ALASKA LEGISLATURE COMMITTEE FILES 1991-1992 8672
7068 HOUSE LABOR & COMMERCE

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

The doctors' new allies

By Janet Novack

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

The medical business isn't taking the challenge lying down. Doctors, hospitals and other health care providers are lobbying the states to regulate the people hired by employers and insurers to screen for unnecessary care. "We expect up to 26 states to take up the issue, and up to 15 of these to pass a law this year," worries Marguerite Snyder, government affairs director of the American Managed Care & Review Association.

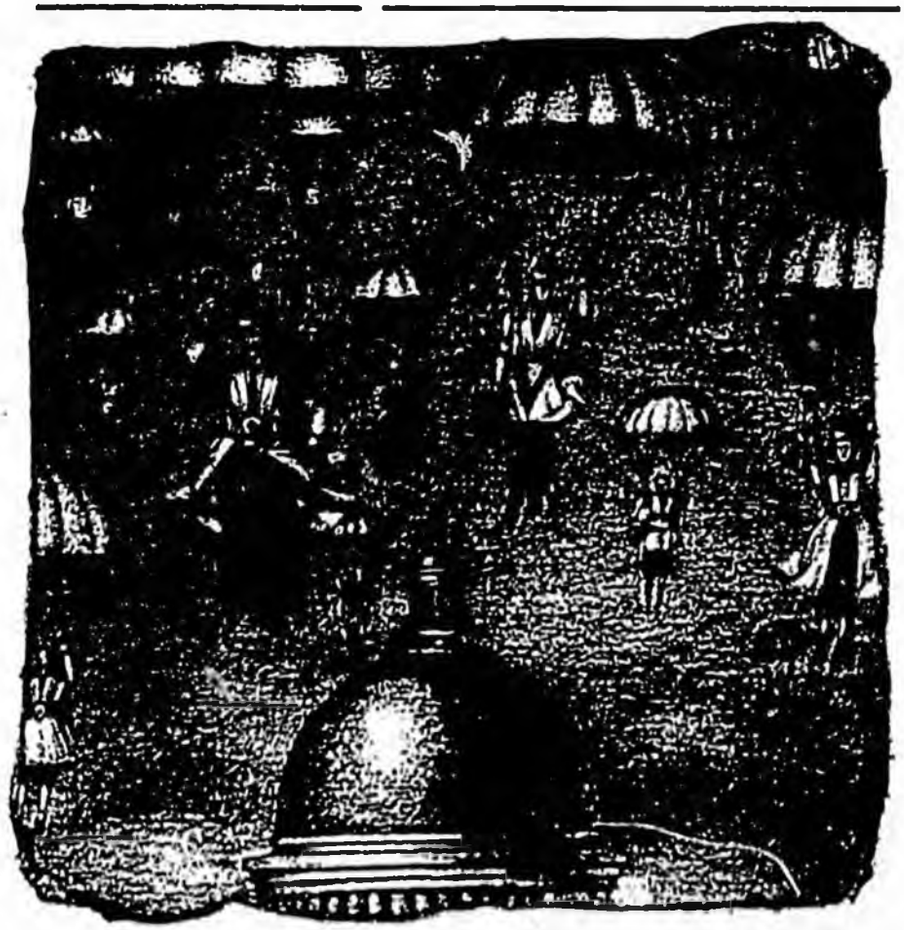
At issue is the so-called utilization review process. Under it, a review nurse looks over the course of treatment a doctor wants to prescribe for a patient. If it doesn't fit set standards for appropriate care, the nurse passes the case on to a doctor who may try to whittle down the physician's proposal. Does the patient really need to go into the hospital at $775 a day? Can't this procedure be done on an outpatient basis? About four out of five companies now require workers to get prior approval for a nonemergency hospital stay, up from about 5% in 1984, according to a survey by consultant A. Foster Higgins & Co.

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

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

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

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



Greg Couch

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

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

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

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

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

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

Pepsi's newest generation

By Claire Poole

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

To counteract the peso devaluations, it started exporting wheat, later expanding to taco shells, frozen juices and pineapples—a business now worth $30 million in sales. In 1984 it added candy and gum to its basic line of soft drinks and chips. And this past fall it spent $320 million to buy nearly 80% of Empresas Gamesa, Mexico's largest cookie company. PepsiCo, based in Purchase, N.Y., is now Mexico's largest consumer products company, with an estimated $1.2 billion in sales—larger than Procter & Gamble or Colgate-Palmolive. Its probable pretax profits in Mexico last year: $140 million.

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

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

Wil van Overbeek

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

State Government Update

by

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

Utilization Review — Managing the Reviewers

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

Four states

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

The newest PUR legislation was passed in January in South Carolina. The law is similar to the Maryland legislation, requiring registration and certification of PUR companies by the Commissioner of Insurance. Utilization review programs must meet certain requirements, including: notification of adverse decisions within five days; procedure for consideration of appeal of denials; availability of reviewer by telephone 40 hours a week, during normal working hours, and types and qualifications of review personnel must be furnished to the Commissioner.

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

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

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

National level

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

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

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

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

One group has developed draft model state legislation. The National Association of Private Psychiatric Hospitals (NAPPH) convened a special task force to draft the model bill, with the objective of "bringing about a means of establishing a level of uniformity and appropriateness in the conduct of utilization review." The model bill's requirements include: certification of review agents; provision for utilization review plan, including criteria used in evaluating care; provision for process for appeals of denials by providers or patients; descriptions of requirements necessary to be a reviewer; use of physician-specialists to make the final determination of whether prescribed care is inappropriate; reasonable access to review agents during normal business hours, and confidentiality of patient records. The model bill also would prohibit reviewers from interviewing patients without approval of the admitting physician, and prohibit payments to reviewers based on number of denials.

Trends

A crystal ball is not necessary to see that the trend in health care is toward managed care — not just for medical and dental care, but for psychiatric, alcohol and drug abuse treatment as well. And key to any successful managed care program will be the cost-effective utilization of available services, together with the review of that utilization. Some form of regulation of the reviewers — whether by legislation or guidelines — is the logical next step. The coming months will bring a clearer picture of just how such regulation will occur.

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

HOUSE BILL NO. 1477
(DeMers, Svedjan, Clayburgh)

AN ACT to provide for utilization review of health care services; and to provide a penalty.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. Purpose. The purpose of this Act is to:

1. Promote the delivery of quality health care in a cost-effective manner;

2. Assure that utilization review agents adhere to reasonable standards for conducting utilization review;

3. Foster greater coordination and cooperation between health care providers and utilization review agents;

4. Improve communications and knowledge of benefits among all parties concerned before expenses are incurred; and

5. Ensure that utilization review agents maintain the confidentiality of medical records in accordance with applicable laws.

SECTION 2. Definitions. For purposes of this Act, unless the context requires otherwise:

1. "Commissioner" means the commissioner of insurance.

2. "Enrollee" means an individual who has contracted for or who participates in coverage under an insurance policy, a health maintenance organization contract, a health service corporation contract, an employee welfare benefit plan, a hospital or medical services plan, or any other benefit program providing payment, reimbursement, or indemnification for health care costs for the individual or the individual's eligible dependents.

3. "Provider of record" means the physician or other licensed practitioner identified to the utilization review agent as having primary responsibility for the care, treatment, and services rendered to an individual.

4. "Utilization review" means a system for prospective and concurrent review of the necessity and appropriateness in the allocation of health care resources and services given or proposed to be given to an individual within this state. Utilization review does not include elective requests for clarification of coverage.

a. An agency of the federal government; or

b. An agent acting on behalf of the federal government, but only to the extent that the agent is providing services to the federal government.

SECTION 3. Certification. A utilization review agent may not conduct utilization review in this state unless the utilization review agent has certified to the commissioner in writing that the agent is in compliance with section 4 of this Act. Certification must be made annually on or before March first of each calendar year. In addition, a certification review agent must file the following information:

1. The name, address, telephone number, and normal business hours of the utilization review agent;

2. The name and telephone number of a person for the commissioner to contact; and

3. A description of the appeal procedures for utilization review determinations.

Any material changes in the information filed in accordance with this section must be filed with the commissioner within thirty days of the change.

SECTION 4. Minimum standards of utilization review agents. All utilization review agents must meet the following minimum standards:

1. Notification of a determination by the utilization review agent must be mailed or otherwise communicated to the provider of record or the enrollee or other appropriate individual within two business days of the receipt of the request for determination and the receipt of all information necessary to complete the review.

2. Any determination by a utilization review agent as to the necessity or appropriateness of an admission, service, or procedure must be reviewed by a physician or, if appropriate, a licensed psychologist, or determined in accordance with standards or guidelines approved by a physician or licensed psychologist.

3. Any notification of a determination not to certify an admission or service or procedure must include the principal reason for the determination and the procedures to initiate an appeal of the determination.

4. Utilization review agents shall maintain and make available a written description of the appeal procedure by which enrollees or the provider of record may seek review of determinations by the utilization review agent. The appeal procedure must provide for the following:

a. On appeal, all determinations not to certify an admission, service, or procedure as being necessary or appropriate must be

b. Utilization review agents shall complete the adjudication of appeals of determinations not to certify admissions, services, and procedures no later than thirty days from the date the appeal is filed and the receipt of all information necessary to complete the appeal.

c. Utilization review agents shall provide for an expedited appeals process for emergency or life-threatening situations. Utilization review agents shall complete the adjudication of expedited appeals within forty-eight hours of the date the appeal is filed and the receipt of all information necessary to complete the appeal.

5. Utilization review agents shall make staff available by toll-free telephone at least forty hours per week during normal business hours.

6. Utilization review agents shall have a telephone system capable of accepting or recording incoming telephone calls during other than normal business hours and shall respond to these calls within two working days.

7. Utilization review agents shall comply with all applicable laws to protect confidentiality of individual medical records.

8. Physicians or psychologists making utilization review determinations shall have current licenses from a state licensing agency in the United States.

9. Utilization review agents shall allow a minimum of twenty-four hours following an emergency admission, service, or procedure for an enrollee or the enrollee's representative to notify the utilization review agent and request certification or continuing treatment for that condition.

However, the commissioner may find that the standards in this section have been met if the utilization review agent has received approval or accreditation by a utilization review accreditation organization.

SECTION 5. Utilization review agent violations - Penalty. Whenever the commissioner has reason to believe that a utilization review agent subject to this Act has been or is engaged in conduct that violates section 3 or 4 of this Act, the commissioner shall notify the utilization review agent of the alleged violation. The utilization review agent has thirty days from the date the notice is received to respond to the alleged violation.

If the commissioner believes that the utilization review agent has violated this Act, or is not satisfied that the alleged violation has been corrected, the commissioner shall conduct a hearing on the alleged violation in accordance with chapter 28-32.

If, after the hearing, the commissioner determines that the utilization review agent has engaged in violations of this Act, the commissioner shall reduce the findings to writing and shall issue and cause to be served upon

1. Payment of a penalty of not more than ten thousand dollars for a violation that occurred with such frequency as to indicate a general business practice; or

2. Suspension or revocation of the authority to do business in this state as a utilization review agent if the utilization review agent knew that the act was in violation of this Act.

Speaker of the House

President of the Senate

Chief Clerk of the House

Secretary of the Senate

This certifies that the within bill originated in the House of Representatives of the Fifty-second Legislative Assembly of North Dakota and is known on the records of that body as House Bill No. 1477.

House Vote:	Yeas	89	Nays	1	Absent	15
Senate Vote:	Yeas	51	Nays	0	Absent	2

Chief Clerk of the House

Received by the Governor at 11:36 A.M. on April 5, 1991.

Approved at 9:07 A.M. on April 8, 1991.

Governor

Filed in this office this 8th day of April, 1991,

at 2:25 o'clock P M.

Secretary of State

UR Bill

UTILIZATION REVIEW BILL

Section 1. The purpose of this act is to:

(A) Promote the delivery of quality health care in a cost effective manner;

(B) Assure that Utilization Review Agents adhere to reasonable standards for conducting Utilization Review;

(C) Foster greater coordination and cooperation between health care providers and Utilization Review Agents;

(D) Improve communications and knowledge of benefits among all parties concerned before expenses are incurred; and

(E) Ensure that Utilization Review Agents maintain the confidentiality of medical records in accordance with applicable laws.

Section 2. As used in this act, the following words have the meaning indicated:

(A) "Utilization Review" means a system for prospective and concurrent review of the necessity and appropriateness in the allocation of health care resources and services given or proposed to be given to an individual within this state. Utilization review shall not include elective requests for clarification of coverage.

(B) "Utilization Review Agent" means any person or entity performing utilization review, except:

(1) An agency of the federal government or

(2) An agent acting on behalf of the federal government, but only to the extent that the agent is providing services to the federal government.

(C) "Commissioner" means the Commissioner of Insurance.

(D) "Enrollee" means an individual who has contracted for or who participates in coverage under an insurance policy, a health maintenance organization contract, an employee welfare benefit plan, a hospital or medical services plan or any

other benefit program providing payment, reimbursement or indemnification for health care costs for himself and/or his eligible dependents.

[Drafting Note: Where "hospital or medical services plan" is inappropriate, insert the appropriate statutory designation for Blue Plans in the state.]

(E) "Provider of Record" means the physician or other licensed practitioner identified to the Utilization Review Agent as having primary responsibility for the care, treatment and services rendered to an individual.

Section 3. A Utilization Review Agent may not conduct utilization review in this state unless the Utilization Review Agent has certified to the Commissioner in writing that it is in compliance with Section 4 of this Act. Certification pursuant to this Section shall be made annually on or before March 1 of each calendar year. In addition, the following information is required to be filed:

(A) Name, address, telephone number and normal business hours of the Utilization Review Agent;

(B) Name and telephone number of a person for the Commissioner to contact; and

(C) A description of the appeal procedures for utilization review determinations.

Any material changes in the information filed in accordance with this section shall be filed with the Commissioner within 30 days of the change.

[Drafting Note: Staff may need authority to agree to a prior approval or filing process.]

Section 4. All Utilization Review Agents must meet the following minimum standards:

(A) Notification of a determination by the Utilization Review Agent shall be mailed or otherwise communicated to the provider of record and/or the Enrollee or other appropriate individual within two business days of the receipt of the request for determination, and the receipt of all information necessary to complete the review.

(B) Any determination by a Utilization Review Agent as to the necessity or appropriateness of an admission, service or procedure shall be reviewed

by a physician or determined in accordance with standards or guidelines approved by a physician.

(C) Any notification of a determination not to certify an admission or service or procedure shall include:

(1) the principal reason for the determination, and

(2) the procedures to initiate an appeal of the determination.

(D) Utilization Review Agents shall maintain and make available a written description of the appeal procedure by which enrollees or the provider of record may seek review of determinations by the Utilization Review Agent. The appeal procedure shall provide for the following:

(1) On appeal, all determinations not to certify an admission, service, or procedure as being necessary or appropriate shall be made by a physician.

(2) Utilization Review Agents shall complete the adjudication of appeals of determinations not to certify admissions, services and procedures no later than 30 days from the date the appeal is filed, and the receipt of all information necessary to complete the appeal.

(3) Utilization Review Agents shall also provide for an expedited appeals process for emergency or life threatening situations. Utilization Review Agents shall complete the adjudication of such expedited appeals within 48 hours of the date the appeal is filed,and the receipt of all information necessary to complete the appeal.

[Drafting Note: Pay heed to the state definition of "physician", which may be inclusive of other health care providers.]

(E) Utilization Review Agents shall make staff available by toll-free telephone, at least 40 hours per week during normal business hours.

(F) Utilization Review Agents shall have a phone system capable of accepting and/or recording incoming phone calls during other than normal business hours, and shall respond to these calls within two working days.

(G) Utilization Review Agents shall comply with all applicable laws to protect confidentiality of individual medical records.

(H) Physicians making utilization review determinations shall have current licenses from a state licensing agency in the United States.

(I) Utilization Review Agents shall allow a minimum of 24 hours following an emergency admission, service or procedure for an enrollee or his representative to notify the Utilization Review Agent and request certification or continuing treatment for that condition.

Provided, however, that the Commissioner may, find that the standards in this Section have been met if the Utilization Review Agent has received approval or accreditation by a utilization review accreditation organization.

Section 5. Whenever the Commissioner has reason to believe that a Utilization Review Agent subject to this act has been or is engaged in conduct which violates the provisions of Sections 3 or 4 of this act, the Commissioner shall notify the Utilization Review Agent of the alleged violation. The Utilization Review Agent shall have 30 days from the date the notice is received to respond to the alleged violation.

If the Commissioner believes that the Utilization Review Agent has violated this act, or is not satisfied that the alleged violation has been corrected, he shall conduct a hearing on the alleged violation, in accordance with the state's Administrative Procedures Act [citation to the appropriate code section].

If, after such hearing, the Commissioner determines that the Utilization Review Agent has engaged in violations of this Act, he shall reduce his findings to writing and shall issue and cause to be served upon the Utilization Review Agent a copy of such findings and an order requiring the Utilization Review Agent to cease and desist from engaging in such violations. The Commissioner may also, at his discretion, order:

(A) Payment of a monetary penalty of not more than $10,000 for a violation which occurred with such frequency as to indicate a general business practice; or

(B) Suspension or revocation of the authority to do business in this state as a Utilization Review Agent if the Utilization Review Agent knew that it was in violation of this Act.

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

Personal Services	$ 65.9
1 - Occupational Licensing Examiner I, Range 12A GGU, 12 months (PFT), ($39.0); and	
1 - Investigator III, Range 18A, GGU 6 months (PPT), ($26.9)	
Travel	$ 2.0
This funding provides travel for the Investigator III to conduct investigations where necessary in preparation for the administrative proceedings described in Section 08.85.070.	
Contractual Services	$ 6.0
This funding will provide for printing, advertising, communications, and other contractual costs.	
Supplies	$ 2.0
This funding will provide daily operating supplies for the two positions shown above.	
Equipment (one-time costs)	$ 10.2
This funding will provide one-time equipment costs for the two positions mentioned above.	
TOTAL:	**$ 86.1**

***REVENUE

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

STATE OF ALASKA FISCAL NOTE BILL NO. CSHB 269(HES)

1992 LEGISLATIVE SESSION

Revision Date. 02/24/92 Department Affected: Commerce & Economic Development

Title: Providing for the licensing and regulation of private helath care review agents. BRU: Occupational Licensing

Component: Administration

Sponsor: Reps. Boyer & Navarre

Requestor: House HES COMPONENT SERIAL NO. 0356

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY 93	FY 94	FY 95	FY 96	FY 97	FY 98
PERSONAL SERVICES	65.9	65.9	65.9	65.9	65.9	65.9
TRAVEL	2.0	2.0	2.0	2.0	2.0	2.0
CONTRACTUAL	6.0	6.0	6.0	6.0	6.0	6.0
SUPPLIES	2.0	2.0	2.0	2.0	2.0	2.0
EQUIPMENT	10.2					
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	86.1	75.9	75.9	75.9	75.9	75.9
CAPITAL						
REVENUE	***	***	***	***	***	***

FUNDING: (Thousands of Dollars)

GENERAL FUND						
FEDERAL FUNDS						
OTHER - GF/PR	86.1	75.9	75.9	75.9	75.9	75.9
TOTAL	86.1	75.9	75.9	75.9	75.9	75.9

POSITIONS:

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

Estimate of current year impact: None

ANALYSIS: (Attach a separate page if necessary)

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

Prepared By: Jennifer Strickler Phone: 465-2144

Division: Occupational Licensing Date: 02/24/92

Approved by Commissioner: Glenn A. Olds for

Agency: Commerce & Economic Development Date:

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

Rev 10/90

HB
269

Alaska State Legislature

REPRESENTATIVE
MARK BOYER

VICE-CHAIRMAN
HOUSE FINANCE COMMITTEE

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House of Representatives

MEMORANDUM

DATE: May 3, 1991

TO: Representative David Finkelstein, 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).

HOUSE COMMITTEE REPORT

(7)

Date Referred: April 10, 1991 FURTHER REFERRALS: Labor & Commerce
Finance

Date of Committee Action: 05/03/91

The HEALTH, EDUCATION AND SOCIAL SERVICES Committee considered: HB 269

HOUSE BILL NO. 269 PRIVATE HEALTH CARE REVIEW AGENTS

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

RECOMMENDATIONS: [ ] the same title
be replaced with CS HB 269 (HES) [ ] a new title

[ ] have attached amendments(s)

[ ] do pass

[ ] do not pass

[ ] no recommendations

[ ] individual recommendations

[ ] additional referral to the _____ Committee

ADOPTS: _____ letter of Intent

ATTACHES NEW FISCAL NOTE(s): (Dept)

[✓] 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*
		Doris Davis		✓	
		Kathleen Cox		✓	
		Bettye Davis		✓	
		Pete Story	✓		

Kathleen Cox
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 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.

(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 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:

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* **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 XV II 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 CF 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).

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 18.20.480;

(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
STATE OF ALASKA

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

240 Main Street, Suite 500
Juneau, Alaska 99801-2101

MEMORANDUM February 21, 1992

SUBJECT: Sectional Summary - CSHB 269(HES)

TO: Representative Mark Boyer
Attn: Fawn Helms

FROM: Jerry Luckhaupt JL
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.

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.

CORRECTION

THIS DOCUMENT
HAS BEEN REPHOTOGRAPHED
TO ASSURE LEGIBILITY

Alaska State Legislature

Legislative Research Agency

P.O. Box Y
Juneau, AK 99811-3100
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June 3, 1991

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

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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 2774) 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

[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

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[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 re-consideration 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	MJ***	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 Caroline	Department of Insurance
Kentucky	Cabinet for Human Resources/Health Dept.	Pennsylvania	Department of Insurance
Maine	Bureau of Insurance	South Caroline	Department of Insurance
Maryland	Dept. of Health & Mntal 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 Caroline	Final Regulations Pending
Kentucky	Drafting Regulations	Pennsylvania	Drafting Regulations
Maine	Proposed Regulations	South Caroline	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	10/1/92	10/1/89	11/1/91	1/1/87	1/1/91	1/1/92	7/30/90	11/1/89	?	?	7/1/89	?	1/1/91	1991	1/1/91	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	88A	X	x 2 yrs	X	x 1 yr	x 2 yrs	x 2 yrs	x 2 yrs	x 2 yrs	x 2 yrs
Appeals and Reconsideration Process	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Specialty 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	–
UR 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 payers	X	–	–	–	–	X	–	–	X	–	X	X	–	–	X	X	–	–	–
No Financial Incentives	–	X	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.

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

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

CORRECTION

THIS DOCUMENT
HAS BEEN REPHOTOGRAPHED
TO ASSURE LEGIBILITY

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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;
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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.

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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:

- The staff model, where providers are directly employed by the HMO;
- The group model, where medical groups contract with the HMO (Kaiser plans are the best-known example of this type);
- 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
- 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:

- 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;
- Physician-sponsored PPOs, which are developed by local medical societies, other local professional associations or clinics, or groups of physicians;
- Third-party payer-sponsored PPOs, which include those initiated by commercial insurers and Blue Cross and Blue Shield plans;
- Entrepreneur-sponsored PPOs, which create a broker relationship with the entrepreneur acting as an intermediary between the provider and payer of service;
- Employer- or labor-sponsored PPOs, which contract directly with providers on behalf of their employees or members;
- 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.

- 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.

- 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.
- 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.
- 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.
- 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.
- 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.
- Retrospective review provides for the establishment of a utilization profile of inappropppriate 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.

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
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									

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FOR UTILIZATION REVIEW

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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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** TOTAL PAGE.003 **

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

The doctors' new allies

By Janet Novack

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

The medical business isn't taking the challenge lying down. Doctors, hospitals and other health care providers are lobbying the states to regulate the people hired by employers and insurers to screen for unnecessary care. "We expect up to 26 states to take up the issue, and up to 15 of these to pass a law this year," worries Marguerite Snyder, government affairs director of the American Managed Care & Review Association.

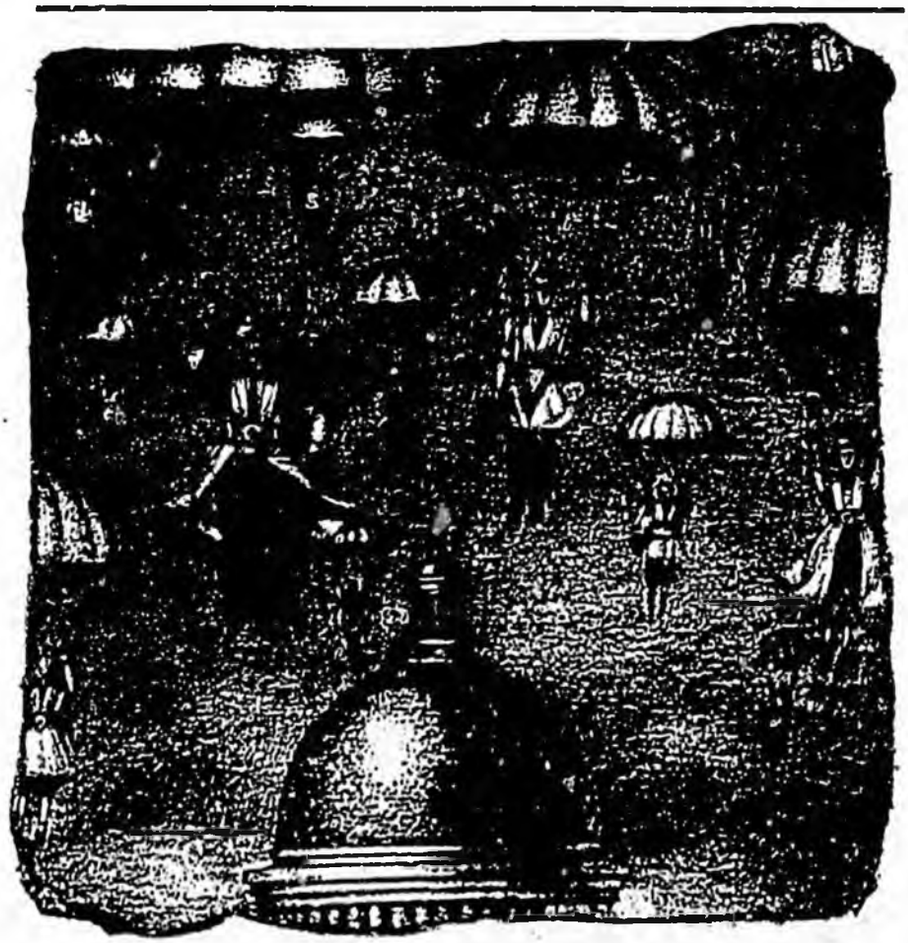
At issue is the so-called utilization review process. Under it, a review nurse looks over the course of treatment a doctor wants to prescribe for a patient. If it doesn't fit set standards for appropriate care, the nurse passes the case on to a doctor who may try to whittle down the physician's proposal. Does the patient really need to go into the hospital at $775 a day? Can't this procedure be done on an outpatient basis? About four out of five companies now require workers to get prior approval for a nonemergency hospital stay, up from about 5% in 1984, according to a survey by consultant A. Foster Higgins & Co.

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

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

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

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



Greg Couch