ALASKA LEGISLATURE COMMITTEE FILES 1991-1992 8672

7414 SENATE HEALTH EDUCATION & SOCIAL SERVICES

SENATE BILL NO. 232

IN THE LEGISLATURE OF THE STATE OF ALASKA

SEVENTEENTH LEGISLATURE - FIRST SESSION

BY SENATOR FRANK

Introduced: 4/2/91
Referred: HES, Finance

A BILL

FOR AN ACT ENTITLED

1 **"An Act relating to revenue bonds issued by the University of Alaska and approving the**
2 **issuance of revenue bonds for construction of a student recreation center at the University**
3 **of Alaska Fairbanks; and providing for an effective date."**

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

5 * **Section 1.** AS 14.40 is amended by adding a new section to read:
6 Sec. 14.40.254. UNIVERSITY REVENUE BONDS. (a) Subject to AS 14.40.253, the board
7 may issue revenue bonds to pay the cost of acquiring, constructing, or equipping a facility that
8 the board determines is necessary.
9 (b) The board may enter into an agreement with a trustee or bond owner for the purpose
10 of securing payment of revenue bonds issued by the University of Alaska to acquire, construct,
11 or equip a facility that the board determines is necessary. The agreement may include the fixing
12 and collection of fees, charges, or rentals pledged to secure payment of the revenue bonds and
13 agreement regarding the use of the proceeds of the revenue bonds.
14 (c) The state pledges not to limit or alter rights vested in the University of Alaska to

1 fulfill the terms of a contract with revenue bond owners.

2 (d) The board may pledge revenue received by the University of Alaska as fees, charges, or rentals in order to secure payment of the revenue bonds. A pledge of revenue received by the

4 University of Alaska is considered a perfected security interest and is valid and binding from the

5 time the pledge is made. The pledge creates an immediate lien against property pledged without

6 physical delivery or other act.

7 * Sec. 2. As required by AS 14.40.253, the Board of Regents of the University of Alaska is

8 authorized to issue revenue bonds of the University of Alaska in the principal sum not to exceed

9 $6,000,000 to pay the cost of acquiring, constructing, and equipping a student recreation center at the

10 University of Alaska Fairbanks.

11 * Sec. 3. This Act takes effect immediately under AS 01.10.070(c).

James F. Lynch
Controller and A ociate Vice
President for Finance

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University of Alaska
Statewide System of Higher Education

April 8, 1991

Mr. Rick Solie, Legilative Aid
Office of Senator Steve Frank
Alaska State Senate
P.O. Box V
Juneau, AK 99811

Re: Senate Bill 232, University of Alaska Student Recreation Center Revenue Bond Authorization

Dear Rick:

This letter is in response to your request for information regarding the student recreation center debt authorization request.

In its narrowest sense, the bill provides authorization to issue revenue bonds for a specific project, the Fairbanks campus student recreation center; and in a broader sense it provides the university with the ability to pledge university receipts to secure that debt or any debt issued under AS 14.40.253.

A student referendum was held in October 1990 at which the Fairbanks studentbody approved a proposal for assessment of a separate activity fee of $75 per semester for payment of debt service to construct an indoor recreation center on campus. Based on that statement of student commitment for the project, the Board of Regents approved seeking legislative authorization to issue revenue bonds for the recreation center. The university administration is supportive of the project because of the personal commitment by the students to pay for the facility and its improvement in the quality of student live on campus. However, although the student commitment on a per student basis is quite large, the revenue base is relatively small for a project this size. Depending on design and construction costs, the project may have to be scaled down, or other revenue sources pledged, in order to make the financing feasible and attractive to underwriters, bond insurers and investors. Details of the project are enclosed.

The bill also gives the university a broader base of revenue to pledge as support for debt transactions. Historically, specific revenues have been pledged to finance specific projects such as housing fees for student housing, student fees for the Anchorage recreation center, and power plant rent for plant construction. Although specific pledging of project revenues keeps the issue neat and tidy from an accounting perspective, it provides

considerably less security from the perspective of investors, bond insurers and rating agencies. It results in higher interest rates, higher bond issuance costs and restrictive covenants such as debt service and renovation reserves, property and liability insurance requirements, and environmental hazard indemnification.

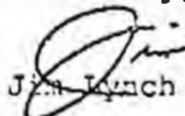
In principle, a broader revenue base for support of a specified debt, provides a more attractive debt instrument for investors. This provision will put the university in a better position to obtain more favorable rates, terms and conditions than merely being forced to accept the dictates of bond insurers, rating agencies and underwriters. For example, in structuring a debt issue for a specialized service facility, such as the student recreation center, the project fees may be adequate to pay the actual debt service, but bond insurers, rating agencies or the market may require pledged fees to be 125 percent or 140 percent of the estimated annual debt service. The minimal revenue pledge may also require alternative terms and conditions to provide comfort to the investor such as higher interest rates, large debt service and renovation reserves, and a host of restrictions on construction and operation of the facilities.

A broader revenue base will allow the university to put together more sensible, flexible and saleable financing packages. For instance, it may be able to pay the actual debt service with project fees, but provide a critical margin of security to investors by an additional pledge of other student fees; it may be able to structure the debt over a shorter term if considered necessary for market or debt policy reasons; it may be able to structure level debt service payments or subsidize the student contribution in early years, so as to take advantage of higher student contributions resulting from a larger student population and fee inflation in later years.

The university has issued very little long-term debt. Its total FY91 debt service, including principal and interest payments, for long-term debt is $2.7 million (approximately 1.3 percent of unrestricted current fund revenues, which is extremely low) and levels off at approximately $2 million in FY94. The Board of Regents is currently working on debt policy which will place constraints on further debt issuances. Enclosed for your information is a draft copy of the Regents' debt policy relating to facilities and real property improvements, a copy of a university long-term debt service schedule and a copy of a schedule of revenue bond debt comparison for several other states which I received from Dan Kaplan of John Nuveen & Co. several months ago.

If you have any questions or if I can be of any assistance, please let me know.

Sincerely,



Jim Lynch

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OF COUNSEL
ROGER G. CONNOR

April 4, 1991

Mr. Rick Solie
Office of Senator Steve Frank
Alaska State Senate
P.O. Box V
Juneau, Alaska 99811

RE: University of Alaska Legislative Bill
Our File Number 3120.0004

Dear Mr. Solie:

You have asked me to explain the technical reason for the Bill relating to Bonds issued by the University of Alaska and approving the issuance of Revenue Bonds for Construction of a Student Recreation Center at the University in Fairbanks.

The bill is a necessary addition to the legislation passed last year allowing the University to issue debt. The bill provides that the University may enter into agreements securing bonds and that those agreements may provide for the fixing and collecting of fees, rentals, or charges of the University to secure bonds. The bill also gives the Board of Regents power to pledge revenues to secure bonds.

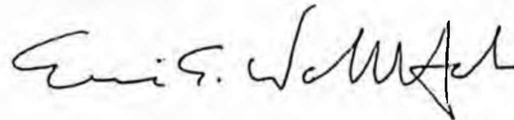
The power to pledge revenues to secure bonds is an essential element of the permission to issue revenue bonds. Revenue bonds are by nature bonds secured only by the revenues of particular facilities. The existing permission of the University to issue debt lacked the essential feature of the ability to pledge revenues of the University to secure that debt. The proposed bill remedies that omission.

In addition, the bill contains a specific authorization for indebtedness in respect of the student recreation center in Fairbanks.

If you desire further information, please contact me.

Very truly yours,

WOHLFORTH, ARGETSINGER, JOHNSON
& BRECHT



Eric E. Wohlforth

:gt

cc: Mr. James Lynch
University of Alaska, Fairbanks

Regents' Policy

05.01.09

DRAFT

Part V

Finance and Business Management

Chapter I

Debt and Credit

A. Scope:

This policy applies to all external debt transactions of the University.

B. Purpose:

The purpose of this policy is:

1. To maintain the creditworthiness of the University and the state of Alaska;

2. To minimize the cost of capital for acquisition and construction and/or leasing of facilities;

3. To provide guidelines for debt financing the acquisition or construction of essential facilities and other real property improvements; and

4. To provide guidelines for equipment financing and other credit transactions.

C. Facilities and Real Property Improvements:

1. All facilities and other real property debt issuances must be approved by the Board of Regents.

2. The University's annual debt service, including any proposed issue, shall not exceed 5% of the University's unrestricted revenues.

3. Refunding or refinancing debt shall be issued only if it results in a net present value savings, eliminates restrictive covenants or provides other benefits which can be clearly demonstrated.

4. Each debt issue, or homogeneous group of debt issues, shall have a level or declining debt service schedule.

5. The final maturity for any new debt issues, excluding refunding issues, shall shall not exceed 75% of the useful life of the facility purchased or constructed with the proceeds.

6. The final maturity for any refunding issues, excluding interim or temporary financings, shall not exceed the final maturity of the debt being refunded.

7. Debt proceeds not expended for direct acquisition or financing costs in accordance with the expenditure plan approved by the Board shall be used to defease or redeem the related debt at the earliest allowed time.

8. Debt proceeds shall not be used to pay or reimburse University departments or employees for the cost of services or expenses unless such costs are directly assignable to the project in accordance with the expenditure plan approved by the Board.

9. The University shall engage an external financial advisor for each debt issue to prepare a letter of comment and recommendation (including the type of financing, call, security and credit enhancement features, term, time and manner of sale, reasonableness of costs and other terms and conditions) and evaluate at the time of issuance the reasonableness of interest rates, underwriter fees, financing costs, reserve requirements and other related issues.

10. The University shall engage external bond counsel for each tax-exempt debt issue to perform all services customarily provided by bond counsel, including preparation or review of all debt authorizing resolutions and related documents and agreements.

11. The University shall use appropriate competitive procedures for selection of financing consultants, bond counsel, underwriters, trustees, bond insurance and for sale of debt.

12. The University shall provide the State Bond Committee notice of all debt issuances 60 days prior to planned issuance, including a description of the project and details of the financing plan.

13. The Commissioner of Revenue shall be invited to participate in the organization and management of all presentations to rating agencies and the preparation of official statements.

University of Alaska
Total Debt Service Schedule
December 31, 1990

	Notes	Revenue Bonds	Leasehold Obligations	Certificates of Participation	Total
FY91	$ 992,276.08	$ 530,067.90	$ 1,144,607.50	$ 53,889.53	$ 2,720,841.01
FY92	993,176.08	524,511.65	1,139,720.00	162,313.76	2,657,407.73
FY93	2,072,215.02	528,749.16	1,137,820.00	180,638.76	3,738,784.18
FY94	475,285.80	527,430.41	940,170.00	187,791.26	1,942,886.21
FY95	475,435.80	539,736.65	1,178,505.00	194,273.76	2,193,677.45
FY96	191,935.80	527,167.91	1,171,002.50	205,086.26	1,890,106.21
FY97	191,935.80	529,567.91	1,170,077.50	209,726.26	1,891,581.21
FY98	191,935.80	531,442.90	1,160,510.00	218,603.76	1,883,888.70
FY99	191,935.80	527,736.65	1,162,027.50	221,326.26	1,881,699.95
FY00	191,935.80	522,884.16	1,159,075.00	223,338.76	1,873,894.96
FY01	191,935.80	470,233.06	1,156,365.00	229,641.26	1,818,533.86
FY02	191,935.80	439,617.43	658,535.00	229,878.76	1,290,088.23
FY03	191,935.80	289,732.31	656,858.75	229,303.13	1,138,526.86
FY04	191,935.80	230,551.03	657,450.00	237,503.13	1,079,936.83
FY05	191,935.80	132,410.25	654,957.50	244,228.13	979,303.55
FY06	191,935.80	128,810.25	654,005.00	239,662.50	974,751.05
FY07	191,935.80	130,210.25	654,115.00	233,806.26	976,261.05
FY08	191,935.80	50,135.25	650,312.50	103,687.50	892,383.55
FY09	191,935.80				191,935.80
FY10	191,935.80				191,935.80
FY11	191,935.80				191,935.80
FY12	159,932.12				159,932.12
	$ 8,239,293.70	$ 7,160,995.13	$ 17,106,113.75	$ 3,604,699.04	$ 36,111,101.62

Comparison of State General Obligation and University Debt (dollars in thousands)

	Alaska	Delaware	Montana	North Dakota	Oklahoma	Vermont	Wyoming
Population	534,000	633,000	819,800	679,000	3,305,000	541,000	507,000
General Obligation Debt	$490,000	$456,530	$83,390	$138,095	$80,376	$271,810	$ -0-
G.O. Ratings	Aa/AA-	AA/AA+	Aa/AA-	Aa/AA-	Aa/AA	Aa/AA	NR/NR
University Revenue Debt (1)	$9,390	$45,515	$123,828	$26,375	$66,040	$63,530	$46,265
Ratings (2)	NR/NR	NR/AA+	Aaa/AAA	A1/A	A/A	A/AA	Aaa/AAA

(1) Student fee, general receipts or auxiliary enterprise fund debt.

(2) Triple A ratings are for insured issues.

Note: All but three state university systems (Hawaii, Mississippi and Oregon) have received legislative authorization for some type of university revenue bond financing.

Source: Moody's Bond Record
S & P Municipal Bond Bank

John Vosmek Architect

16 January 1991

UAF ATHLETIC FACILITY DESIGN RECEIVES STUDENT APPROVAL AND SUPPORT

John Vosmek Architect has recently completed preliminary plans and a model of a student recreation center for the campus of the University of Alaska - Fairbanks. The design and model were used as informational materials in a successful campaign to win student approval of a fee assessment to service approximately $5,000,000 in bonds to support the project. Snow on the ground from October to May and temperatures commonly dropping to -40F make indoor recreation space particularly important to the quality of life and recruitment and retension on this campus.

The student recreation center will house the first increment of an indoor running course and a multi-purpose space (to support three basketball, tennis or volleyball courts or, with a roll-out synthetic turf, a multi-purpose indoor field). Space for free weights and conditioning equipment, a dance and aerobics area and support facilities for cross country skiing are included with recreational lockers and changing rooms. The design also defines additions to accommodate an extended indoor running course and needed circulation and handicapped access improvements, which would be accomplished with complementary state funds.

This step toward the funding of the facilities improvements is part of a multi-year effort to find funding alternatves during the economic downturn which started in 1985-1986 in the state of Alaska.

Revisions updating an athletic facilities master plan for the campus, originally drafted in 1986, are currently being completed.

PROJECT SUMMARY

Project:	Student Recreation Center (Fieldhouse) University of Alaska - Fairbanks
Client:	University of Alaska Facilities Planning and Constr.
Constr. Budget:	approx. $4,000,000 (~~$6,600,000 incl. site/access~~)
Area:	55,700 sf ~~(77,700 sf)~~
Completion:	Fall 1992 (earliest)

University of Alaska
Student Recreation Center on Fairbanks Campus

Background

A self evaluation study in 1985 determined that the Physical Education intramural, recreation and athletic program on the University of Alaska Fairbanks campus has major constraints because of facility inadequacies. Nationally recommended standards for recreational facilities show UAF currently at a deficit of 30,000 square feet and project a deficit of 60,000 square feet by the year 2000.

A comprehensive master plan to aid the orderly implementation of both the immediate and long term facilities for athletic and recreation needs was developed in 1986. Last Fall, the master plan was revised to prioritize the enhancement of student recreation and intramural facilities in the most cost-effective manner.

The proposed recreation center will be primarily for student use. A committee of student representatives will ensure the new facility is responsive to the recreational needs and interests of students.

Project Scope

It is the recommendation of the Department of Athletics and Campus Recreation that a new all-weather multipurpose facility (est. 40,000 square feet) be built adjacent to the hockey arena that would include an elevated indoor jogging track (8 laps to a mile) and a synthetic playing surface which would consist of three (3) basketball courts. Any one of the courts could accommodate the following activities: volleyball, badminton, tennis, soccer, dance, or free play. A portable mesh netting would separate each court. With the three courts covered with artificial turf, it would be used for soccer, softball, and flag

football. On the second floor, along with a jogging track, will be a weight and conditioning area. In the future, a connection of the Student Recreation Center to the existing Patty Center will be built to complete the project.

Funding

A student petition, with over four hundred signatures, was presented to the UAF Administration in December of 1989, asking for a referendum on the proposed project. The petition proposed that funding for design and construction of the Student Recreation Center come from the sale of revenue bonds to be amortized over the twenty years by an increase in student activity fees. The referendum was approved by student vote on October 25, 1990.

At it's meeting on February 21-22, 1991, the Board of Regents approved the funding concept for the facility on the Fairbanks Campus and authorized the University Administration to request the legislature enact legislation authorizing the University of Alaska to issue tax exempt revenue bonds, certificate of participation, or other financing instruments for the construction of the facility. Further, the Board of Regents motion included the authorization to initiate action to secure interim and permanent financing and construction of the facility at a cost of approximately $5.9 million, inclusive of cost of debt issuance and financing reserves.

DRAFT

January 21, 1991

FINANCIAL STATEMENT FOR
UAF STUDENT RECREATION CENTER

Construction Estimate 1/16/91	$4,076,863
Total Project Cost Estimate	$5,435,817
Rounded	$5.5 Million

UAF Enrollment Figures:

A $75/semester additional activity fee would be charged to students carrying eight (8) or more credits.

Spring 1990 = 3,437 students
Fall 1991 = 3,763 students (before drop/add)

For estimating purposes, we used 3,600 students with 8 or more credit hours:

3,600 students X $150/year = $540,000/year fee income.

OPTION 1

Use student fees to pay off debt over twenty years

Annual debt service (20 yrs) for 5,500,000 @ 7.5% interest = $539,511/per yr.

OPTION 2

Not Approved by BOR

Request state financing assistance for $2.5 million and reduce the debt to ten (10) years.

$3,000,000	Student Financed Debt
$2,500,000	State Appropriation
$5,500,000	Total Project Cost

Annual debt service (10 yrs) for $3,000,000 @ 7.5% interest = $437,058/per yr.

(This could produce approximately $100,000/yr cushion against declining enrollments or unfunded operating costs or early debt retirement).

NOTE: This option requires amending the FY92 Capital Request.

SB
239

Alaska State Legislature

SENATOR ARLISS STURGULEWSKI, Chairman
SENATOR PAUL FISCHER, Vice Chairman
SENATOR SAM COTTEN
SENATOR LYMAN HOFFMAN
SENATOR CURT MENARD

P.O. BOX V
ROOM 427
STATE CAPITOL
JUNEAU, ALASKA 99811
(907) 465-3762

Senate Committee on
Health, Education and Social Services

MEMORANDUM 23 April 1991

TO: Members, Senate HESS Committee

FROM: Senator Arliss Sturgulewski

Senate Bill 239 requires companies conducting utilization reviews to obtain a license from the Department of Commerce & Economic Development.

SECTION 1:

Adds regulation of private review agents to the duties of the Department of Commerce & Economic Development for centralized licensing.

SECTION 2:

This legislation adds a new chapter to Title 8 entitled Private Review agents.

Sec. 08.85.010 sets out the purposes of this chapter.

Sec 08.85.020 requires companies conducting utilization reviews to obtain a license from the Department of Commerce & Economic Development.

Sec 08.85.030 requires the applicant to submit an application with a utilization review plan includes:

-standards used in evaluating care proposed or delivered,

-circumstances under which utilization review may be delegated to a hospital utilization review program,

-provisions for appeal and a time frame for that appeal

-number, type, and qualifications of personnel employed

-procedures to ensure access by patients and providers

-assurances that a determination of medical inappropriateness will not be rendered unless an appropriately qualified physical and conferred with the patient's attending physician

-assurances that a determination of medical inappropriateness will not be rendered except in writing

-procedures to ensure confidentiality of confidential medical records

-prohibitions against patient interviews without consent

-prohibitions against incentive payments

-a copy of material furnished to patients and providers informing them of the requirements of the utilization review plan

-a list of health care insurers for which the agent performs services

-evidence of liability insurance

-prohibitions against retrospective denial of payment for treatment.

Sec 08.85.040 allows the department of renew a license after receipt of an application, a renewal fee, and a list of complaints made

to the agent and their resolution.

Sec 08.85.050 provides for additional time to prepare documentation and allows the applicant to apply for a hearing if an application is denied. The hearing is to be held in accordance with the Administrative Procedures Act.

Sec. 08.85.060 allows the department to revoke a license if the holder of the license fails to comply with the plan required under 08.85.030.

Sec. 08.85.070 provides that a patient or provider may file a complaint against a private review agent and may request that the department revoke the license of the agent or require that the agent demonstrate proof of compliance.

Sec 08.85.080 directs the department of adopt regulations to implement this chapter.

Sec 08.85.090 exempts private review agents that operate under federal law or under contract to the fede al government.

Sec 08.85.100 requires the department to furnish a list of private review agents and their license expiration dates to hospital utilization review programs and others who may request the list.

Sec 08.85.110 prohibits a private review agent from disclosure or publication of individual medical records.

This section prohibits a person seeking payment of a reimbursement for hospital or medical ser.ices from invoking the privilege of confidentiality arising from a physician-patient relationship.

This section says a patient is entitled to inspect and copy records developed or maintained by a private review agent pertaining to the health care in question.

Sec 08.85.150 defines terms used in this chapter

SECTION 3:

amends the Administrative Procedures Act to add the

Department of Commerce concerning the licensing and regulation of private review agents under 08.85.

SECTION 4:

Gives an immediate effective date to section two of this bill.

Alaska State Legislature

During Session
P.O. Box V
Juneau, Alaska 99811
(907) 465-2828

During Interim
3111 C Street, Suite 510
Anchorage, Alaska 99503
(907) 561-2040

Senator Virginia Collins

w/ SB239

MEMORANDUM

To: Senator Arliss Sturgulewski
Senate HESS Chair

From: Senator Virginia Collins

Date: April 24, 1991

Subject: SB239

I have read SB239 and have notes from my staff about the first hearing on this bill in Senate HESS today.

I would like your consideration of changing the qualifications of the nursing staff for the Utilization Review Agent. I feel a Registered Nurse with five years clinical experience in the field they are reviewing would be sufficient.

Thank you for your consideration, I will be happy to talk to you further about this bill at your convenience.

PRINTED ON RECYCLED PAPER

Master's Degree where physician located

Problem - publishing criteria

Disclosing proprietary info - criteria - lease contracts - proprietary provision

"Dump" system -

SENATE BILL NO. 239

IN THE LEGISLATURE OF THE STATE OF ALASKA

SEVENTEENTH LEGISLATURE - FIRST SESSION

BY THE SENATE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

Introduced: 4/5/91
Referred: HES, L&C, Finance

A BILL

FOR AN ACT ENTITLED

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

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

4 *** Section 1.** AS 08.01.010 is amended by adding a new paragraph to read:
5 (33) regulation of private review agents under AS 08.85.
6 *** Sec. 2.** AS 08 is amended by adding a new chapter to read:
7 CHAPTER 85. PRIVATE REVIEW AGENTS.
8 Sec. 08.85.010. PURPOSE. The purpose of this chapter is to
9 (1) promote the delivery of quality health care in a cost-effective and efficient
10 manner;
11 (2) foster greater coordination between those paying for health care services and
12 health care providers in the conduct of utilization review activities;
13 (3) assure protection for patients, state employers, and health care providers by
14 ensuring that private health care review agents are qualified to perform utilization review

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

2 (4) ensure that private review agents maintain the confidentiality of medical

3 records in accordance with applicable state and federal laws.

4 Sec. 08.85.020. LICENSE REQUIRED. (a) A person who is affiliated with, under

5 contract to, or acting on behalf of a health care insurer or a person doing business in the state,

6 whether or not for profit, may not perform a utilization review in this state unless a private

7 review agent license is held by the person, the person's employer, or another for whom the

8 person is providing those services under contract. This section does not apply to a person

9 affiliated with a hospital.

10 (b) The department shall issue a license to an applicant that meets the requirements of

11 this chapter and regulations adopted under this chapter.

12 (c) A license issued under this chapter is not transferable and expires biennially on a date

13 determined by the department.

14 Sec. 08.85.030. APPLICATION FOR LICENSE. (a) An applicant for a private review

15 agent license shall submit an application to the department and pay an application fee set by

16 regulation. The application must be on a form approved by the department.

17 (b) An applicant is entitled to a license if the applicant submits and the department

18 approves a utilization review plan that will be provided to patients and providers that includes

19 (1) the specific review standards, criteria, and procedures to be used in evaluating

20 hospital or outpatient care that has been proposed or is being or has been delivered;

21 (2) those circumstances under which utilization review may be delegated to a

22 hospital utilization review program;

23 (3) the provisions by which patients or providers may seek prompt reconsideration

24 or appeal of adverse decisions by the private review agent and the time period in which the

25 private review agent must respond to the request for reconsideration or appeal;

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

27 contract with the private review agent to perform the utilization review including

28 (A) the requirement that a private review agent have available the services

29 of sufficient numbers of registered nurses with masters degrees, or similarly qualified

30 persons, supported and supervised by physicians trained in the appropriate specialty area,

31 to carry out its utilization review activities, or to have appropriate numbers of physicians

New Text Underlined [DELETED TEXT BRACKETED]

1 trained in the appropriate specialties for which utilization review is being conducted; and
2 (B) a requirement that only a physician trained in a relevant specialty or
3 subspecialty and licensed in the state be permitted to make a final determination that care
4 rendered, being rendered, or to be rendered in that specialty or subspecialty is medically
5 inappropriate;
6 (5) the procedures and policies to ensure that a representative of the private
7 review agent is reasonably accessible to patients and providers at least five days a week during
8 normal business hours and that payment will not be denied for treatment rendered
9 (A) during a period when a private review agent is not accessible; or
10 (B) when the appeal of an adverse decision is pending;
11 (6) the requirement that, except in exceptional circumstances, a determination that
12 care rendered, being rendered, or to be rendered is medically inappropriate may not be made until
13 an appropriately qualified review physician has conferred with the patient's attending physician
14 and reviewed all pertinent information concerning the medical care delivered or proposed;
15 (7) the requirement that a determination that care rendered, being rendered, or to
16 be rendered is medically inappropriate must include the written evaluation and findings of the
17 reviewing physician;
18 (8) the procedures and policies to ensure that all applicable state and federal laws
19 to protect the confidentiality of individual medical records are followed;
20 (9) prohibitions against a private review agent entering a hospital to interview a
21 patient unless the attending physician is advised of the interview with reasonable advance notice,
22 and the attending physician or the physician's designee is allowed to attend the interview;
23 (10) a prohibition against an incentive payment provision or plan contained in a
24 private review agent's contract with an entity paying for health care services under which the
25 agent's compensation is based on controlling the amount charged for services, duration of
26 services, or setting in which services are rendered and a prohibition against the agent receiving
27 the incentive payment;
28 (11) a copy of the written material intended to be sent to patients and providers
29 to inform them of the requirements of the utilization review plan;
30 (12) a list of the health care insurers for which the private review agent is
31 performing utilization review in the state and a brief description of the services it is providing

1 for each client, including an affirmation that a payment incentive provision or plan designed to
2 control the amount, duration, or setting in which services are rendered does not exist with respect
3 to each client;
4 (13) evidence of liability insurance carried by the private review agent to cover
5 potential liability from its activities under this chapter in an amount, type, nature, and carrier
6 satisfactory to the department;
7 (14) provisions that, in the absence of fraud, prohibit retrospective denial of
8 payment for treatment after it has been initially approved by the private review agent;
9 (15) other information the department determines to be appropriate.
10 Sec. 08.85.040. RENEWAL OF LICENSE. (a) The department shall renew the license
11 of a private review agent holding a license under AS 08.85.020 if, before the license expires, the
12 agent
13 (1) files an application for renewal, including the information required under
14 AS 08.85.030(b), and submits the appropriate renewal fee; and
15 (2) meets the qualifications for issuance of a license under AS 08.85.020(b).
16 (b) An application for renewal of a private review agent license must include a list of
17 all complaints made to the agent by patients or providers and a brief description of how the
18 complaints were resolved, including the nature of the complaint, the review process, and the time
19 between the filing of the complaint and its resolution.
20 Sec. 08.85.050. DENIAL OF LICENSE OR RENEWAL APPLICATION. (a) Before
21 denying an application for a private review agent license or for renewal of a license, the
22 department shall provide the applicant with reasonable time to supply additional documentation
23 establishing that the applicant is entitled to a license or to renewal of a license.
24 (b) An applicant who is denied a license or renewal of a license shall be afforded the
25 opportunity for a hearing. The hearing shall be conducted by the department. The hearing shall
26 be held in accordance with AS 44.62.330 - 44.62.630.
27 Sec. 08.85.060. REVOCATION OF LICENSE. (a) The department may revoke a
28 license if the holder fails to comply with a utilization review plan filed by the holder under
29 AS 08.85.030(b) or otherwise violates a provision of this chapter or a regulation adopted under
30 this chapter.
31 (b) Before revoking a license under this section, the department shall provide the license

New Text Underlined [DELETED TEXT BRACKETED]

1 holder with reasonable time to supply additional information demonstrating the holder's
2 compliance with the requirements of this chapter.
3 (e) A license holder whose license is proposed for revocation by the department shall be
4 afforded the opportunity for a hearing. The hearing shall be held in accordance with
5 AS 44.62.330 - 44.62.630.
6 Sec. 08.85.070. COMPLAINTS AGAINST LICENSE HOLDER. (a) A patient or
7 provider may file a complaint with the department alleging that a private review agent is not in
8 compliance with this chapter or the regulations adopted under this chapter or with other
9 applicable federal or state law. The complaint may request that the department revoke the license
10 of the agent or require that the agent demonstrate to the department proof of compliance.
11 (b) Proceedings under this section shall be conducted in accordance with AS 44.62.330 -
12 44.62.630.
13 (c) If the department fails to render a decision on a complaint brought by a patient or
14 provider within 90 days, the patient or provider shall have the right to bring suit in the superior
15 court to compel the department to take an action specified in (a) of this section.
16 (d) This section may not be construed to deprive a patient, a provider, a private review
17 agent, or a health care insurer of a right available under other provisions of law.
18 Sec. 08.85.080. REGULATIONS. The department shall adopt regulations to implement
19 the provisions of this chapter, including regulations
20 (1) establishing license application and renewal fees in an amount sufficient to
21 pay for the costs to the department of administering this chapter;
22 (2) establishing rules of procedure consistent with AS 44.62.330 - 44.62.630.
23 Sec. 08.85.090. EXEMPTION. A private review agent that operates solely under contract
24 with the federal government or an agency of the federal government for utilization review of
25 patients eligible for health related services under 42 U.S.C. 1395 - 1395ccc (Subchapter XVIII
26 of the Social Security Act), 42 U.S.C. 1396 - 1396s (Subchapter XIX of the Social Security Act),
27 and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) is exempt
28 from the licensing requirements of this chapter.
29 Sec. 08.85.100. LIST OF PRIVATE REVIEW AGENTS. The department shall
30 periodically provide a list of licensed private review agents and the expiration date for their
31 licenses to all hospital utilization review programs and to other individuals or organizations

1 requesting the list. The department may charge a reasonable fee for providing the list.

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

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

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

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

15 Sec. 08.85.150. DEFINITIONS. In this chapter,

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

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

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

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

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

31 (6) "utilization review plan" means a description of the criteria, procedures, and

1 standards governing utilization review activities performed by a private review agent.

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

3 (57) Department of Commerce and Economic Development concerning the

4 licensing and regulation of private review agents under AS 08.85.

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

6 AS 01.10.070(c).

HO –

Masters unnecessary

David Stratton –

State plan – Sen Duncan say same b'c.
"U.R." } feels costs
"pre-authorization" } down.

Dr. Brady – feels this is consumer protection.
3rd party intervening re medical necessity.

"U" – Craig –

Cathy Cronin

TESTIMONY TO THE ALASKA SENATE
HEALTH, EDUCATION, AND SOCIAL SERVICES COMMITTEE
ON SENATE BILL 239
PRIVATE HEALTH CARE REVIEW AGENTS

SEPTEMBER 18, 1991
STEPHEN W. HO, M.D.

Good afternoon, Madam Chairwoman Sturgulewski and members of the Health Education and Social Service Committee. My name is Stephen Ho, I am the Associate Regional Medical Director for the Western Region of AETNA Health Plan. With me are:

Lynn Withrow, Senior Account Executive
Beverly Hodge, UM Manager
Judy Ketterling, our On Site Concurrent Review Nurse in Anchorage
Lyn Gale, Manager of the Anchorage office

I am a board certified physician and have practiced in different parts of the country for over 13 years. My experience with utilization management and managed care includes practicing in a managed care environment for over eight years and managing utilization review programs for over ten years as medical director for managed indemnity plans, commercial and MediCare health maintenance organizations. I joined AETNA earlier this year to oversee the medical management programs, both utilization review and quality assurance, for their HMO's and managed indemnity plans in the western region and the on site concurrent review program in Alaska.

I would like to make a few points concerning utilization review programs and the bill that is in front of this committee.

First, the goal of utilization review program is to make sure that optimal medical care is being provided in a cost effective and cost efficient manner. Second, the utilization review program needs to be as flexible as the medical care that it is reviewing. Third, the full impact of a utilization review program can only be realized when there is cooperation between the payer and the provider of the medical care.

As I have mentioned, the goal of utilizatio[illegible] program is to make sure that optimal medical care is bein[illegible]ed at a cost effective and efficient manner. Various research [illegible]citutions have shown that 15-35% of the procedures which they studied are clearly inappropriate. Furthermore, there is wide variation for the rate of performance and the length of hospital stay for certain procedures from region to region within a state and within the

country. Why is the length of stay of a Caesarian Section in the East Coast 5 days versus 3 days in the West Coast? Why is the length of stay for vaginal delivery in California 0.9 day versus 2 days in the East Coast? Why one facility will advocate a 14 day alcohol rehabilitation program while another one will advocate a 28 or 30 day program? As these have been studied many times, no sound reason for the variability can be found.
The aim will then be to identify whether certain practices are more efficient and provide the optimal outcome for the patient. Unnecessary and inappropriate care can not only increase the total cost of the health care system, but also increase the risks to the patients of untoward events, such as infection, bleeding, adverse reaction, whether from the medications or anesthesia, pain and occasionally death.

More health care service or a higher level of service does not necessarily mean a higher quality of medical care. In medicine, every intervention, whether it is diagnostic or therapeutic, has its risks and its benefits. Utilization review, in this instance, is asking the physicians to assess the way they treat their patient by weighing the benefit and risk of this intervention.

As I have mentioned, the utilization review program requires the same flexibility as the practice of medicine. The utilization review standards and criteria are based on professional standards collected from professional and specialty societies, written and approved by physicians with various specialty backgrounds. Many of these standards and criteria are reviewed by outside panels of experts. As the advancement of medical science and technology progresses rapidly, the utilization review program must have the latitude to quickly incorporate these new changes into their protocols and criteria for certification. Requiring that these protocols be published prior to implementation and requiring the review agency to strictly adhere to these protocols, will result in the inability to incorporate changes which maybe beneficial to the patient, in a timely fashion.

Some may think that the practice of medicine is an exact science, but in reality it is more art than science. Every patient, no matter how similar the presentation of the signs and symptoms, is different. The application of diagnostic and therapeutic modalities must be tailored to the individual need of each patient. Similarly in utilization review, the application of clinical criteria must be tailored to each patient's distinct condition. Furthermore, just as a physician must alter his/her daily treatment plan in response to the changing need of the patient, the utilization review agent needs the same type of accessibility to current clinical information in order to determine the appropriateness for certification. On site review allows for daily, firsthand review of a patient's condition by looking at the medical record. This reduces the frequency of phone calls and telephone tags that are a common occurrence between the UR company

and the attending physicians or the hospitals. In over 90% of the review, the process is transparent to both the physician and the patient. It is only when indication for the continuous certification is missing, that the review nurse contacts the physician for additional information. The restriction in the form of advance notification and prior arrangement in order for on site review will hinder this timely process. For the State of Alaska, on site review has saved the State 11.8% of net submitted expenses.

Now, let me say a few words about the impact of timely utilization review. As can be seen in both the private and public sector, health care cost is skyrocketing. The Federation government through HCFA have contracted with HMO's to provide care to MediCare and Medicaid populations. Many private corporations have engaged utilization review programs in the form of HMO's and managed indemnity plans to decrease their health care cost.

In the case of the State of Alaska, the introduction of utilization review program has shown a one year saving of $13.8 million or 21% in health care expenses in one year. With AETNA as a administrator to CHAMPUS, The Department of Defense has saved $200 million or 20% of cost over a two year period in California and Hawaii. For every dollar AETNA spends on utilization review, claim payments are reduced by an average of $10. This translates to a lower premium and increase availability of health care insurance.

Similar kinds of savings would not be realized when restrictive regulations are imposed on the utilization review program. A recent study by The Wyatt Company, a national consulting firm, revealed that:

1. The requirement that UR decisions be made by local physicians of the same specialty or subspecialty, would increase administrative costs by 42.5% in the first year and 34% the second year.

2. The requirement that the utilization agent be continuously accessible would increase the administrative cost by 44%.

Of course, with this kind of increase in administrative cost, the health care cost saving will be greatly diminished.

Finally, I would like to address some of the other provisions of this bill which are of concern:

1. The requirement of the utilization review nurse to have a Master's Degree is unnecessary. Clinical experience is just as important, if not more important, than an advanced degree. Requirement of a Master's degree will only service to prohibit the hiring of otherwise qualified individuals. Our nurse reviewers have an

average of over five years of clinical experience. Many of them do possess advanced degrees, such as a Master's degree. As part of our quality assurance program, they received formal training on the application of clinical criteria, customer service techniques and communication skills. They are well versed in managed care operations with continuing education requirements each year. Furthermore, through our medical information system, they can keep up with the latest medical advances.

2. While the bill has put licensing regulations and strict provisions in order to alleviate some of the concern of the providers, in order to promote cost effective and efficient optimal medical care and greater coordination between the payer and the provider of health care, to achieve that end, legislation should also include some provisions to help promote the effectiveness of utilization review programs. For example:

   A. Provider must also be reasonably accessible to discuss the case with the utilization review agent and provide needed information which is not included in the medical records, within a reasonable period of time. Many times certification of the medical services were delayed because the providers did not answer or return phone calls, despite numerous attempts. And, in some situations, the representatives of the providers, for example, the office personnel, the on-call physicians or the facility's UR personnel, did not have the current information at hand.

   B. The providers must willingly discuss with the patients in a timely manner the limitations on their coverages when informed of a non-coverage by the UR decision.

   C. The act of providing false or misleading information to an UR agent should be identified as fraudulent with the appropriate penalties as with any other prosecution for fraud.

3. Finally, there is no research that has shown that the utilization review program now in effect in Alaska, is failing in any significant manner. Even if there are differences between the providers and the utilization review agents, the State should encourage the parties to resolve their differences voluntarily instead of resorting to an expensive licensing procedure. This licensing procedures will not produce any significant benefits to the patients, but will definitely increase the cost of health insurance.

In conclusion, the purpose of a flexible utilization review program is to strive for optimal medical care and at the same time to make health care service more cost effective, cost efficient and affordable.

Thank you for allowing us to testify today and we will be happy to answer your questions.

HIAA

Health Insurance Association of America

STATEMENT OF HIAA

ON

LICENSING AND REGULATION OF PRIVATE HEALTH CARE REVIEW AGENTS

SENATE BILL 239

PRESENTED BY

JAN ANDREA MEISELS

LEGISLATIVE DIRECTOR

BEFORE THE

ALASKA SENATE COMMITTEE ON HEALTH, EDUCATION AND SOCIAL SERVICES

SEPTEMBER 17, 1991

6052 Hackers Lane
Agoura, California 91301
818-991-6817

I am Jan Andrea Meisels, Legislative Director, Health Insurance Association of America (HIAA). HIAA is a national, voluntary trade association of 300 private health insurance companies which provide health insurance for 95 million Americans. HIAA is opposed to the provisions contained in SB-239.

The cost of health care has risen at a rate that is matched by no other item represented in our economy. The rate of growth consistently outstrips the other items in the Consumer Price Index and is soon going to exceed 15 percent of the value of all goods and items produced in the United States. Studies performed by the world-renowned Rand Corporation conclude that many medical services performed are not medically necessary. In fact, they list that 25-40 percent of certain procedures are medically unnecessary or equivocal. Studies conducted by Dartmouth University researchers conclude a physician's practice pattern has more to do with surgical rates than the appropriateness of care or medical necessity.

Utilization review is a method being used by both the private and public sectors to reign in the costs of inappropriate medical usage. These plans require that <u>before</u> the patient is admitted to the hospital and/or undergoes a procedure, approval must be obtained from the utilization review firm. Utilization review is a sound and reasonable approach for assuring that only medically necessary, quality care is rendered in the most appropriate and cost-effective setting. Utilization review

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

During the past five to ten years, the health care delivery and financing system in this country has evolved at an impressive pace. The most visible change has been the explosion of what is becoming known as managed care delivery systems, including HMOs and PPOs, which incorporate utilization review.

Continued growth and use of managed care arrangements represent our best hope of reigning in health care costs. Moreover, managed care, as contrasted with an all payer system of rate setting, is more, not less, likely to achieve cost control results without the kind of economic disruptions associated with rate setting.

The basis of a managed care plan is not discount medicine, but quality medicine at a reasonable price. Every health care plan provider recognizes that delivering poor quality care will only drive up plan costs in the long term. A person who receives poor care will become sicker, requiring more care at additional cost. Managed care plans seek quality care providers,

recognizing their potential liability for directing people to those who fail to deliver proper treatment.

Proponents of restrictions on managed care, including restrictions on utilization review, maintain they are protecting patients to assure quality care. That is not the reason they are trying to restrict managed care plans; rather it is for their own self-interest, by attempting to thwart any controls on their rising fees and medically unnecessary utilization of services. As previously stated, managed care plans foster quality care. HIAA believes that state legislatures should not place inappropriate barriers in the way of insurers, establishing effective managed care and utilization review programs.

Recently, the HIAA commissioned the Wyatt Company, an employee benefits and compensation consulting firm, to study and estimate the costs associated with legislative provisions that would restrict managed care programs. Attached to my statement is an executive summary of the Wyatt study.

Provisions of SB-239 include some of the provisions that were studied by the Wyatt Company. The proposed requirement of local utilization review by professionals licensed in Alaska and denial reviews by physicians of the same specialty as the attending physician was one of the six areas studied by Wyatt. Many utilization review firms operate centralized units because of the cost-efficiency associated with minimizing overhead and limiting administrative expenses. They typically employ

registered nurses and physicians with years of clinical experience to perform utilization reviews. If SB-239's provisions were enacted, this provision would require utilization review to be performed by such professionals only if licensed in the state where their proposed medical service would occur, i.e., Alaska. The Wyatt study indicates that first-year administrative costs for centralized utilization review firms would increase by over 42 percent. Moving and start-up costs as well as additional personnel, would be required for a utilization review organization to move a substantial percent of its business to an in-state location and to have locally licensed specialty physicians under contract for all denial reviews. Subsequent-year utilization review costs would also increase.

Such a provision is not justified. Quality of care and competence of physicians do not change when crossing state lines. Any physician licensed to practice medicine by any of the 50 United States should be allowed to perform the review. Alaska has less than 1,000 licensed physicians. According to the American Medical Association, there are over 50 recognized specialties. Requiring only Alaskan-licensed physicians to perform reviews when there are over 550,000 licensed physicians in the United States is not only unnecessary but also places a severe drain on the limited medical resources in Alaska.

An example of how improper this provision of SB-239 is: If someone had a heart condition and saw a cardiac surgeon, his/her proposed invasive (surgical) treatment would be required to

receive prior approval, or a second opinion. If only another like-type subspecialist, i.e., cardiac surgeon, could perform the review, only an invasive procedure would be considered. If, on the other hand, another physician, i.e., an internist or cardiologist, was permitted to perform the review, perhaps an equally effective, noninvasive less dangerous to the patient and less costly treatment regimen might be recommended.

Another provision of SB-239 with which HIAA takes exception is that nurses performing the review must have M.A.'s. Nurses are basically reviewing the medical indications of treatment against criteria used by the review firm. That criteria was developed with physician input. A qualified professional is what is important, not the number of degrees after the particular nurse's name.

Another objectionable provision of SB-239 is the requirement of disclosing all proprietary specific criteria, review standards and procedures. Not only is this provision impractical; in many cases it is impossible. Many of the criteria that are being used by a variety of utilization review firms and insurance companies have contracted with private organizations to use under a purchase-lease option contract, criteria developed by these other organizations. Included in those contracts is the prohibition to release or share the criteria due to the proprietary nature of the material. Another issue is the major concern that some providers game the system, i.e., if they know what will be accepted, regardless of what is medically indicated or needed,

they will advise the utilizaton review organization they are following those procedures in order to get approval, even if that is not what is planned or best for the patient.

The provision prohibiting denial of claims once an initial review has been approved does not recognize the various components required to determine that all provisions of the insurance contract are in compliance. For example, in obtaining the initial approval, all pertinent information may not have been disclosed, i.e., the patient may have had a preexisting condition; the diagnosis could change to one that is not covered under the policy, or covered only under a limited manner or in a different setting. Other claims may arrive after the initial approval, and before the claim in question was received, which may have consumed the remaining benefits allowed under the policy; or the initial approval occurred during a grace period and the policyholder did not subsequently pay the premium which negates the policy. Insurers always reserve the right to deny payment based on fraudulent information provided by the claimant, provider, agent, policyholder, etc.

The provision that requires payment not be denied for treatment during the period when a private review agent is not accessible or when the appeal of an adverse decision is pending also raises many concerns. Private review agents are available during normal working hours five days a week. It is generally recognized that when an emergency occurs, that the utilization review firm be notified within 24 to 48 hours after the patient

has been stabilized. Therefore, it is not necessary to have 24 hour, seven day a week coverage by the utilization review firm, nor is it appropriate to legislate that payment will be made when a private review agent is not accessible, i.e., what if it is an elective admission and not an emergency admission.

Under the Employee Retirement Income Security Act (ERISA), the insured always has the right of appeal. This ERISA provision addresses both self-funded and fully insured insurance contracts. If the appeal finds that the care is not medically appropriate, why, then, would the Alaska State Legislature want to mandate reimbursement for medically unnecessary care, by stating that reimbursement shall not be denied during an appeal of an adverse decision? Utilization review and all of its parameters are there for two reasons: to assure quality health care and to provide that care in the most cost-effective manner. By legislating reimbursement for care that may be found to be medically inappropriate, health insurance costs will continue to escalate unnecessarily.

We recognize that the majority of providers are ethical. However, the provision requiring payment to continue if the provider is unable to reach the utilization review agent or while the case is under appeal allows the unethical provider to "game" the system and appeal all denials, declinations, modifications to treatment proposals, while continuing to generate revenues. This is not in the best interest of the patient, policyholder or the overall health care system of Alaska.

The provision requiring the attending physician to be in attendance when a review agent is meeting with the patient is another tactic which can be used to deter the utilization review representative in meeting with the patient -- due to the physician's schedule not permitting the visit until an inconvenient time or date. When a decision to discontinue approval of treatment is made, the physician is always notified first. This helps to preserve the patient-physician relationship and allow the physician to offer any additional information not yet rendered which may affect the final decision.

We are also concerned with the legislation attempting to prohibit contract provisions between the utilization review entity and the insurance company or policyholder under which they are contracting for such services. The state should not be in the business of determining what kind of provisions between two contracting entities are permissible when one is paying for a service performed by the other.

A recent study by Foster Higgins (see attached) of over 1,900 employers whose benefit plans cover more than 12.5 million employees and whose data represented responses from all 50 states indicated that utilization review programs have had a positive effect on the behavior patterns of medical practitioners and on medical care plan use. Today, utilization review is the rule rather than the exception. Given the high rate of health plan cost increases, few employers dare go without utilization review programs -- typically preadmission certification, concurrent

review and catastrophic case management. Those employers that could estimate their savings reported an average savings of 5.1 percent of total plan costs. In another study, recently reported in Spencer's Research Reports (see attached), the Blue Cross Blue Shield Association did a year-long pilot study which found that 11.2 percent of the cases that were examined called for inappropriate use of certain procedures. Over 9,000 cases were reviewed evaluating the appropriateness of procedures. While the inappropriateness level varied by procedure, i.e., tonsillectomies, 27.1 percent; hysterectomies, 21.5 percent; and tonsillectomies combined with adenoidectomies, by 17.6 percent; the issue was determined that utilization review is important to the quality of care provided the patient as well as cost savings to the policyholder, the insured and the insurance company.

Many things are happening on the national scene which preclude the need for such onerous legislation as SB-239. The Utilization Review Accreditation Commission (URAC) has developed accreditation standards for utilization review firms. A copy of the final standards endorsed in June is attached. Currently, URAC is reviewing utilization review firms against their criteria in order to accredit these firms. The marketplace will encourage utilization review firms to receive this accreditation as policyholders will only want to use such firms that have met such standards. The purpose of these URAC standards is to encourage consistency in the procedures for interaction between utilization review organizations, providers, etc., and establish processes that cause minimal disruption to the health care delivery system

while providing consistent standards and an accreditation mechanism that can be applied efficiently nationwide for credentialing and accrediting utilization review organizations.

Utilization review is a critical component to providing quality health care, that is medically appropriate and medically necessary in the most cost-effective setting. This committee is also reviewing access to health care. No one single step can achieve on its own the results we all seek. Just as we must take those steps necessary to improve and reform access to care, so, too, must we come to grips with perhaps one of the most significant components of the problem -- cost. Placing barriers to appropriate utilization of services such as those presented in SB-239, go far astray from the desires of providing access and affordable health care to all Alaskans. HIAA encourages the Senate Health, Education and Social Services Committee to determine that SB-239 is not necessary, and therefore reject SB-239. HIAA is most willing to work with the committee in looking at access to and affordability of health care in Alaska. I will be most happy to try and answer any of your questions.

Utilization Review Accreditation Commission

Fact Sheet

In December 1989, the American Managed Care and Review Association (AMCRA) sponsored a meeting, in Washington DC, of utilization review (UR) industry representatives seeking to address a growing movement among state legislatures to regulate the UR industry. At the December meeting, and at a subsequent meeting in March 1990, there was general agreement that the relatively new and growing UR industry needed to formulate a comprehensive response to this movement. Strong support was given to the development of minimum national standards for the industry and for the formation of an independent accreditation organization.

The Utilization Review Accreditation Commission (URAC) was created in response to this need and has been incorporated as a not for profit corporation in the District of Columbia. URAC currently has an Interim Board, officers and four standing committees: Accreditation, Finance, Community Interface, and the Steering Committee.

URAC has received nationwide press for its efforts and has broad industry backing for its goals. After the National Utilization Review Standards receive final approval, URAC will began using them to survey and accredit UR firms. In preparation for this, the URAC Interim Board will be replaced with permanent members who represent a broad spectrum of interests including providers, insurers, employers and regulators.

The National Utilization Review Standards are currently being refined by the URAC Standards Subcommittee. The Standards were first published in January 1990, and are designed to:

- Encourage consistency in the procedures for interacting with UR programs;
- Establish UR processes that cause minimal disruption to the health care delivery system;
- Establish standards for the procedures used to certify medical services and to process appeals of certification determination;
- Provide the basis for an efficient process of credentialing and accrediting UR Organization;
- Provide consistent standards and an accreditation mechanism that can be applied efficiently nationwide for those states which choose to regulate UR.

Provided by Reed Stoops

UTILIZATION REVIEW

BACKGROUND

Rationale for Utilization Review

Health care costs in this country have escalated steadily to the extent that they pose a very serious and imminent threat to both our health care system and the strength of the national economy. Those costs have put health insurance beyond the means of many tens of millions of Americans. Uninsured people receive poorer quality, more expensive care because they usually defer seeking treatment until later in an illness.

A great deal of the cost explosion in health care has been attributed to an overuse of health care services. Burgeoning malpractice liability and cost-plus third-party reimbursement have led providers to order more tests, procedures and hospital admissions than necessary. Recent independent studies indicate that, despite inroads by managed care programs, key decisions that affect the use, cost and quality of health care are still made by providers. At the same time, there is ample and persuasive evidence of inappropriate variations in practice patterns, of unnecessary testing, and of self-serving decision-making by providers that call into question the necessity, appropriateness or quality of health care that was once presumed.

- A recent study by the Public Citizen Health Research Group found that use of Cesarean sections in birth deliveries varies enormously from city to city, topping 50% in some (the national rate for C-sections was 24.4% in 1987). C-sections increase the risk of maternal death 2-4 times and (in 1987 alone) cost about $1 billion more than vaginal deliveries would have cost.

- A 1988 Rand Corporation study found that 32% of carotid endarterectomies (removal of fatty deposits from neck veins) were unnecessary and that 10% of those patients undergoing the procedure died or suffered a stroke as a direct result.

- About 15% of physicians have a financial interest in medical testing laboratories. A recent study of Medicare physicians showed that those having an interest in labs order 45% more tests than those that do not.

An important national strategy for the reduction of these costs is a form of managed care known as utilization review, which has been described as:

> The assessment of treatment in accordance with guidelines and standards established and accepted by health care professionals before and during the delivery of health care with the purpose of enhancing the quality, appropriateness, medical necessity and cost-effectiveness of such health care.

Provided by Reed Stoops

Utilization review may include <u>prior</u> approval for certain services and <u>concurrent</u> review during hospitalization. It involves the use of comprehensive guidelines developed by specialist in the appropriate fields regarding appropriateness and effectiveness of treatments and services for the entire range of medical conditions. Although today some form of utilization review service is offered by most health insurers, self-insurers, health maintenance organizations and preferred provider organizations, the advent of such programs is very recent. For example, surveys conducted by benefits consulting firms show that in 1984 as few as 5% of large employers included utilization review provisions in their health benefit programs. Today, one-half or more of these employers have implemented utilization review programs.

<u>Who Does Utilization Review/How Does It Operate</u>

A wide variety of organizations are involved in conducting prospective and concurrent utilization review in the United States. They include insurers who may conduct review internally or through a subsidiary or subcontractor, independent utilization review organizations, third party administrators (TPAs), hospital or other provider-sponsored organizations, utilization review components of PPOs, HMOs or other network provider structures, an employers' own internal utilization review staff and others.

A utilization review organization conducts a review of the clinical information about the patient's condition, the proposed site of service, the length of stay, the health care resources required and the proposed procedure or treatment. Based on the information provided at the time of the review, the utilization review organization certifies that the proposed site, service or treatment appears to meet the applicable health benefit plan's requirement that covered services be medically necessary and appropriate.

Utilization review determinations are not directions to the provider to offer or refuse to offer any course of treatment; they are rather assessments of the medical necessity or appropriateness of proposed care for the purpose of offering an advance indication concerning benefits (is the proposed service medically necessary? appropriate?). Utilization reviewers <u>have no authority</u> (and seek no such authority) to direct the provider of care or patient to do or omit anything, and the provider and patient are always the final arbiters of any treatment plan. Utilization review denials simply indicate that the proposed treatment does not meet the medical necessity or appropriateness requirement in the absence of new information or changed circumstances; this is subject to rights of appeal at the certification and claim stages.

In short, by creating a managed care system characterized by (1) <u>consumer and provider knowledge</u> and purchaser oversight of provider services and (2) <u>consumer involvement</u> in utilization decisions, utilization review establishes appropriate incentives that support health care quality consistent with sound public policy.

Employer Demand for Utilization Review

Utilization review is critical to the health benefits business in general. It is demanded by the majority of employers as a feature of their insurance and self-funded benefits programs. Enrollment in managed care programs, most of which involve utilization review, is roughly as follows:

HMOs	(HIAA)
PPOs	(HIAA)
MULTIPLE OPTION PRODUCTS	(HIAA)

BARRIERS TO UTILIZATION REVIEW

Anti-Utilization Review Legislative Proposals

The utilization review industry is a new and emerging one and the variety of organizational structures and approaches that constitute utilization review should be given an opportunity to evolve without the constraints of premature regulatory oversight. Legislative and regulatory initiatives in many states threaten the ability of utilization review programs to effectively reduce unnecessary care. Further, the imposition of regulatory restrictions on utilization review organizations will result in increased overhead costs for such organizations. These costs will be passed along to payer groups, resulting in an overall increase in the cost of health care for the public. The state will also be fiscally impacted by utilization review regulation as a payer of health care for state employees and through the cost of administering regulatory programs. These additional costs are not justified in the absence of proven demonstrable harm to the public.

Institute of Medicine Endorses Non-Regulation

In response to the question, "Is public regulation of utilization management desirable and feasible now?" the Institute of Medicine's Committee on Utilization by Third Parties ("Committee") answered "No" and recommended that the state regulation of utilization review programs was premature.

In particular, the Committee concluded:

> Proposals to regulate utilization management involve uncertainties and risks that should be understood. This rapidly evolving activity could become a major pathway to disseminate and apply standards for appropriate care that are being developed through research and consensus mechanisms. To the extent that regulation raises the cost or diminishes the effectiveness of utilization management, it becomes less attractive than other approaches that

do not consider individual patient conditions. The cross-pressures in utilization management provide opportunities for dialogue between payer and physician that may educate both parties and permit more sensitivity to patients' needs than do alternatives that provide incentives to reduce services across the board.

The conduct of utilization management merits continued oversight. However, a strong argument can be made now for allowing the field to continue its rapid evolution, for increasing purchasers' scrutiny over utilization management services and for disclosing the clinical bases for utilization management decisions. State regulation, however, remains an option if abuse becomes apparent involving either harm to patients or unreasonable burdens on physicians and institutional providers. Federal action may be warranted if highly discrepant state regulations develop.

Existing Regulatory Requirements are Currently Sufficient

Utilization review organizations do not operate in isolation, but must work in conjunction with other regulated entities such as health insurers, health maintenance organizations, preferred provider organizations and self-insurers whose claims payment practices are already regulated by the state or federal government (e.g., bad faith insurance laws, ERISA rules, etc.). Thus, existing state and federal laws provide an adequate remedy for members of the public who are aggrieved by the decisions of a utilization review organization.

Opposition from Providers

But provider interest groups have nonetheless been very successful at using anecdotal information in an inflammatory way to convince state regulators that inflexible and burdensome regulation is necessary. This legislation has taken a number of forms but is primarily focused on state certification of utilization review firms, the application of general standards and criteria and the qualifications for utilization review personnel. While seemingly well-intended, these laws often make it much more difficult for managed care firms to perform the important task of overseeing the delivery of care in accordance with guidelines and standards designed to ensure quality care in a cost effective setting. Additionally, the many differences among state laws make it difficult and costly for national firms to undertake their utilization review processes.

Unfortunately, many of these laws and regulations greatly inhibit the effectiveness of managed care options in reducing rising health care costs. The following discussion will highlight the regulatory provisions which should be considered particularly harmful to utilization review.

MEDICAL STANDARDS

Limitations on use of medical protocols as an acceptable standard.

We strongly oppose the imposition of limitations on the use of medical protocols as an allowable standard for utilization review. This sometimes appears in the form of legislation to impose the use of local or community standards as a regulatory requirement for utilization review. A utilization review program is both most well founded and most effective if it is able to draw on all available medical knowledge, rather than the knowledge and practice patterns of one location only. Good utilization review standards necessarily incorporate all available accepted medical literature on the procedure or dysfunction in question. Such standards are thus by their nature national and even international. Thus, for state-by-state licensure of reviewers as local practitioners to make sense from a public policy standpoint, strong evidence would have to exist that local standards are clinically superior.

Vast differences in the frequency with which particular procedures are performed and other variations in practice patterns from location to location more clearly arise from the distribution of specialist practitioners than from the needs of local enrollees. Utilization review standards must be based on all knowledge available nationally about the effectiveness of procedures.

PERSONNEL RESTRICTIONS-RESIDENCY

Requirement that physician reviewer be licensed in the same state in which the care is being given.

We strongly oppose such a requirement. Such a requirement confuses utilization review with medical care. While it is important to have local licensure for the attending physician to provide state oversight of such local practitioners, the same requirement for utilization review physicians threatens the very existence of national review firms and utilization review in general (which, of course, is the goal of such a requirement). Variations in local practice represent an obstacle to effective and consistent utilization review, which is only exacerbated by a local licensure requirement. Such a requirement would probably require arrangements with local clinicians, which arrangements would subject the reviewer to unnecessary peer pressure and would significantly reduce reviewer consistency and individual effectiveness. Training and general oversight of review and day-to-day management would be problematic and costly. Furthermore, there is the added problem of objectivity when one local clinician reviews another; the more similar the locality the more likely objectivity will be compromised.

PERSONNEL RESTRICTIONS-CREDENTIALS

Requirement that physicians performing utilization review must be practicing or board certified in the same speciality as the attending physician of the patient.

We oppose the requirement that physician reviewers must possess the same specialty as the attending physician. (However, it should be noted that "same speciality" physicians sometimes are used affirmatively by review firms, where appropriate). Utilization review firms typically review medical requests for resource use first by registered nurses (or other appropriately qualified personnel) using protocols developed by physicians for this purpose. If agreement on hospitalization or other resource use can be accommodated with the attending physician at the time, no involvement of a physician reviewer is necessary. If agreement is not reached, a physician reviewer is generally involved. The second level of review is generally by a board certified physician generalist (internist, pediatrician, family practitioner, general surgeon). These highly trained physicians have been patient case managers in their own clinical practices and are thoroughly familiar with the indications for most types of diagnostic and therapeutic procedures, without the bias that can ensue when one has been trained only in a subspecialty area.

Additionally, it can be advantageous for patients to have their clinical case reviewed by a non-procedure-oriented physician to get a more objective assessment of the need for a potentially expensive and invasive procedure.

Requiring specialist review will significantly increase the administrative and claim costs (passed through to employers and patients) of performing appropriate utilization management in several ways:

1. Specialists are frequently paid more than generalists for doing reviews. One company has estimated the additional cost to be approximately 2.5% to 3% of program costs.

2. Specialists may be more sympathetic (less objective) to their colleagues' pleas than generalists, resulting in higher costs.

3. The higher use of specialists will necessitate larger networks of non-employed reviewers, resulting in less rigorous control of utilization review decisions.

We also oppose requirements that denials be made only by specialists in the same field as the attending provider. Our review protocols are developed or reviewed by specialists. Involving specialists in all denials is not necessary, although there are some circumstances when review by a specialist is warranted, in which case a specialist is indeed involved.

DISCLOSURE OF PROTOCOLS

Requirement that protocols be disclosed to the state or to providers.

We oppose any requirement of such disclosure, although disclosure of a summary of the utilization review system might be appropriate.

- Utilization review protocols are proprietary; in many cases they are not the property of the reviewer but rather the property of third party vendors who require confidentiality.
- Medical protocols are often lengthy, technical and subject to frequent modification or alteration. The Institute of Medicine concluded in 1989 that utilization review needs to be allowed to continue its rapid evolution; disclosure of protocols would thwart this development.
- Disclosure of protocols increases liability to employers and managed care programs.
- Protocols are not arbitrary rules that are applied without discretion; they are always subject to clinical judgment in any certification denial. A requirement of disclosure thus reflects a misunderstanding of the proper use of protocols.

INCENTIVE PAYMENT PROVISIONS

Prohibitions against tying payment (to a utilization review agent) to a reduction in utilization.

We do not oppose prohibitions on compensating individual reviewers on the basis of numbers of denials, but we do oppose prohibiting the utilization review firm from putting its fees partially (or wholly) at risk based on overall achievement of target cost savings. Many employers demand such arrangements, asking us to "put our money where our mouth is." In enacting the HMO Act of 1973, Congress accepted the view that prospective financial risk in health care serves cost-effective treatment and preventive care.

PHYSICIAN INVOLVEMENT IN DENIAL OF CERTIFICATION.

Requirement that all denials of certification be made by a physician.

We oppose requirements that all denials of certification be made by a physician. To require physician involvement in certain denials (e.g., those with which the attending physician agrees) would be burdensome and unnecessary. The concern here is adequately addressed by review procedures which include physician review at some point in the process. Certification is a complex process involving discussion, suggestion and negotiation. Regulatory requirements simply governing "denials" are ill-suited to such a complex process.

Such a requirement would be hard for the state to administer given the complexity of the utilization review process. If treated as a "bright-line" rule, it would add significantly to costs.

UTILIZATION REVIEW AS THE PRACTICE OF MEDICINE

Requirement that utilization review be defined as the practice of medicine.

We strongly oppose such a definition. Utilization review determinations do not direct a provider of care to offer or refuse to offer any specific course of treatment. They are rather an assessment of the medical necessity of proposed care in the appropriate setting for the purpose of offering an advance indication concerning benefits. Utilization reviewers have no authority to direct the provider of care or patient to do or omit anything; this is not the practice of medicine. This requirement is not justified and would add substantially to costs and interfere with effectiveness.

Initiatives defining chiropractic utilization review as the practice of medicine are particularly regrettable. Many seek to re-define the practice of chiropractic to include the review of chiropractic services so that chiropractic reviewers must be licensed to practice in the relevant state. This exhibits a fundamental misunderstanding of the nature and intent of utilization review, which does not seek to replace the practitioner or seek to dictate that certain services be offered or not offered or be performed a certain way. Further, to define the practice of an art to include a paper review of appropriateness could lead to unintended and illogical results. Such an approach, if applied consistently in other practice areas, would require that medical claims review be considered the practice of medicine, and that all reviewers by physicians. Such a position is insupportable.

In Connecticut, the Board of Chiropractic Examiners itself recently (and correctly) ruled that the review of chiropractic services was not the practice of chiropractic services.

RETROSPECTIVE REVIEW AS UTILIZATION REVIEW

Requirement that the definition of utilization review includes "retrospective review."

We oppose including "retrospective review" in any statutory or regulatory definition of utilization review and support its specific exclusion from such definitions in the event of ambiguity. Retrospective review is by and large already regulated (e.g., through state regulation of insurance claims processing and unfair claims practice laws, through ERISA etc.); consequently, standards applicable to prospective or concurrent review are inappropriate.

In states requiring physician review in utilization review denials, the inclusion of retrospective review as utilization review would add substantial additional cost to claim processing.

SPECIALIZED CONCERN IN UTILIZATION REVIEW

Psychiatric and Chemical Dependency

In some states, legislative initiatives regarding utilization review have focused on psychiatric, chemical dependency and chiropractic services, due to the efforts of certain discrete groups of providers. Utilization review in these areas, however, carries no unique problems or risks, and it is equally (if not more) important in efforts to control health care costs. For example, psychiatric and chemical dependency is an area of health care which has seen a particularly rapid rise in costs: five years ago employers spent approximately 6% of their health care costs in the psychiatric and chemical dependency area; presently the share is 15% to 30%.

Many legislative proposals nonetheless seek to restrict utilization review in the psychiatric and chemical dependency area so as to either render such programs too expensive to be provided by benefit programs or so as to drastically diminish their effectiveness. This is particularly unfortunate because psychiatric and chemical dependency not only constitute a rapidly growing segment of health care costs, but because these services are especially appropriate to utilization management. For example, the cost difference between inpatient and outpatient psychiatric or chemical dependency programs is significant. However, the effectiveness of outpatient programs is comparable to or better than, the inpatient programs. Utilization management could encourage the use of these less expensive, equally appropriate outpatient programs.

Psychiatric and chemical dependency services are also fields in which there are an increasing number of treatment options. Psychiatric review specialists can assist practitioners in assessing the appropriateness of these various options. For these reasons, efforts to restrict psychiatric and chemical dependency utilization review are particularly unfortunate.

CONCLUSION

Utilization review is an important and significant health care cost containment tool to ensure the appropriate utilization of health care services in our country without jeopardizing the delivery of quality care to the patient. Its development should be nurtured and encouraged rather than proscribed by needless regulation.

In evaluating and combating state legislative initiatives, it should be recognized that utilization review has grown rapidly from almost non-existence before the late 1970s to its current status of pre-eminence over the traditional fee-for-service arrangements without such utilization review, especially in employee benefit plans. Because it has proven to be an effective cost-containment tool, providers of late have organized to attack utilization review by proposing deathknell legislation designed to negate its effectiveness.

Organized provider groups are often politically active and powerful; they are supported by a base of members who are both geographically dispersed throughout all legislative districts and influential leaders in their communities. Rational arguments and independent studies are, by themselves too often no match for carefully chosen and well-presented anecdotes that appear to represent the "tip of the iceberg" of consumer abuse, particularly in the sensitive area of health care. Often lost in the debate is the not so surprising realization that providers critical of utilization review have an appreciable financial interest to protect in seeking anti-utilization review legislation.

An environment favorable to managed care can and should be protected. The principal danger is that state anti-utilization review legislation will be forced through legislative committees on the basis of anecdotes and alleged harm to the patient without an appropriate consideration of the value of utilization review and an understanding that much of the complaint can be traced to reductions in payments to providers. Once objections are raised, however, the process slows down and allows an opportunity for more measured advocacy, debate and compromise. Identifying the proposals at an early stage of the political process, understanding the impact of the bills on utilization review and coordinating opposition to the measures are early steps that require attention and effort. Protection of utilization review, however, is worth the price.

ALASKA STATE

HOSPITAL & NURSING HOME

ASSOCIATION

March 20, 1991

Senator Arlis Sturgulewski, Chair
Committee on Health & Social
Services
Alaska State Senate
Legislative Building
Juneau, AK 99801

Re: Utilization Review Legislation

Dear Senator Sturgulewski:

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

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

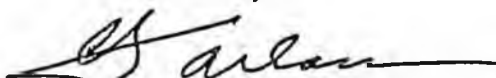
Alaska hospitals do not feel the legislation need be cumbersome, or punitive, rather that it should assure physicians and hospitals that the individuals doing the review are qualified, that all private UR organizations reviewing patient care in Alaska are registered with the state, that the hours of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

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

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

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

Sincerely



Harlan R. Knudson
President/CEO

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

319 Seward Street #11 • Juneau, AK 99801 • (907) 586-1790 • Fax (907) 463-3573

SUMMARY OF STATE PUR STATUTES

OCTOBER 1990

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

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

RESPONSIBLE AGENCY

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

STATUS

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

BARTLETT MEMORIAL HOSPITAL

3260 HOSPITAL DRIVE • JUNEAU, ALASKA 99801 • TELEPHONE (907) 586-2611

October 11, 1990

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

Subject: Utilization Review Legislation

Dear Senator Duncan:

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

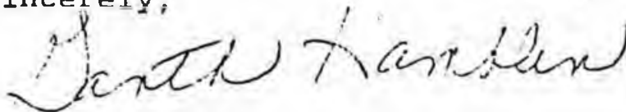
1) Improve communication and cooperation between providers and utilization review agents.

2) Assure that reasonable standards are adhered to in conducting utilization reviews.

3) Promote the delivery of quality, cost effective health care.

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

Sincerely,



Garth M. Hamblin
Controller

GMH/mem

cc: Task Force Members
Ray Gillespie

Alyeska pipeline
SERVICE COMPANY

[illegible] SOUTH BRAGAW STREET, ANCHORAGE, ALASKA [illegible] TELEPHONE [illegible]

March 25, 1992

Senator Arlis Sturgulewski
Alaska State Legislative
State Capitol
Juneau, AK 99301-1182

Dear Senator Sturgulewski:

Reference: Senate Bill 239

In the 1991 legislative session, I was aware of similar proposed legislation which failed for lack of a sponsor. I understand this item is now before your committee.

Alyeska adopted a Managed Care program in January 1989. Along with the State of Alaska and other employers we were facing continually increasing cost of providing health benefits. Since our employees contribute torward their coverage, they were also experiencing increased premium costs.

Our Managed Care program has at its core a responsible utilization review and concurrent review procedure for medical in-patient/surgical care as well as chemical dependency and mental health. We use the services of Intracorp and Human Affairs Alaska . The programs have worked, providing cost effective care by reviewing the need for hospital, surgical and chemical/mental health treatment without diminishing care quality. Through the use of U.R. Programs, in conjunction with a hospital Preferred Provider Arrangement, we have been able to hold our premiums at 1990 levels.

The proposed Senate Bill 239 sounds laudable on the surface but has the following problems:

- It establishes another level of bureaucracy where none is needed. This at a time when the state is trying to bring under control a short fall in the state budget. I doubt seriously the state will collect enough fees under Sec. 08.85.080 "in an amount sufficient to pay for the costs to the department for administering this chapter",

- It is a bill that unduly benefits hospitals (Sec. 08.85.020 and 08.85.030).

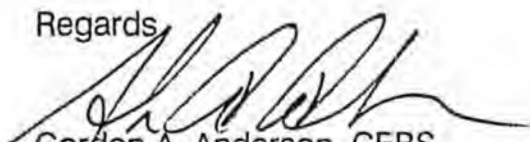
  - It considers all UR activities as being hospital related ignoring Employee Assistance Programs (EAP) and related UR activities which are frequently not hospital directed nor do they use nurses.
  - requires a license for anyone not affiliated with a hospital (exempting hospitals).
  - "...have available... sufficient numbers of registered nurses"... supervised by physicians trained in the appropriate specialty area, ..."
  - "prohibitions against a review agent entering a hospital to interview a patient unless the attending physician is advised... with reasonable advanced notice".

These requirements totally favor hospitals such as Charter North and one would suspect were written by them. A hospital "UR" facility would be similar to the old saying: " the Fox guarding the Hen house".

Costs to employers and employees will increase as a result of restraining reasonable "UR" programs which evaluate the appropriateness of care, the length of confinement, and the selection of the appropriate provider. Add the cost of qualifying for a license, providing an extra layer of communication to patients and providers duplicating employer efforts (Sec 08.85.030,(b)(11), and other compliance efforts. Frankly, many small employers may not be able to continue to provide medical and EAP programs if costs increase. Most of us have worked for years to remove unnecessary controls of our own insurance carriers to lessen overhead and the need for expensive practitioners and specialists to "oversee" every case when only the most severe required such management.

I would appreciate your reconsideration of Senate Bill 239 based upon my comments.

Regards,



Gordon A. Anderson, CEBS
Manager, Benefits and Annuitant Affairs

CHARTER
NORTH HOSPITAL

2530 DeBarr Road
Anchorage, Alaska 99508
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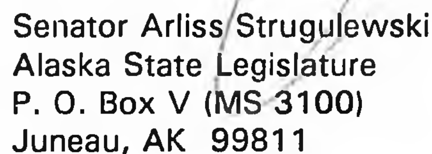
January 31, 1992



Senator Arliss Strugulewski
Alaska State Legislature
P. O. Box V (MS 3100)
Juneau, AK 99811

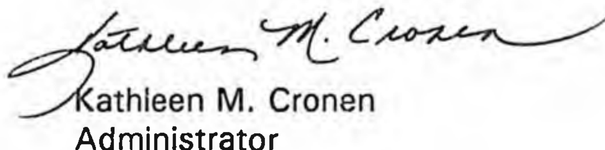
Dear Senator Sturgulewski:

I wanted to write and express my sincere thanks for meeting with us to discuss Senate Bill 239. It was very helpful for the physicians to hear first hand your concerns about the bill. It is my understanding that the meeting you suggested is being arranged. I appreciate your willingness to assist in this endeavor. It has always been our goal to work with the utilization review firms to create a win-win situation.

I believe the dinner held in Juneau was a success. Individuals left with a greater understanding of the utilization review process and the objectives of the legislation.

Best wishes for a productive and successful session.

Sincerely,



Kathleen M. Cronen
Administrator

COUNSELING CENTERS

240 E. Tudor Road, Suite 240
Anchorage, Alaska 99503
(907) 561-7576

950 E. Bogard Rd., Suite 110
Wasilla, Alaska 99687
(907) 373-7575

3504 International St., Suite 1
Fairbanks, Alaska 99701
(907) 456-7575

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I can't find anything else TFA

Association of Alcoholism /Addictions Programs

"The Statewide Association of Quality Chemical Dependency Treatment and Prevention Programs."

P.O. Box 1172 Ellensburg, WA 98926 (509) 962-6202

THE NEED TO REGULATE UTILIZATION REVIEW

Perspective from Chemical Dependency Treatment

Many people in need of alcohol and drug treatment are now being denied access to the proper level of care--and sometimes any treatment at all--because of inappropriate decisions by utilization review programs.

While we recognize the value of managed care when it is properly conducted, we strongly oppose arbitrary or discriminatory practices that endanger the lives of youth or adults who are ill and in need of treatment.

In 1987 the Washington State Legislature expanded mandatory coverage for alcoholism to encompass all chemical dependency. Since that time health insurance companies have increasingly used utilization review to circumvent the laws and regulations standardizing coverage for chemical dependency.

There currently are no statutes or regulations that govern the operation of utilization review programs by insurance companies, health care companies, and health care maintenance organizations. As a result, there are as many as 150 national and regional corporations conducting private reviews, most applying differing criteria for coverage. Most criteria do not reflect the professional norms for delivery of care.

Among the growing list of problems for patients and providers generated by private utilization review entities are the following:

- Most companies call their standards of care "proprietary" and will not share them with either the patient or provider until after the patient has commenced treatment and is denied coverage.

- Review entities invent continuums of care that exclude customary and statutorily defnied modalities, such as requiring patients fail at one modality before receiving the medically prescribed treatment.

- The reviewing agent often utilizes personnel without training or qualifications in the illnesses about which they make critical decisions on access to care, level of care and length of stay.

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

Washington State should enact legislation to regulate utilization review by requiring each review agent to develop a plan to be filed by the insurance entity that discloses standards, criteria and procedures to be used in managing health care plans. Such legislation will assure full disclosure to consumers of what they have purchased and what they can expect from their health care coverage.

LAKESIDE
RECOVERY CENTERS, INC.
JUNEAU

April 18, 1991

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

Dear Pat,

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

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

1. Most companies call their standards of care proprietary and will not share them with either the patient or provider until after the patient has commenced treatment and is denied coverage.

2. Review entities invent continuums of care that exclude customary and statutorily defined modalities, such as requiring patients fail at one modality before receiving the medically prescribed treatment.

3. The reviewing agent often utilizes personnel without training or qualifications in the illnesses about which they make critical decisions on access to care, level of care and length of stay.

3412 Glacier Highway • Juneau, Alaska 99801 • (907) 780-4948

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

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

Once again, it is with regrets that I will not be able to be at the committee hearings over the next couple of weeks. I will be out of town until May 6, 1991. At that time, I will call to see if I can be of any assistance in regards to clarifying any of the above issues.

Respectfully submitted,

/S/

Judi Bixby, Administrator
Lakeside Recovery Center, Juneau

JB:ym

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

Melissa

PROVIDENCE HOSPITAL
3200 PROVIDENCE DRIVE
PO BOX 196604
ANCHORAGE, ALASKA 99519-6604
PHONE (907) 562-2211

SISTERS OF PROVIDENCE
SERVING IN THE WEST SINCE 1856

February 20, 1992

TO WHOM IT MAY CONCERN:

I, Geneva Craig, R.N., want it to be known that I support the reason for development of Senate Bill No. 239. As Assistant Director of Utilization Management at Providence Hospital, (a provider,) I can attest to the many difficulties and challenges providers face when dealing with review agencies. The provider's reimbursements for services are frequently jeopardized. The standards and criteria utilized by review agencies are not consistent. The information requested/required is more than what is needed to certify the admission and length of stay. I find this very unreasonable and am highly suspicious that such information may be used to deny their client eligibility at a future date. Often times request for the medical chart is inapproopriate. We have had instances where the chart has been requested after the hospital U.R. Coordinator had spoken with the Review agent and extension of stay had been granted. The copying charges were at the hospital's expense.

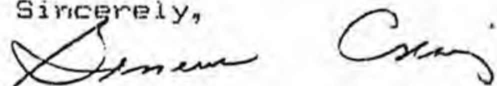
Arbitrary denial of patient care days occur without clarifying reason, even when the reason for the denial has been requested. Physicians are often the last to know of a denial, therefore they have not had any input into that decision making process. Review companies tell us they could not reach the doctor after one attempt, if any. We have had them say to us they will not call the physician, and yes the patient stay is denied. In order to appeal the hospital must write an appeal letter, (hopefully the disgruntled physician will write it), copy the medical records and mail it to the review company. We then wait several weeks for notification of payment or non-payment. The appeal process could have been prevented, if the review agent had interacted with the physician at the time of the proposed denial. We wonder why the cost of health care continue to rise and why hospitals have been forced to close their doors, shifting the direction of expenses is part of the problem.

Often the denial is issued by a nurse, or a physician outside the medical specialty with which they are dealing. It is only reasonable to expect that the person issuing the denial is in the same specialty or a specialty that is similar. Criteria utilized by the review company is considered privileged information. They seem to have a fear that the physicians will alter their practice along those guidelines to obtain payment and possibly not use their medical judgement.

I am very much aware of the reason for the evolution of Review firms. I am convinced that we need someone to regulate private-health care review agents. The bare minimum for approval of payment for the delivery of health care service is that the care is medically necessary. The need for that care is determined through evaluation of the symptoms exemplified by the patient.

Thank you for this opportunity to express my support in the development of SB 239. If needed, I am willing to help those who do not fully understand the process gain.

Sincerely,



Geneva Craig, R.N., M.A.
AD Utilization Management
& Discharge Planning

February 14, 1992

SENATOR ARLISS STURGULEWSKI
ALASKA STATE LEGISLATURE
ROOM 427-C
PO BOX V
JUNEAU AK 99811

LETTER OF SUPPORT FOR NEW UTILIZATION REVIEW LEGISLATION
SENATE BILL 239

Dr. Patrick Brady asked me to write a letter in support of Senate Bill 239, which is an act providing for licensing of private care review agents.

In my capacity as a specialist in general internal medicine in Anchorage since 1978, I have been well aware of the gradually changing health care environment and increasing review of many of my hospital patients as well as outpatients. It has been my impression and consternation that a number of times reviewers would be incapable of understanding a medical case, in the hospital especially, and would be so confused as to challenge normally accepted medical therapy. To that end, most physicians have learned to write hospital notes which sometimes are quite didactic and explain things in much greater detail than would normally be required so that reviewers that don't understand the medical problem would be more likely to accept treatment.

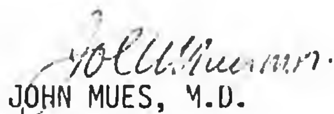
Two pertinent examples include:
1. About 2 years ago I had a serious question about admitting a patient to withdraw from a drug called Quinidine. Quinidine was used by this gentleman to treat a ventricular cardiac rhythm disturbance, and he was ill from the drug. Stopping the drug required admission to the hospital for cardiac monitoring. This is a normally and well accepted type of observation, and in fact, had I not admitted the gentleman for monitoring, I would have been severely criticized by Cardiology. The reviewer in this setting did not understand this kind of treatment and actually challenged admission for Quinidine withdrawal. The reviewer eventually approved this gentleman, but it was only after several letters and telephone conversations that approval was given.

2. The second incident occurred when I treated a patient with pneumonia with intravenous antibiotics. The reviewer felt that intravenous antibiotics only needed to be given for four (4) days, and I felt they needed to be given for seven (7) days. Considering that there is no accepted, written guideline for intravenous antibiotic therapy and that physicians need to individualize this treatment for any patient, I was quite surprised at the results of this review. This reviewer was finally reversed only after extensive letter writing campaigns, and a Providence Hospital sponsored meeting with the reviewer in person in Anchorage as well as the reviewer's supervisors.

In the setting of extensive medical review especially, the extra effort that goes into writing letters and defending what is normal, common and appropriate medical practice amounts to a serious disincentive for physicians to take care of patients in this category, Medicare. As these reviews are expanded to private pay patients, it only adds to the burden of paper work and physician anger which makes it much more difficult to practice medicine.

Most of these problems could be avoided if the reviewers had equal training to the diseases treated. The kinds of questions that I have had serious problems with have all been relatively simple for both myself and my colleagues to understand, and it was very unclear as to why the reviewers thought what they did. I can only assume that the reviewers were incompetent or undertrained or possibly both. For a review organization to produce any kind of effective results, it must have some sort of credibility and accuracy. Without some sort of oversight of review organizations, I am sure that they will only cause medicine to become a much more difficult place to practice and even perhaps a battle ground for physicians. In that setting you can only expect to see a gradual and progressive deterioration of medical practice. This has been occurring in this country related to the various and numerous new regulations and activities presented by insurance company reviewers, the Federal Government, etc., and can only lead to lower quality of medical care.

Please take these considerations seriously. Physicians, especially primary care physicians, are near the end of their rope nationwide in being able to cope with the numerous problems created by our ever expanding bureaucracies. These will not do any of us any good and in fact may seriously jeopardize the medical care that you and I will receive when we become ill.



JOHN MUES, M.D.

:cc

xc: Patrick Brady, MD

3260a/19-20

Mr. Glenn Olds, Insurance Commissioner
Division of Insurance
State of Alaska
800 E. Dimond Blvd., Suite 560
Anchorage, Alaska 99515

Patient agreed to release information to Aetna [illegible] 3/19/92 per Dr. Brody — [illegible] for file

March 3, 1992

Dear Mr. Olds:

On January 10, 1991 I was stricken with a brain aneurysm. I was rushed to Providence Hospital and was admitted in serious condition in a live and death situation. My test at that time showed my brain was hemorrhaging and they had to stabilize me before they could operate. I really don't remember very much of those days because of my condition. I was under the care of a number of doctors. Dr. Marjorie Smith was my physician who had the final say as to my release. Dr. Smith discussed my release date with Aetna priorier to my release and Aetna agreed that was acceptable to them. She came in to my room on the 25th of January and said that she was going to release me tomorrow. I was so happy to be able to go home and continue my recovery.

When I was in the hospital I realized I could not read or write. Each day I had to order my meals for the next day and I was not able to because I could not read the menu, and then the first time I wrote my name correctly, I cried. My daughter wrote down everyone phone numbers for me and put it by my phone. When I wanted to call someone, I had to look at each number individually and then on the phone try to find a number that looked like the ones on the list. It was very flustering, and even to this day I still have problems reading and I still transpose number or read them wrong.

In the letter from Aetna refusing the pay the last night in the hospital they said that I was "showering and ambulating independently." Even something as simple a taking a shower was an ordeal because I would forget to wash something or I would wash the same arm two or three times and not wash the other one. Then I would forget what I just washed.

When I was released I was afraid to write a check because every time I did I would spell everything wrong and it was embarrassing. When I go out with my son or daughter and had to write a check, they would stand there and spell the words for me. I would forget where I was or forget what I was there for.

A couple of weeks after my release was the Fur Rondy activities and Glenn, (my boyfriend), and I thought that I would enjoy getting out of the house for a while. We went over to the Sullivan Arena to see the exhibits. As soon as we got down on the lower level I became so terrified because of all the people moving all around me. If I would have become separated from Glenn, I would have become hysterical. We had to leave. I am leery of large crowds even now.

At home I wanted to work on an afghan I was making but I could not count to ten to count the stitches that were needed. Can you imagine no being able to count to ten. When I was finally able to drive, I went shopping one evening for our dinner and I wanted to pickup some seafood cocktail, I was so proud of myself for being able to do one more thing for myself. Well, I got chili sauce instead. This may sound like a normal mistake but to me it was really traumatic because I wanted to do it so perfect and I failed.

I know that when I was released I was totally dependent on Glenn to take care of me. If I did not have him, I know I could not have been able to take care of myself. He did all the cooking and cleaning and he had to call me throughout the day to tell me what color pills I had to take and when to take them. We would play scrabble for therapy. It made me think and try to use my brain. I still have troubles reading, I do not think I will ever read like I used to and that is sad because I love to read.

The object of this letter is to appeal Aetna's decision not to pay for my last night in the hospital. Aetna has reviewed my files, and any and all phone calls from me have been totally ignored. I spoke a number of times with Judy Ketterling, our representative in Anchorage for Aetna, on the phone. She never came to my hospital room and explained to me or my family that I was being considered as and out-patience and I should go home, against my Dr's orders. I spoke with Barb Sandors, of Aetna, on February 26, 1992 to ask if Ms. Ketterling was to advise me that Aetna was responsible for explaining to me the decision to classify me as an out-patience. Since the decision was made, why didn't anyone let me or my family know this decision was made. Ms. Sandors said that when I was preauthorized to stay in the hospital a certain time limit was established for the length of my stay. I had to tell her I had a brain aneurysm and was admitted in a life and death situation and so no preauthorization was made.

I feel that under the circumstances of my illness and the care that I need that this decision is unfair and unethical. I cannot understand how people is Seattle can second guess my doctors orders and blatantly ask me why I did not go home earlier. I was under no condition to question my doctors orders, nor would I want to. They are trained professionals and I am sure they knew what was best for me. Enclosed you will find several letters from co-workers, friends, and family explaining their thoughts of my condition, before and after my aneurysm, and the progress of my recovery. These people have helped me tremendously in my recovery with patience and encouragement to keep trying and reach a little harder to accomplish the task at hand. Over the months I could see my improvements. Something I could not do 2 months ago, I can do now. I feel very fortunate to have these wonderful people near me.

Therefore Commissioner Olds, I am asking you to read my letters and review my case. Any assistance you can provide me in resolving this $495 debt to Providence Hospital will be greatly appreciated.

Sincerely,

Margaret J. (Peggy) Frazier

Margaret J. (Peggy) Frazier
403 W. 22nd, Apt 211
Anchorage, Alaska 99503
(907) 272-5996 Home
(907) 349-7755 Work
SS# 531-52-7652

ATTACHMENTS

cc: Aetna Insurance Company
Mr. Gary Bader, Director of Retirement & Benefits
Providence Hospital
Dr. Marjorie Smith, M.D.

TO AETNA INSURANCE COMPANY:

Margaret "Peg" Frazier had an aneurysm explode in her head about a year ago and subsequently had life saving surgery. While she was hospitalized I visited her frequently and called her frequently between visits. I am both a co-worker and a friend.

During these numerous visits and phone calls it was obvious that she was unable to retain memory and would easily be confused. For example, another frequent visitor and caller was S. Kaye Fergert, also a co-worker and friend. Because we both worked with Peg, I had the feeling that Peg, in her condition, was often confused about which one of us had actually visited or called her. While on the phone I often felt that, even though I had identified myself, Peg was thinking I was Kaye. Kaye reported to me similar incidents. Another thing that was obvious is that Peg didn't seem to be able to judge time spans. For example, I could have talked to her or seen her the day before, but in our next contact it was to her like it had been many days.

After her release from the hospital it was many months before she was able to perform as her old self. She went through many frustrating months were she had to relearn the basic skills of reading, writing, and numbers. These functions would confuse her and frustrate her.

She had a very competent doctor who knew her case and used her best judgement on when to release Peg from the hospital. Peg was not capable of making these judgements for herself. Nor did Aetna advise her to go against doctor's orders and release herself early. In my observation, Peg needed her medical care the entire time she was hospitalized. When I visited her shortly before her release she was in bed and still on medications. Upon her release she needed the constant care of her family. It was obvious to those around her that without constant care she would have been unable to function. It was several weeks before she could return to work and then several more months before she could perform to her old standards.

I feel it is cruel of Aetna to now tell her that she should have released herself, against her doctor's orders, any earlier than medically recommended. In the first place, she was incapable of making that kind of decision; and secondly, the doctor was monitoring her case all along and no one from Aetna advised her any differently. If Aetna feels they are wiser than the doctor on the case, perhaps Aetna should send in their own DOCTOR (not nurse) to monitor each case involving an Aetna patient and to CONSULT with the primary physician. Until then, it is certainly unwise, and perhaps dangerous, for patients to go against their doctor's orders by releasing themselves from the hospital early in the event that Aetna may decide to not pay for their last days of medical care. As an Aetna client, I am very unhappy over the handling of this case.

Barbara A. Miller

Cheryl Flothe
State of Alaska, D.E.C.
800 E. Dimond Blvd.,
Suite 3-470
Anchorage, Alaska 99515

February 18, 1992

Aetna Life Insurance Co.
Repeals Review Board
P.O. Box 21645
Seattle, Washington 98111

SUBJECT: Margaret Frazier, SS #531-52-7652

Dear Sirs:

I would like to protest a claim denial for Margaret (Peggy) Frazier, SS #531-52-7652, for her last day in the hospital, January 26, 1991. I work in the same office as Peggy Frazier. She and I are both employed by the State of Alaska, Department of Environmental Conservation. Peggy was stricken by a cerebral hemorrhage on January 10, 1991 and was immediately hospitalized and had brain surgery right away. She was incoherent for days, did not know people, couldn't speak or think clearly and so on. She was released from the hospital on January 26, 1991, just 16 days after her stroke. At the time of her release from the hospital, Peggy was still in a confused state, barely, if able to bathe herself, certainly not in any condition to deal with paperwork or able to think logically. If Peggy did not have friends and family at home with her to take care of her, she probably would have to have had paid nursing.

Peggy was on sick leave until February 25, 1991 and worked part-time for two weeks following her return to work. She used up all her sick leave and even used donated sick leave before her ordeal was through. At the time Peggy returned to work she was still a little confused, couldn't get her words straight and couldn't remember how to spell as well as she used to. She still has a problem with spelling and a little confusion, and this is a year later.

Again, I would like to protest the denial of her claim for the last day she was in the hospital. She was told by Aetna when her claim was denied that she should have just gone home the last day, that it wasn't necessary for her to be there, and she could have come in as an outpatient rather than staying overnight another night. Peggy was confused and ill--it wasn't even known at first whether she would live or die--it certainly wasn't known, even at the time she left the hospital, how much of her faculties she would retain. Her doctor, Dr. Smith, even spoke with Aetna the day before she was discharged, telling them that Peggy would remain another day, the Aetna representative acknowledged and/or agreed. All these things considered, Aetna has refused to pay for Peggy's last day in the hospital.

My complaint is that an insurance company is in the business of paying for our major medical expenses so that we will not be devastated with these major medical bills. We rely on our major medical carriers to help us through these times, especially when we are deathly ill. This is clearly a case of the big insurance company (Aetna) looking into their book of statistics, and saying, "Usually, people go home after x amount of time after having a catastrophic stroke..." [does it say 16 days in your statistics?]

I do not believe that in cases such as this we can go by a rule of thumb. When someone is under the doctor's care for a catastrophic illness, the insurance company just has to believe the opinions of the doctors who are caring for the patient, and not rely on opinions of those who are thousands of miles away in the insurance office. Neither you nor your consultants saw the person who was ill--you just looked into your book of statistics to make a ruling.

Furthermore, neither I nor my family have had to put in a claim for a catastrophic illness, thank goodness. I fear for the time we, too, may be put in a position to have to fight your list of statistics after we become well enough to realize what is going on.

Lastly, most of us never have a catastrophic illness, we usually have everyday illnesses such as doctor's visits and minor ailments. Are the few that do have major illnesses going to bankrupt our insurance plans?

I hope you will reconsider this claim, and I hope Aetna will rethink its attitude of second guessing doctors' judgments when extreme illnesses arise. Perhaps it would be in Aetna's interest to have a doctor stationed at each hospital to give a "second opinion" in each of these cases; this would be more legitimate.

Sincerely,

Cheryl Flothe

cc: Margaret Frazier

THE FOLLOWING PAGES MAY
NOT FILM LEGIBLY BECAUSE OF
THE POOR QUALITY OF THE ORIGINAL

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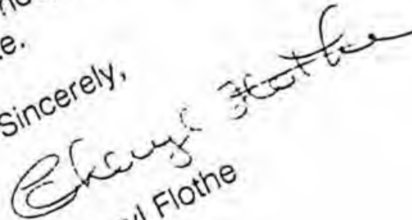
Sincerely,



Cheryl Flothe

cc: Margaret Frazier

409 Atlantis Ave.
Anchorage, Alaska 99518
907/563-5616

February 24, 1992

Aetna Insurance Company
P.O. Box 21645
Seattle, Washington 98111

Dear Madame/Sir:

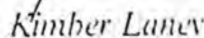
I am writing to you on behalf of my mother, Margaret J. Frazier. She has brought to my attention the fact that you refuse to provide coverage for her last night stay, January 26, 1991, in Providence Hospital. She was instructed by her physician Dr. Marjory Smith to stay that last night in the hospital and that your company had agreed to cover this expense. Now you are going back on your word - the word you gave the acting physician for my mother.

After my mother's brain surgery she could not make even the simplest decisions for herself. She relied on family, friends, and her physicians to make those decisions for her. She could not even remember her address or phone number and on many occasions could not remember how old she was or what state she was in. Though she is much better now and is able to work she often has trouble with spelling and mathematics. She transposes letters and numbers. She also has holes in her memory. The losses cannot be given back to her - not now or ever.

Our family feels that you have taken advantage of the most traumatic time in her life by not offering the coverage promised. Ms. Frazier has always paid her premiums and has relied on the coverage your company, by contract, has been paid to provide. We greatly appreciate the coverage your company offered, it was life saving, but to go back on your word to a woman who could not make even the simplest decision is highly unprofessional and even deplorable.

My mother is requesting that you make good on your promise to cover her last night stay in the hospital and that you have whatever damage you have caused to her credit rating taken care of. If these requests are not fulfilled she will be forced to seek legal counsel and Union support.

Very Truly yours,



Kimber Laney

February 20, 1992

Aetna Insurance company
Seattle, Washington

Re: Margaret Frazier/Hospitalization 1/91-2/91

To Whom it may Concern:

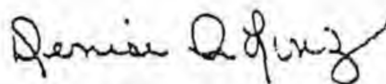
I am adding my voice to the many others requesting a review of your decision not to allow full coverage for Ms. Frazier during her illness last year.

Ms. Frazier could have died from the brain hemorrhage she experienced. I firmly believe that it is only due to the excellent care she received from her physician and Providence Hospital that she is now a vital and productive member of our society. Her healing will continue to improve with time and her last physical gave her a clean bill of health. It amazes me that you would ignore the statements made by her physician to the necessity of her hospilization for however long. Perhaps its common practice in your area for people to leave the hospital before being formally released by their physician, but it's not the norm in Alaska.

I have known Ms. Frazier since July, 1987, she and I are friends of long standing. We went through six months of schooling together. I am quite aware of what Ms. Frazier was capable of before her illness. I also saw the effects her illness had on her. She couldn't read a newspaper article let alone a novel after the illness. Her eyes wouldn't state focused long enough. She couldn't remember the content of conversations that had taken place a few days before. She avoided writing checks for fear of making major errors. She was embarrassed by how long it took her to write a note or a check. Her handwriting was different. Its' taken her a year to feel comfortable doing these mundane things of life. After her release from the hospital it was four to six weeks before she was finally considered capable of returning back to work and then only on a part-time basis.

I strongly suggest you review her appeal with the utmost speed. I also suggest that you rely on the opinions of her physician in this matter, after all no one knows better all the aspects of Ms. Fraziers' case.

Sincerely,



Denise A. Linz
3100 Ward Place, Unit 21
Anchorage, AK 99517

Mr. Glenn Hirst

March 1, 1992

Aetna Life Insurance
P.O. Box 21645
Seattle, WA 98111

To Whom it May Concern:

I am writing this letter in regards to Margaret (Peggy) Frazier's final day of hospitalization.

The letters that have been written on Peggy's behalf are both "eye opening" for me and a painful reminder of what we endured following her release from the hospital. Peggy still suffers from the effects of her aneurysm and subsequent surgery to save her life. The denial of insurance benefits for the final day of her stay has become another hurdle she feels compelled to overcome.

I can, without any reservation what so ever say that Peggy's release from the hospital was far from premature. The assertion made by Aetna that the final day of hospitalization was for consultation purposes only is ludicrous to say the least, Peggy was totally incapable remembering any instruction for longer than few minutes.

Peggy's letter to you describes what she remembers in the days after her release from the hospital. The fact is she remembers mostly what I related to her in those first few days home. Peggy was quite dysfunctional the first weeks out of the hospital. She was unable to read or write, even dialing a phone was a task beyond her abilities. If it had not been for the after care support provided by her parents, her children, and myself, Peggy could have needed professional care in order to stay at home.

In conclusion, I would like to mention that the cost to our family has been much higher than the $495 dollars denied for the final day of Peggy's hospital care. Peggy's parents flew from California to be with her at the hospital and at home. I took time off from work to give her the support she needed while in the hospital as well as afterward. Do not let the final cost be the loss of faith and trust in another insurance carrier.

Sincerely,

Glenn Hirst

Aetna Insurance Feb. 26, 1992

Dear Aetna:

It has recently come to my attention that your company is refusing to cover expenses for Peggy Frazier's last day in the hospital following her unexpected illness last year. Peggy is a very conscientious and dedicated co-worker. Prior to her illness, she had worked with us for a short period of time and was doing an excellent job.

The sudden onset of Peggy's illness came while she was at work and was quite a shock to everyone who knows her.

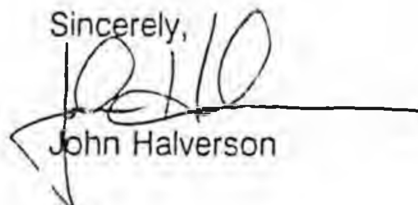
Following her stay in the hospital, Peggy returned to work and initially worked reduced hours due to complications from her illness. I imagine that she would have preferred to recover at home for a longer period of time, however, due to the financial hardship of not receiving a paycheck, she returned to work. When she initially returned to work, Peggy had a very difficult time reading and writing. She had to re-learn things that we all take for granted. She appeared to be physically and emotionally drained by the medical problems that she had been through.

Based on my observations, it does not seem that Peggy's stay in the hospital was excessive by any means. Her body was put through a terrible shock. Rest and close observation were necessary to insure her recovery.

I am pleased to say that since she has been back at work Peggy has made a remarkable recovery and is once again doing an excellent job in performing her work.

It is disheartening to see a large company such as Aetna refusing to compensate policy holders for expenses incurred at the direction of professional medical providers during what was virtually a life threatening situation. This is especially upsetting when one considers the significant monthly premiums that the state of Alaska pays to Aetna for medical coverage. I sincerely hope that Aetna will reconsider this matter.

Sincerely,



John Halverson

February 18, 1992

Aetna Insurance
P.O. Box 21645
Seattle, WA 98111

RE: Peggy Frazier
Alaska State Employee Medical Expenses

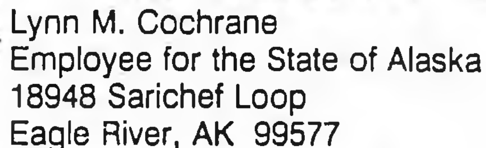
To Whom it May Concern:

I am writing in behalf of Ms. Peggy Frazier. Peggy is a Clerk Typist III with the Department of Environmental Conservation, Western District Office. She was a bright, intelligent, and extremely productive staff member before having her stroke last year. Peggy has made great strides towards recovery, but this has not been easy. I have known Peggy before the stroke and after, and she continues to face hurdles as a result of her condition. She has had to relearn even the most simple of thought processes that you and I take for granted.

I understand that Aetna Insurance has elected to not pay for Peggy's last days stay in the hospital. It is my concern that this decision was based on insurance guidelines, or standards, or "averages", and not based on the decision made by her physician. Peggy was in no condition nor did she have the medical expertise to make that decision or judgement herself.

If I were in the same position I would heed my physicians advice. I feel that Aetna should reevaluate their decision in the case of Ms. Peggy Frazier and pay for her final days stay in the hospital based on her doctors judgement and his best interest for her health and recovery, rather than on textbook "averages".

Sincerely,

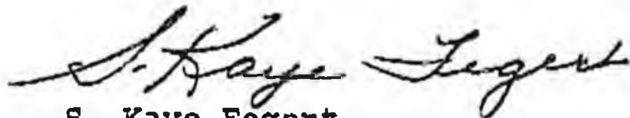


Lynn M. Cochrane
Employee for the State of Alaska
18948 Sarichef Loop
Eagle River, AK 99577

TO WHOM IT MAY CONCERN: March 4, 1992

I worked with Peg (Margaret) Frazier from December 17, 1990 through August 1, 1991. I was in the office with her the day she became ill. All of us here in DEC were terribly worried because of the severity of the illness and the fact that her response to visitors in the hospital was so confused. I spoke with her on a daily basis once she was able to have phone calls. She would confuse my calls with those of other people. When I visited her in the hospital she was not capable of realizing from one minute to the next which fellow workers were actually there. She knew all of us, but had the wrong names with the wrong faces. She was not capable of making decisions for herself when she was released from the hospital. Personally, I felt she should have been under care for a much longer period of time. After her release I again called her on a daily basis, and up to the time she returned to work she was still having serious problems.

I believe that AETNA Insurance should be ordered to reconsider and pay the disputed amount to the hospital. She should have actually been kept longer and put on some type of a therapy program to assist her in recovery from her brain surgery.



S. Kaye Fegert
Box 2111
Palmer, AK 99645

February 18, 1992

Aetna Insurance
Seattle, WA

RE: Peggy Frazier
Alaska State Employee

To Whom it May Concern:

I am writing in behalf of Ms. Peggy Frazier. Peggy was a Clerk Typist for me while I was an environmental engineer with the Department of Environmental Conservation, Western District Office. Peggy was one of our most capable clerk typists. Immediately after returning to work from the hospital she was disoriented. She had trouble typing, writing, and coordinating movements. I was surprised that she was attempting to work as she was obviously not completely recovered from her serious injury.

It is even more surprising to see this quibbling over hospital stay. Peggy was debilitated from her injury and should have been in the hospital at least a few days longer.

Sincerely,

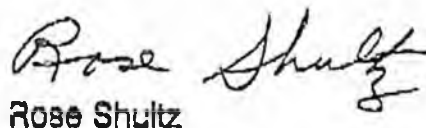
Steve Eng
State of Alaska

March 3, 1992

TO WHOM IT MAY CONCERN,

I am writing in behalf of Peggy Frazier, an employee of Alaska Department of Environmental Conservation. I saw a definite change in her work when she came back from the hospital. When she submitted information to me such as weekly issues I noticed that Peggy was having problems in sentence structure. Her thoughts seemed to be scrambled as though she were confused. If I can be of more help, please don't hesitate to ask.

Sincerely,



Rose Shultz