemptions)
GEORGIA	Y	In proc	YES	X					Y	Bill states: "No incentives"
ILLINOIS	N									
INDIANA	N									
IOWA	N									
KANSAS	N									
KENTUCKY	Y	Compl	NO	X	X			X		2 bills passed. Excludes HMO's
LOUISIANA	N									
MISSISSIPPI	Y	Compl	YES	X	X	X	X	X		
MISSOURI	Y	No regs	NO	X	X	X	X	X		Contains min stds for benefit cov
NEVADA	N									
NEW MEXICO	N									
NORTH CAROLINA	Y	Compl	NO	X	X	X	X	X	Y	
OHIO	N									
PENNSYLVANIA	N									
SOUTH CAROLINA	Y	No regs	NO		X					Excludes Ins Co & HMOs
SOUTH DAKOTA	N									
TENNESSEE	N									

16-Oct-91

OVERVIEW OF STATE LEGISLATION
FOR UTILIZATION REVIEW

STATES WITH HOSPITALS	BILL (Y/N)	STATUS OF REGS	CRITERIA TO BE AVAIL?	PHYSICIAN INVOLVEMENT: DENIAL	PHYSICIAN INVOLVEMENT: SUPERVIS.	TIMING STIPULATED IN BILL/REG: DECISION	TIMING STIPULATED IN BILL/REG: RECONSID	TIMING STIPULATED IN BILL/REG: EXPED APPEAL	INCENTIVES PROHIBITED	COMMENTS
TEXAS	Y	No regs	YES		X	X	X	X		
UTAH	N									
VIRGINIA	Y	Compl	NO	If Requested	X		X	X		Excludes all but private UR companies
WISCONSIN	N									

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