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Report
to
Health Insurance Association of America

Cost Analysis of
State Legislative Mandates on
Six Managed Health Care Practices

by

The Wyatt Company
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THE Wyatt COMPANY

COST ANALYSIS OF STATE LEGISLATIVE MANDATES ON SIX MANAGED HEALTH CARE PRACTICES

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COST ANALYSIS OF STATE LEGISLATIVE MANDATES ON SIX MANAGED HEALTH CARE PRACTICES

Executive Summary

Background

The Wyatt Company (Wyatt) was commissioned by the Health Insurance Association of America (HIAA) to study and estimate the costs associated with six legislative provisions that would mandate state control of managed health care practices. These provisions are either under discussion by state legislatures or have been enacted by one or more states. Wyatt's study aimed to estimate the costs for each legislative provision in terms of a percentage change in administrative costs, claim costs, or both. The following legislative provisions were studied:

1. Mandating that "any willing provider" be permitted to join a managed care network.

2. Prohibiting "gatekeeper" physicians in preferred provider organizations (PPOs).

3. Requiring local utilization review of health care services by professionals licensed in that state and denial reviews by physicians of the same specialty as the attending physician.

4. Mandating extended hours of operations for utilization review organizations to 24 hours a day, 7 days a week.

5. Requiring state-specific statistical reporting on utilization review organizations' activities.

6. Mandating a maximum differential of 20 percent between in-network and out-of-network benefits.

Study Overview

For each of these mandates, Wyatt developed an approach to accomplish the following goals:

- Determine the typical or favored way each of the managed care practices addressed by these mandates are administered today in the United States.

- Determine whether the principal and documentable effect of the mandate would be on administrative costs, claims costs, or both.

- Identify and access sources of data needed to complete this study, including published data, surveys, interviews, and internal Wyatt data.

- Construct models for estimating the administrative and/or claims costs of each mandate, based on the assumptions and approaches developed.

- Calculate the baseline and projected costs associated with administering managed health care programs under current law and under each potential regulatory scenario, and report results.

Wyatt surveyed 17 health care organizations representing a cross-section of organizational types and models. We received 10 responses from organizations whose combined PPO membership exceeds 8 million lives. We incorporated PPO network data from the 29 most mature PPOs in these organizations. We also incorporated data from 7 organizations providing utilization review services to over 40 million lives. Wyatt's study included total experience data from one "point-of-service" network and from 5 employers utilizing various other point-of-service networks across the country. The total lives covered by these plans exceed 0.5 million.

Not all of the six legislative mandates lend themselves to the same quantitative approach or analysis. Furthermore, a large number of assumptions were necessary due to the diversity of managed care activities and models and to the lack of data isolating the effects of the individual managed care practices addressed in each legislative mandate. There is no experience on the impact of many of the mandates on a mature managed care market, requiring the construction of models to simulate that effect. In addition, the legislative mandates being analyzed are only an approximation of fact, since individual states may vary from the "average" mandate modeled in this study. The approaches, assumptions, and models used in this study were documented and successfully tested for reasonableness against available data and experience.

Each legislative mandate was studied as an isolated event. The financial impact associated with that mandate assumes that only the variables addressed in the models will change. The multi-year projections are made in base year dollars. This study did not attempt to analyze the financial effect of mixing these legislative mandates.

Some judgment was involved in determining which set of assumptions were to be labeled "before" and "after" for the purposes of calculating projected effects on administrative and claims costs. The sets of assumptions used for this calculation were documented and, in most cases, enough information was provided to allow the reader to model costs from other points along the continuum. Where it seemed appropriate, both "possible effect" and "worst case effect" were projected.

Summary of Findings

The following pages of the executive summary briefly review the background and Wyatt's findings for each legislative mandate. The full detailed report devotes a section to each mandate. Each section in the full report contains: background; conclusions; methodology; and detailed conclusions. The survey instrument used for this study can be found in the appendix.

Section 1: Mandating that "Any Willing Provider" Be Permitted to Join a Managed Care Network

Background

The "any willing provider" mandate requires that managed care networks accept any willing provider that meets the network's established selection criteria. Such mandates are usually intended to insure that all licensed health care practitioners in a state are allowed equal access to patients who join managed health care plans. Proponents of this legislation do not deny that network managers have the right to set criteria for network participation, but they want the criteria to be public and evenly applied to all licensed providers state-wide. Managed health care organization representatives contend that network selection must include a mixture of criteria, needs analysis, credentialing committee review, discount negotiations and market demands for optimal effect. Further, prepublished fixed state-wide standards would make it very difficult to eliminate more than a relatively small percentage of total willing providers.

This study attempts to model a wide range of possible network participation assumptions to show the trends in cost impact caused by that participation. We first separately analyzed the increase in administrative and claims costs associated with the "any willing provider" mandate. Wyatt then attempted to combine the two effects and calculate the change in the marginal value of a PPO as network participation grows. We postulated that there is a point where the value in claims reduction from enlarging the PPO network will decrease to the point where the increased administrative cost of maintaining that enlarging network will eliminate all marginal value of having a PPO. We used a PPO model for this legislative mandate because most such state mandates are targeting PPOs. If health maintenance

organizations (HMOs) or other managed care network structures were included, we would expect the same general direction in cost trends.

This legislative mandate was determined to have both administrative cost and claim cost effects. Because the assumptions and methodology differ between the two, they are separated as subsections 1.A and 1.B.

Conclusions

Subsection 1.A: Administrative Costs

Implementing an "any willing provider" legislative mandate would result in increased administrative costs, which grow as network participation increases. Wyatt established the average surveyed networks' size, staffing, and percent provider penetration as a baseline. We also established the average cost associated with managing and maintaining this "typical" PPO. Increasing penetration from the average of 25.5% to 60% of physicians, 10% to 60% of other providers and 44% to 80% of hospitals increases the costs associated with network administration costs 170% above the baseline. For the purposes of this study, a 170% increase in network administration costs is considered a valid "possible" outcome of this mandate. A less likely, but "worst case," scenario of increased penetration to 80% of physicians and other providers and 100% of hospitals would increase the cost of network administration by 259%. To project the effect on total administration, we assumed a "typical" non-PPO benefit plan has a retention rate (general and claims administration costs and profit) of 12% of premium and our total additional retention for administration of our "typical" PPO is 3% of premium. Using these assumptions, the overall retention (or non-claims costs) would increase by 34% over the baseline PPO in our "possible" scenario. Retention would increase by 52% over the baseline PPO in our "worst-case" scenario under this mandate.

Subsection 1.B: Claims Costs

Wyatt constructed a provider revenue requirement model and analyzed provider behavior in a mature market with 30% PPO market share toward a "typical" PPO network comprised of 25.5% of the available physicians and 44% of the available hospitals. On average, a physician with excess capacity, making an economically rational decision, would be willing to accept a 32.6% effective discount (including the effects of both medical management and discount off changes) from current revenue per encounter while still attaining his or her income goal. A hospital provider in this "typical" PPO exhibiting like-behavior would accept an effective 10.4% discount, which yields a composite physician and hospital effective discount of 19.5%. This "typical" PPO would experience a 17.6% reduction in baseline health care claims cost (as compared to average claims costs in current revenue experience),

assuming a mature market with 90% of care received in the network. It should be noted that these effective claim reductions are not the same as discounts off charges. These are the amounts that the provider could accept off current revenue. This qualification is particularly important for hospital fees where charges are typically much higher than average revenue.

Imposing an "any willing provider" mandate would result in a variable increase in the number of network providers. In a larger network with less channeling, the average provider must either increase utilization or accept smaller discounts if he or she is to maintain the current level of net income or operating margins. If this mandate results in the "possible scenario" of a 60% participation rate for physicians and 80% for hospitals, the maximum effective discount that a provider would accept would be 17.5% for physicians and 3.7% for hospitals, or 9.4% overall. A PPO in this "possible" scenario resulting from this mandate would loose 8.8% in claims savings compared to the "typical," or baseline, PPO discussed above. The "worst case" scenario would result in a 14.2% loss in claims savings compared to baseline.

Overall Conclusion:
The detailed conclusions in subsection 1.A document an increase in administrative costs associated with the progressively larger network participation that is anticipated as a result of this legislative mandate. A decrease in claims savings associated with progressively larger network participation is documented in subsection 1.B.

The Wyatt Company combined these two separate trends to model the overall impact on the marginal value of having a PPO associated with progressively larger network participation. It should be emphasized that this is not an analysis of specific benefit plan data, but a discussion model that mixes extracted and projected data from separate sources for the purpose of demonstrating trends.

The model demonstrates that a point exists where a PPO product or sponsor will be unable to sustain any marginal value to the community if it is forced to accept more than a certain limited percentage of available providers, assuming providers follow a rational economic model for discounting. In this discussion model of a mature PPO with 30% market penetration, that point lies at or near 60% of doctors and other providers and 80% of hospitals. This is a significant finding in that, given current technology, it would be unlikely that reasonable fixed state-wide provider selection criteria could eliminate 40% or more of all licensed professionals and 20% or more of all licensed hospitals. The model suggests that, if a large percentage of providers are willing to join a PPO, this legislative mandate would eliminate the value of that PPO to the community.

Section 2: Prohibiting "Gatekeeper" Physicians in PPOs

Background

Several states have enacted or are considering a legislative mandate prohibiting managed care organizations from using physicians as "gatekeepers" for PPOs. As used in this analysis, a gatekeeper is usually a primary care physician chosen by a health care benefit plan beneficiary to provide primary medical services and to direct referrals to other providers and facilities as medically necessary. Proponents of this legislative mandate contend that the gatekeeper role does not belong in insurance products. While these proponents acknowledge that Health Maintenance Organizations (HMOs) have successfully utilized gatekeeper physicians for years, they feel it may be more acceptable there due to the increased regulatory oversight of HMOs. Managed care organizations contend that "gatekeepers" are a critical part of their health care cost containment strategies for the 1990s. They point out the substantial efficiencies seen in the last few years in "point-of-service" PPOs, which utilize primary care gatekeepers for both cost and quality management. Opponents of this legislative mandate contend that it is not in society's interest to limit successful cost-efficient medical delivery systems at this time.

Conclusion

Wyatt's analysis of the claims experience of "point-of-service" PPOs with a primary care gatekeeper indicates that savings associated with the gatekeeper function range from 4.23% to 13.5% of total claims. The mean savings associated with a gatekeeper in a "point-of-service" PPO was 6.83% of total claims costs. This is higher than the 3.5% to 6% savings prospectively estimated by most underwriters surveyed. For the purposes of this study, we consider a 6.83% loss of claims savings to be the possible result from this mandate. We consider the loss of 13.5% in claims savings as a "worst-case" result. Wyatt's findings are corroborated by survey data, studies performed by insurance carriers on their respective blocks of PPO business, Wyatt's client experience and by interviews, articles, and shared data from employers that have converted to primary care gatekeeper model PPOs. For the purposes of this report, no change in administrative costs was projected when compared to non-gatekeeper model PPOs, although more study is needed in this area.

For gatekeeper model PPOs, retrospective analysis of the claims cost impact due to the gatekeeper is complicated by the fact that frequently this product, when compared to non-gatekeeper PPOs, is packaged with substantial benefit modifications, cost sharing provisions and network access limitations. In addition, only a few of these gatekeeper model or "point-of-service" PPOs have more than two years of claims experience available for analysis.

Section 3: Requiring Local Utilization Review of Health Care Services by Professionals Licensed in that State and Denial Reviews by Physicians of the Same Specialty as the Attending Physician

Background

This legislative mandate has been proposed in a number of states in various forms. It is intended to insure that utilization review is conducted with a sensitivity to local practice patterns. Furthermore, it is intended to insure that only a true peer to the specialist or subspecialist treating the patient be allowed to review a service that involves a denial of certification for admission or treatment. Utilization review organizations respond that the standards for medical quality should not vary by state or region. The medical literature that forms the basis for treatment guidelines is national in scope as are the standards established by the medical professional societies. Furthermore, a large percentage of denials for certification occur for reasons that are not specific to the specialty or subspecialty of the provider.

This section models the increases in cost associated with the requirement to move a branch utilization review operation into another state and to include local physician specialists and subspecialists in all reviews for denials of certification. Costs were projected for both year 1 and year 2 to show the initial impact of conversion and the "steady state" of impact of operating separate offices under this legislative mandate. It was assumed that a local license requirement would include all review nurses and physicians and that a utilization review organization would respond to that mandate by opening a local office and contracting with a panel of physicians representing all specialties and subspecialties.

Conclusion

The first year administrative costs for utilization review operations would increase by 42.5% if a utilization review organization must move 20% of its business from an out-of-state central location to a location in-state and begin using locally licensed physician specialists and subspecialists for all denial review. By year two, after initial moving and staffing change costs are incurred, the administrative cost for operations would remain approximately 34% higher than the baseline in constant dollars.

These administrative costs were based on a utilization review organization serving 1 million lives, but the findings do not vary significantly (less than 2%) when a 5-million-life organization is assumed using the same model. The effect on total cost for utilization review services is greatly dependent on the level of non-operational-unit overhead and the degree to which it changes by increasing the number of operational unit sites. Assuming that 25% of total costs are non-operational and do not vary by number of sites, then year 1 after this

mandate would increase total utilization review costs by 31.9% and year 2 and thereafter would be 25.6% higher than the baseline in constant dollars. No change in claims costs was anticipated for the purpose of this study.

Section 4: Mandating Extended Hours of Operation for Utilization Review Organizations to 24 Hours a Day, 7 Days a Week

Background

Requirements that organizations conducting utilization review operate 24 hours per day, 7 days a week have been considered by a number of states. Such a mandate is usually intended to assure that medical review services, including the certification or denial of certification for admission, are available at any time during the day or night. The reported impetus behind this legislative mandate is to insure that no health plan beneficiary would be denied medical treatment due to the unavailability of review personnel. Utilization review industry representatives respond that hospital admissions after normal business hours would typically be for emergency situations only and benefit plans generally stipulate that those can be reported as much as 48 hours after the hospital admission without penalty. Likewise, admissions due to unforseen problems on weekends and holidays can typically be reported the next business day. Opponents of this mandate contend that it creates increased administrative expense for little value that can not be gained from existing plan design provisions and appeal processes.

Conclusion

Under this legislative mandate, organizations would have to significantly expand their staff with no associated increase in volume of covered lives served. Overall administrative expense for a "typical" utilization review organization's operation, which is now open 11 hours each weekday and covers 4 time zones, would increase nearly 44% to 47%. Assuming that 25% of a utilization review organization's costs are non-operational and do not vary with this mandate, utilization review costs would increase under this mandate by 33% to 35%. The cost impact of this mandate would be higher for organizations currently opened less than 11 hours each weekday. No change in claims costs was anticipated for the purposes of this study.

Section 5: Requiring State-Specific Statistical Reporting on Utilization Review Organizations' Activities.

Background

This legislative mandate is usually intended to provide a state with information on utilization review organizations' activity within its boundaries. The information could be used for a variety of reasons, from monitoring to insure compliance with state service standards to simply establishing a database for possible future regulatory or legislative activity. Most utilization review organizations maintain their records and information by employer group. The administrative procedures and protocols are usually the same for that client, regardless of the state in which services are rendered (especially for ERISA exempt benefit plans). Utilization review industry leaders express concern about the high costs and productivity losses that could be associated with state specific modifications of data collection procedures, file lengths and formats, system programs and reporting procedures.

Conclusion

Wyatt estimated that requiring disparate state-specific statistical reporting on utilization review organization activities could cost from $10,000 to $50,000 or more in administrative costs in the first year of implementation for a single state. Assuming no additional changes were made in the data or reporting requirements by that state, the costs for year two and thereafter would be reduced to $3,000 to $5,000 per state. These estimates would vary greatly by the degree to which the data required are not currently collected and available in the utilization review organization's system, the difficulty involved in modifying the manual and computer systems to accommodate the required changes and the degree of non-standard processing, editing, analysis and reporting involved in complying with this legislative mandate. Since these costs should not vary much by organization size or operational budget, Wyatt chose not to project these costs as a percentage of overall administrative costs. No change in claims cost was projected for this mandate.

Section 6: Mandating a Maximum Differential of 20 Percent Between In-Network and Out-of-Network Benefits

Background

Some states have placed restrictions on the maximum differential between in-network and out-of-network benefits in PPOs. The most common mandate is that in-network benefits should not exceed out-of-network benefits by more than 20% for a given service. At least

one state has mandated a maximum differential of 15%. This maximum is often expressed as a co-insurance level but has been discussed as a maximum differential in total paid benefits. The intent of this mandate is to insure that an individual is not unduly disadvantaged if he or she wishes to go to a non-network provider. Managed care organizations contend that employers and individuals should be given the right to choose their delivery system without such restrictions. Further, they contend that this restriction reduces the effectiveness of a PPO and may cause even more serious difficulty for the point-of-service (or primary care gatekeeper) model PPO.

Conclusion

The ability of a PPO to effectively manage health care costs is largely a function of its ability to steer patients towards efficient quality network providers. Thus, the difference between in-network and out-of-network benefits is key in effecting optimal channeling.

There have been no studies that define the specific benefit differential that achieves optimal channeling. However, Wyatt conducted a survey of actuaries at five insurance companies that specifically engage in pricing and analyzing PPO plans. Currently, a 30% benefit differential in plan reimbursement is considered the desired balance between out-of-network coverage and optimal channeling.

Using a 30% benefit differential and the associated channeling effect as baseline, Wyatt concluded that, in the course of 1 year, limiting the in-network versus out-of-network benefit differential to 20% would reduce network patient steerage by 6.1% and would result in 1.3% higher claims costs paid by the benefit plan and plan members. Furthermore, if the benefit differential is restricted to 15%, steerage would be reduced by 9.4%, and claims costs for plan and member would be 1.9% higher. The study included PPOs only because that benefit delivery model has been the principal focus of such mandates. The analysis assumed that the differentials were mandated on a total paid benefits basis, and utilization patterns were assumed to be the same in-network as out-of-network. Further study would be needed to specifically address the cost impact in an HMO or primary care gatekeeper model PPO. It should be noted that most primary care gatekeeper model PPO managers feel a 30% differential or more is necessary to gain the full management potential for this model. If that is the case, this mandate could also threaten the 4.23% to 13.5% of claims savings seen in the study on gatekeepers in section 2 of this report. No administrative cost changes were projected for this mandate.

Utilization Review As A Cost Containment Method Has Become Rule Rather Than Exception

Most employers include some type of utilization review program in employee benefits plans. Typically, utilization review programs include preadmission certification, concurrent review, and catastrophic case management.

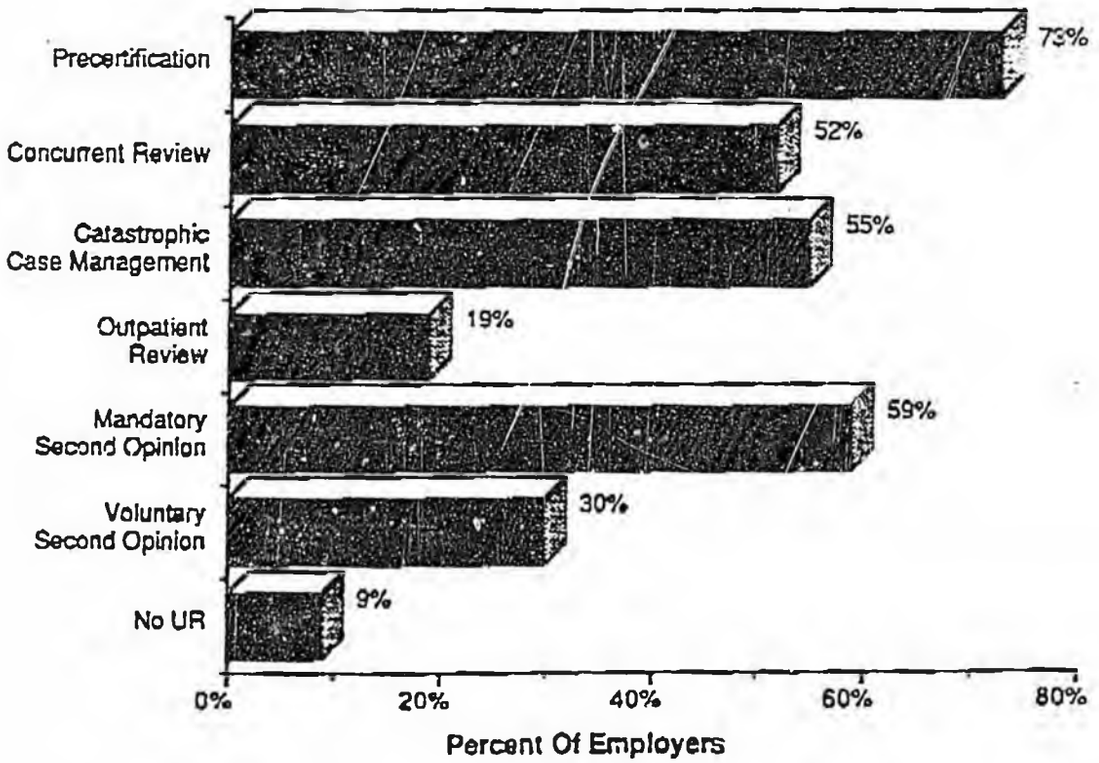
The 1989 Foster Higgins *Health Care Benefits Survey* reflects the input of 1,943 employers, whose benefit plans cover more than 12.5 million employees. The second report in the five-part Foster Higgins series focused on cost, design, and funding of insured and self-funded medical care plans.

This Research Report summarizes the information on utilization review programs offered by the surveyed employers. For additional information, contact Foster Higgins, Survey and Research Services, 212 Carnegie Center, Princeton, NJ 08543-5323, (609) 520-2441.

Utilization review is the rule rather than the exception, according to the 1989 Foster Higgins *Health Care Benefits Survey*. The second report in the five-part Foster Higgins series focused on cost, design, and funding of insured and self-funded medical care plans of 42 employer coalitions around the country. The 1989 report reflects the input of 1,943 employers, whose benefit plans cover more than 12.5 million employees. Participants include organizations of all sizes and industry types, and the survey data represents responses from all 50 states.

Although most employers are unable to determine the

Table 1:
Utilization Review Programs



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Utilization Review As A Cost Containment Method Has Become Rule Rather Than Exception

cost-effectiveness of utilization review (UR) programs, the programs have had a positive effect on the behavior patterns of medical practitioners and on medical care plan use. Given the high rate of health plan cost increases, few employers dare go without UR programs—typically preadmission certification, concurrent review, and catastrophic case management.

There appeared to be little difference in the use of precertification among insured and self-funded employers. Seventy-three percent of the 1,943 employers represented in the Foster Higgins survey require precertification of elective hospitalizations, up from 68% in 1988. Concurrent review was found in 52% of plans and catastrophic case management in 55% of plans. While 89% of employers have second surgical opinion programs, only 59% made obtaining a second opinion mandatory.

Review Responsibility

Nineteen percent of employers have outpatient UR programs—most often with retrospective review of the necessity of physician and/or diagnostic services. The survey noted that half of these employers have preferred provider organizations in which the review of physician practice patterns is the responsibility of the organization. In the absence of contractual relationships between employers and physicians, retrospective denial of payment could result in a financial burden on employees, who are ultimately responsible for paying physicians for services and supplies over and above the amount stipulated by the plan.

In most insured plans, the insurance carrier provides UR services. Self-funded employers, however, split their business between insurance carriers and independent, national, or local UR organizations. UR organizations handle precertification for 49% of self-funded employers, concurrent review for 53%, case management for 48%, and second surgical opinion for 39%.

The breakdown of UR services for all employers included in the survey is shown in Table 2.

Table 2:

	UR Program Administration		
	Commercial	Organization	
UR Program	Carrier	National	Local
Precertification	63%	25%	12%
Concurrent Review	57	27	15
Case Management	63	26	11
Second Opinion	72	18	19
Outpatient Review	53	27	20

Savings

Most survey respondents were unable to estimate how much money they saved through UR programs in 1989. Among the reasons given by employers was that most UR firms did not provide the type of reports that would allow savings to be determined. Employers that could estimate savings reported an average savings of 5.1% of total plan costs.

Table 3:

UR Program	Savings
Precertification	4.2%
Concurrent Review	3.6
Case Management	3.5
Second Opinion	1.7
Outpatient Review	4.3

AMA, BCBS Study Utilization Review Criteria To Uncover Inappropriate Medical Procedures

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Review standards are used to evaluate the appropriateness of medical care before it is provided and can strongly influence what services physicians provide to patients. Currently, there are no uniform guidelines for developing either the content or the format of review criteria. This Research Report summarizes the findings of two separate studies regarding medical care review criteria currently being used.

An increasing number of employers are making it mandatory for employees to participate in hospital preadmission programs, concurrent and retrospective reviews, and discharge planning. Failure to do so can mean the difference in the level of benefits coverage. Such programs, designed to determine the appropriateness of medical care services, can strongly influence the level and type of services physicians provide to patients.

Not all providers are pleased with having their medical care decisions challenged. The most frequent complaint providers have is that there are no uniform guidelines for developing either the content or the format of review criteria. Furthermore, physicians complain that review standards vary greatly and in many cases are not consistent with practice guidelines developed by national medical groups.

To support their recommendation of the need for standard review criteria, the American Medical Association and the Blue Cross and Blue Shield Association conducted separate studies that point out the prevalence of inappropriate medical care. The AMA studied the review criteria used by the 48 Medicare Peer Review Organizations and the BCBSA studied six of its member organizations. In each study, findings support the fact that appropriateness of medical care on a pre-service basis can be a cost-effective.

AMA Study

The AMA study examined review criteria for the three most frequently reviewed procedures by Medicare PROs: cataract removal; carotid endarterectomy, or restoring blood flow to clogged arteries; and cardiac pacemaker implants.

The study found wide variation between the PRO criteria and national practice guidelines developed by the American Academy of Ophthalmology, the American College of Physicians, and the American College of Cardiology.

For example, for cataract removal the AAO recommended that only patients with a visual acuity level of 20/50 or worse be eligible for cataract removal surgery. That level is consistent with the vision standard required to obtain a driver's license. However, the visual acuity standards used by Medicare PROs ranged from 20/30 to 20/300.

Medicare PROs' required levels of artery obstruction ranging from 50% to 90% before a carotid endarterectomy would be certified. ACP guidelines say the procedure may be appropriate for patients who have obstructions of 70% or greater.

BCBSA Study

A year-long pilot study found that 11.2% of the cases examined called for the inappropriate use of certain procedures. The study took place from July 1989 to July 1990. Five Blue Cross and Blue Shield plans and one Blue Cross and Blue Shield health maintenance organization, participated in the study, which encompassed all lines of business, including fee-for-service, as well as preferred provider organizations and both IPA and staff model HMOs. Collectively, the six plans cover a total of 1.5 million people.

The Medical Review System (MRS), developed by Value Health Sciences, Inc. of Santa Monica, California, was used as the tool to evaluate the appropriateness of the procedures in 9,125 cases. Each site chose between seven and 18 procedures to evaluate.

The rate of inappropriateness varied by procedure (see graph on next page). Procedures most often found to be inappropriate when reviewed by the MRS include tonsillectomies (27.1%), hysterectomies (21.5%), and tonsillectomies combined with adenoidectomies (17.6%).

AMA, BCBS Study Utilization Review Criteria To Uncover Inappropriate Medical Procedures

Procedures least likely to be found inappropriate by an MRS review include colonoscopy (1.5%), coronary artery bypass graft (0%), and carotid endarterectomy (0%).

Cost Effectiveness

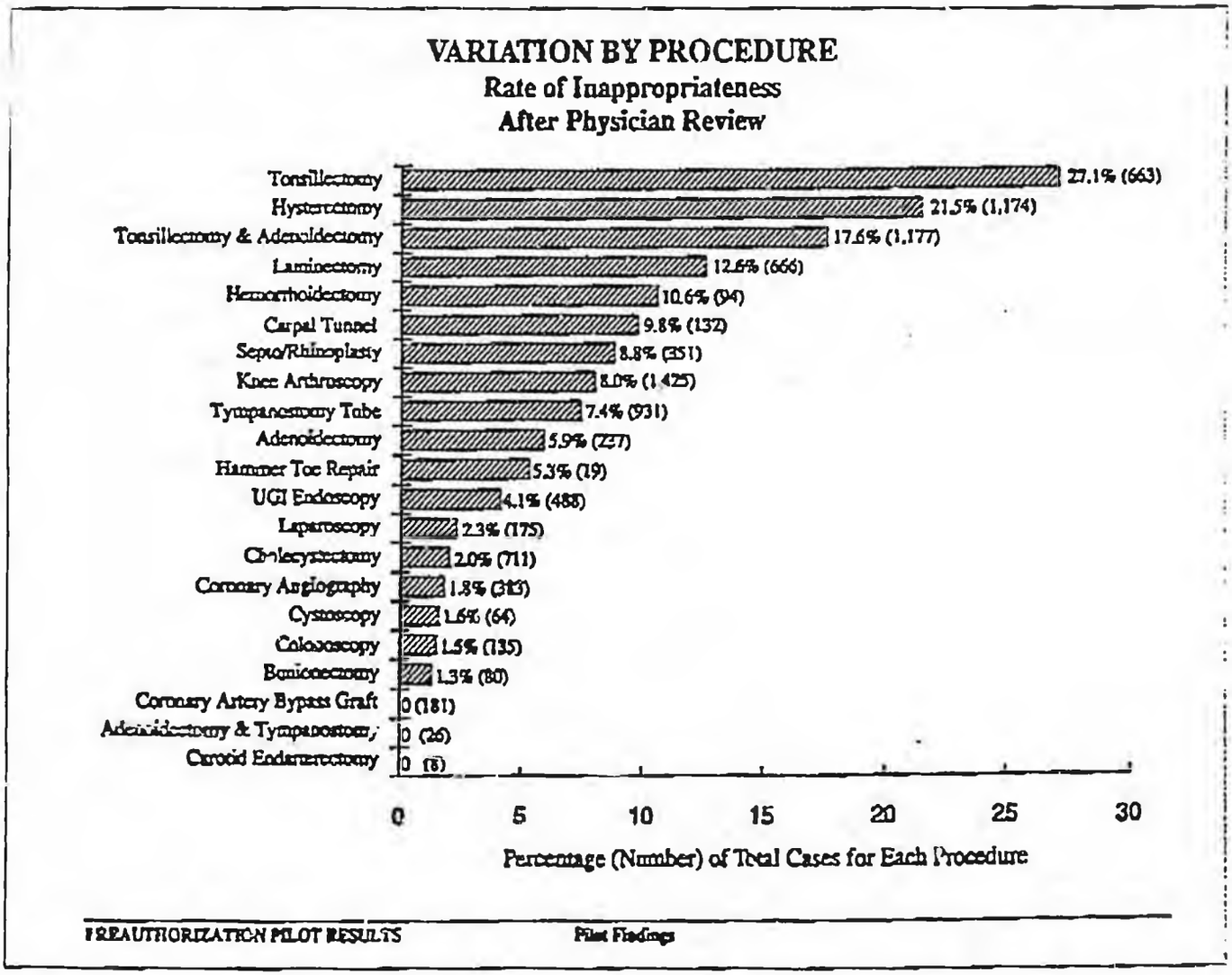
Based on the study finding, the BCBSA concludes that the appropriateness of medical care can be evaluated on a preservice basis. The Association concludes also that preauthorization can be a cost-effective method for evaluating the appropriateness of medical care.

One pilot site conducted a cost/benefit analysis and found preauthorization to be cost-effective. A total of $103,804 was spent during this plan's six-month pilot to achieve a savings of $265,280 (or $2.56 for every dollar spent on the program). For this site, the program saved $0.44 per member per month, and $433 per case.

Some procedures were clearly more cost-effective to preauthorize than others, the study notes. There was not a one-to-one correlation between specific procedures' rate of inappropriateness and their cost of review.

Conclusion

Several organizations are calling for uniform standards of review. The Utilization Review Accreditation Commission, a coalition representing the UR industry, employers, insurers, and the medical community, would like a national set of standards to be developed. The American Medical Association would like to see a sharing of review criteria, which in the Association's opinion could result in improved medical care and fewer inappropriate procedures. The Blue Cross and Blue Shield Association has published and periodically updates its medical necessity standards (see RR 333.03.-5).



UTILIZATION REVIEW ACCREDITATION COMMISSION
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SUITE 610
WASHINGTON, D.C. 20037

TELEPHONE (202) 296-0120

TO: CEO/President
All Utilization Review Organizations

FROM: Roger S. Taylor, M.D.
President

SUBJ: Revised National UR Standards

DATE: November 20, 1990

Enclosed is a copy of the Utilization Review Accreditation Commission's (URAC) revised National UR Standards for your information and review. These standards are the result of a great deal of work by many UR industry representatives serving on URAC's Committees and Board, as well as the Committees of the American Managed Care and Review Association's UR section.

You may recall that a representative group from the UR industry released the first set of National UR Standards on January 22, 1990. This November 1990 update incorporates the many comments and recommendations received to date from UR Organizations and other interested parties. The November Standards also focus more specifically on what UR Organizations must and should do to qualify for accreditation, leaving out much of the background information included with the January 22, 1990 version. And finally, these standards incorporate the principle elements of the "Guidelines for Concurrent Review and General Administrative Procedures" jointly developed by the American Hospital Association, American Managed Care and Review Association, American Medical Association, Blue Cross and Blue Shield Association, and the Health Insurance Association of America.

URAC is continuing with its development and with the expansion of its Board to include health care providers and consumer organizations. We would appreciate your comments and your continued support for URAC. Please contact the URAC offices at (202) 296-0120 with any comments.

UTILIZATION REVIEW ACCREDITATION COMMISSION

NATIONAL UTILIZATION REVIEW STANDARDS

NOVEMBER 1990

This document incorporates the comments and recommendations received from a broad spectrum of interested parties on the January 22, 1990 National UR Standards. Additionally, this edition of the Standards incorporates the principle elements of the "Guidelines for Concurrent Review and General Administrative Procedures," jointly developed by the American Hospital Association, American Managed Care and Review Association, American Medical Association, Blue Cross/Blue Shield Association and the Health Insurance Association of America.

Comments or recommendations regarding these Standards should be submitted to the URAC Standards Subcommittee, 1227 25th Street, N.W., Suite 610, Washington, D.C. 20037. The 1991 URAC Standards Subcommittee and Board of Directors will review these comments and recommendations and may modify or update the Standards prior to their use in URAC's accreditation process.

NATIONAL UTILIZATION REVIEW STANDARDS

Overview

A. Introduction

These standards for utilization review were developed and approved by the Utilization Review Accreditation Commission (URAC) which was established to encourage efficient and effective UR processes and provide a method of evaluation and accreditation of utilization review programs. These standards will be used by URAC to credential Utilization Review (UR) Organizations which apply for voluntary accreditation.

These standards were developed as guidelines for the evolving UR industry and are not intended to discourage the further development of effective, efficient, and innovative methods to address our nation's concern about the continuing escalation of health care costs.

B. Purpose of the Utilization Review Standards

The purpose of these standards is to provide guidelines to assure that effective and efficient utilization review programs are available to patients, health care providers and health benefit plans in the United States. These standards accomplish that purpose by:

- encouraging consistency in the procedures for interacting with UR programs;
- establishing UR processes that cause minimal disruption to the health care delivery system;
- establishing standards for the procedures used to certify health care services and to process appeals of utilization review determinations;
- providing the basis for an efficient process for credentialing and accrediting UR Organizations; and,
- providing consistent standards and an accreditation mechanism that can be applied efficiently nationwide for those states which choose to regulate UR.

These standards apply to all organizations offering UR services which apply for accreditation. Health Maintenance Organizations, Preferred Provider Organizations and other such managed care systems that contract directly with health care providers may vary from these standards to the extent that the variance is addressed in the provider contract or in the terms of the health benefit plan. UR services for health care benefits provided through certain governmental programs such as Medicare, Medicaid and through Workers' Compensation and certain Automobile Medical Payment coverages may vary from these standards to the extent that the variance is required by statute.[1]

UTILIZATION REVIEW STANDARDS

I. Scope of the Utilization Review Standards

A. These standards apply to prospective and concurrent utilization review for inpatient admissions to hospitals and other inpatient facilities as well as to outpatient admissions to surgical facilities.

B. "Inpatient admissions to hospitals" as used in these standards, includes admissions to all acute medical, surgical, obstetrical, psychiatric and chemical dependency inpatient services at a licensed hospital facility, as well as other licensed inpatient facilities such as skilled nursing facilities, residential treatment centers and free standing rehabilitation facilities.

II. Responsibility for Obtaining Certification

In the absence of any contractual agreement to the contrary, the enrollee is responsible for notifying the UR Organization in a timely manner and obtaining certification for health care services. A UR Organization shall allow any licensed hospital, physician or responsible patient representative, including a family member, to assist in fulfilling that responsibility.[2]

III. Information Upon Which Utilization Review is Conducted

A. When conducting routine prospective and concurrent utilization review, UR Organizations shall collect only the information necessary to certify the admission, procedure or treatment and length of stay.

1. UR Organizations should not routinely expect hospitals and physicians to supply numerically codified diagnoses or procedures. UR Organizations may ask for such coding, since if it is known, its inclusion in the data collected increases the effectiveness of the communication.

2. UR Organizations shall not routinely request copies of medical records on all patients reviewed. During prospective and concurrent review, copies of medical records should only be required when a

difficulty develops in certifying the medical necessity or appropriateness of the admission or extension of stay. In those cases, only the necessary or pertinent sections of the record should be required.

3. UR organizations may request copies of medical records retrospectively for a number of purposes, including auditing the services provided, quality assurance, evaluation of compliance with the terms of the health benefit plan or UR provisions. With the exception of the reviewing of records associated with an appeal or with an investigation of data discrepancies and unless otherwise provided for by contract or law, health care providers should be reimbursed the reasonable direct costs of duplicating requested records for retrospective review.

B. Except as otherwise provided in these standards, a UR Organization should limit its initial data requirements to the following elements:[3],[4]

Patient Information
- Name
- Address
- Date of Birth
- Sex
- SS No. or Patient ID No.
- Name of Carrier or Plan
- Plan ID No.

Enrollee Information
- Name
- Address
- SS No. or Employee ID No.
- Relation to Patient
- Employer
- Health Benefit Plan
- Group Number/Plan ID No.
- Other Coverages Available (Workers Comp., Auto, Champus, Medicare, Other)

Attending Physician/Practitioner Information
- Name
- Address
- Phone Numbers
- Degree
- Specialty/certification status
- Tax ID or other ID No.

Diagnosis/Treatment Information
- Primary Diagnosis (with associated ICD or DSM Coding, if available)

Secondary Diagnosis (with associated ICD or DSM Coding, if available)
Tertiary Diagnoses (with associated ICD or DSM Coding, if available)
Proposed Procedure(s) or Treatment(s) (with ICD9 or associated CPT Codes, if available)
Surgical Assistant Requirement
Anesthesia Requirement
Proposed Admission or Service Date(s)
Proposed Procedure Date
Proposed Length of Stay

Clinical Information (sufficient for support of appropriateness and level of service proposed)

Facility Information

Type (such as in-patient, out-patient, special unit, SNF, rehab., office/clinic)
Status (licensure/certification status and DRG exempt status, as needed)
Name
Address
Phone Number
Tax ID No. or Other ID No.

Concurrent (Continued Stay) Review Information

Clinical Contact Person
Additional Days/Services Proposed
Reasons for Extension
Diagnoses (same/changed)
Clinical Information (sufficient for support of appropriateness and level of service proposed)

For Admissions to Facilities other than Acute Medical/Surgical Hospitals, Added Information On:

History of Present Illness
Patient Treatment Plan and Goals
Prognosis
Staff Qualifications
24 Hour Availability of Staff

For Special Situations

Additional information may be required for other specific review functions such as discharge planning or catastrophic case management. Second Opinion Information may also be required, when applicable, sufficient to support benefit plan requirements.

C. Information in addition to that described in this section may be requested by the UR Organization or voluntarily submitted by the provider, when there is significant lack of agreement between the UR Organization and health care provider regarding the appropriateness of certification during the review or appeal process. "Significant lack of agreement" means that the UR Organization:

1. has tentatively determined, through its professional staff, that a service cannot be certified;

2. has referred the case to a physician for review; and

3. has talked to or attempted to talk to the attending physician for further information.

D. A UR Organization should share all clinical and demographic information on individual patients among its various divisions (e.g., certification, discharge planning, case management) to avoid duplicate requests for information from enrollee or providers.

IV. Procedures for Review Determination

A. Each UR Organization shall have written procedures to assure that reviews are conducted in a timely manner.

1. Each UR Organization shall make certification determinations within two working days of receipt of the necessary information on a proposed admission or service requiring a review determination. Collection of the necessary information may necessitate a discussion with the attending physician or, based on the requirements of the health benefit plan, may involve a completed second opinion review.

2. UR Organizations may review ongoing inpatient stays, but shall not routinely conduct daily review on all such stays. The frequency of the review for extension of the initial determination should vary based on the severity or complexity of the patient's condition or on necessary treatment and discharge planning activity.

B. Each UR Organization shall have in place written procedures for providing notification of its determinations regarding certification, recertification or extensions of previously authorized length of stay in accordance with the following:

1. When an initial determination is made to certify, notification shall be provided promptly either by telephone or in writing, to the attending physician. The notification should be transmitted in writing to the hospital and attending physician, as well as to the enrollee or patient, within two working days.[5]

2. A determination to certify resulting from concurrent review should be transmitted to the attending physician by telephone or in writing within one working day of receipt of all information necessary to complete the review process or prior to the end of the current certified period.

3. If a UR Organization transmits written confirmation of certification for continued hospitalization, that notification should include, when possible, the number of extended days, the new total number of days approved and the date of admission.

4. When a determination is made not to certify a hospital or surgery facility admission or extension of a hospital stay, or other service requiring review determination, the attending physician shall be notified by telephone within one working day and a written notification should be sent within one working day to the hospital, attending physician and the enrollee or patient. The written notification should include the principal reason(s) for the determination and the way to initiate an appeal of the determination if the enrollee, patient or their representative, so chooses. Reasons for a determination not to certify may include, among other things, the lack of adequate information to certify after a reasonable attempt has been made to contact the attending physician.

C. UR Organizations shall have in place written procedures to address the failure of a health care provider, patient or their representative to provide the necessary information for review. If the patient or provider will not release the necessary information to the UR Organization, the UR Organization may deny certification in accordance with its own policy or that of the health benefit plan.

V. Appeals of Determinations Not to Certify

Each UR Organization shall have in place procedures for appeals of determinations not to certify an admission, procedure, service or extension of stay. The right to appeal shall be available to the patient or enrollee, and to the attending physician on behalf of the patient.[6] The procedures for appeals shall include at a minimum the following:

A. Expedited appeal

When an initial determination not to certify a health care service is made prior to or during an ongoing service requiring review, and the attending physician believes that the determination warrants immediate appeal, the attending physician shall have an opportunity to appeal that determination over the telephone on an expedited basis. Each UR Organization shall provide for reasonable access to its consulting physician(s) for such appeals. Both providers of care and UR Organizations should attempt to share the maximum information by phone, FAX or otherwise to resolve the expedited appeal (sometimes called a reconsideration request) satisfactorily. Expedited appeals which do not resolve a difference of opinion may be resubmitted through the standard appeal process.

B. Standard appeal

The UR Organization shall establish procedures for appeals to be made in writing and/or by telephone.

1. Each UR Organization shall notify in writing the patient, provider and claims administrator of its determination on the appeal as soon as practical, but in no case later than 60 days after receiving the required documentation on the appeal.

2. The documentation required by the UR Organization may include copies of part or all of the medical record and/or a written statement from the attending physician.

3. Prior to upholding the original decision not to certify for clinical reasons, the UR Organization shall conduct a review of such documentation by a physician who did not make the original determination not to certify.

4. The process established by a UR Organization may include a period within which an appeal must be filed to be considered.

5. An attending physician who has been unsuccessful in an attempt to reverse a determination not to certify should be provided the clinical basis for that determination upon request.

C. Notification to the claims administrator

Each UR Organization shall forward electronically or in writing, a notification of certification or determination not to certify to the appropriate claims administrator for the health benefit plan.[7]

VI. Confidentiality

A. Each UR Organization shall have written procedures for assuring that patient-specific information obtained during the process of utilization review will be:

1. kept confidential in accordance with applicable federal and state laws;

2. used solely for the purposes of utilization review, quality assurance, discharge planning and catastrophic case management; and

3. shared with only those agencies (such as the claims administrator) who have authority to receive such information.[8]

B. Summary data shall not be considered confidential if it does not provide sufficient information to allow identification of individual patients.

VII. Staff and Program Qualifications

Each UR Organization shall have utilization review staff who are properly trained, qualified, supervised and supported by written clinical criteria and review procedures. Clinical criteria and review procedures shall be established with appropriate involvement from physicians.

A. Nurses, physicians and other licensed health professionals conducting reviews of medical services, and other clinical reviewers conducting specialized reviews in their area of specialty shall be currently licensed or certified by an approved state licensing agency in the United States.

B. A physician shall review all cases in which the UR Organization has concluded that a determination not to certify for clinical reasons is appropriate. The physician should be reasonably available by telephone to discuss the determination with the attending physician.

C. In cases where an appeal to reverse a determination not to certify for clinical reasons is unsuccessful, the UR Organization should assure that a physician in the same or a similar general specialty as typically manages the medical condition, procedure or treatment under discussion is reasonably available, as appropriate, to review the case.

D. UR Organizations shall utilize:

1. Written clinical criteria, as needed, for the purpose of determining the appropriateness of the certification; such criteria should be periodically evaluated and updated.

2. Physician consultants, including, as needed and available, specialists who are certified by the Boards within the American Board of Medical Specialists or the American Board of Osteopathy from the major areas of clinical services.

3. A formal program for orientation and training of UR staff.

4. Written documentation of an active Quality Assessment Program.

VIII. Accessibility and On-Site Review Procedures

A. Each UR Organization shall provide access to its review staff by a toll free or collect call phone line, at a minimum, from 9:00 am to 4:00 pm of each normal business day in the local time zone in which the UR Organization routinely conducts review. Each UR Organization shall also have a mechanism to receive timely call-backs from providers and shall establish written procedures for receiving or redirecting after-hour calls, either in person or by recording.

B. Each UR Organization shall conduct its telephone and on-site information gathering reviews and hospital communications during hospitals' and physicians' reasonable and normal business hours, unless otherwise mutually agreed.

C. Each UR Organization's staff shall identify themselves by name and by the name of their organization and, for on-site reviews, should carry picture identification and the UR Organization's company identification card. On-site reviews should, whenever possible, be scheduled at least 1 business day in advance with the appropriate hospital contact. UR Organizations should agree that their on-site review staff register with the appropriate contact position prior to requesting any clinical information or assistance from hospital-staff and shall wear appropriate hospital supplied identification tags while on the premises, if so requested.

D. UR Organizations shall agree, if so requested, that the medical records remain available in designated areas during the on-site review and that reasonable hospital administrative procedures shall be followed by on-site review staff so as to not disrupt hospital operations or patient care. Such procedures, however, should not limit the ability of the UR Organizations to efficiently conduct the necessary review on behalf of the patient's health benefit plan.

E. UR Organizations should verbally inform, upon request, designated hospital personnel and/or the attending physician of the utilization review requirements of the specific health benefit plan and the general type of criteria used by the review agent. UR Organizations should also verbally inform, upon request, hospitals, physicians and other health care professionals of the operational procedures in order to facilitate the review process.[9]

IX. Accreditation Process

A. URAC will establish policies and procedures for credentialling and accrediting UR Organizations to assess compliance with these standards. Once established, an Application Form and a copy of these procedures will be made available to any UR Organization upon request.

B. URAC will establish policies and procedures for providing written confirmation of accreditation status and standard data on currently accredited UR Organizations, upon request, to health care providers, state regulatory agencies and other appropriate parties.

C. Only those UR Organizations which have formally applied for and have received a current accreditation from URAC may make any claim to be credentialed or accredited pursuant to these standards.

NOTES

1. Consideration should be given in the application of these standards to UR services in certain governmental programs such as Medicare, Medicaid and in Workers' Compensation and certain Automobile Medical Payment coverages. For example, in Workers' Compensation coverage, there is technically no enrollee, only a claimant. Under these coverages, the responsibility for obtaining certification is not usually the claimant's. The notification requirements, access to the claimant and appeal procedures may be governed by statute.

2. The timeliness of notification to a UR Organization of an admission or proposed admission is determined by the terms of the applicable health benefit plan.

   a. In general, notification should be considered timely if made a minimum of three working days prior to admission for routine or elective admissions and within two working days after emergency admission, unless otherwise provided for in the health benefit plan.

   b. In cases involving a second opinion, proper notification should be considered seven working days, unless otherwise provided for in the enrollee's health benefit plan.

   c. Hospitals and physicians should notify the UR Organization prior to actual admission, whenever possible, on cases where it is uncertain whether the admission would be defined as an emergency.

3. Hospitals and licensed physicians are encouraged to assist in providing information to UR Organizations by telephone and otherwise. Review determinations by UR Organizations are based on the information provided. Health care providers and UR Organizations are encouraged to develop more efficient and cost effective means of communicating the information in a timely and confidential fashion.

4. The information release forms signed by or on behalf of a patient at the time of treatment by hospital or physician should include language, as needed, to clarify that providers have the right to release information by telephone and in writing for utilization review purposes. Hospitals and physicians may reserve the right to discuss the release of sensitive information to a UR Organization with the patient.

5. In certain health benefit plans where the enrollee or patient incurs no financial liability for failing to obtain certification, the UR Organization is not required to notify the enrollee or patient of their determination. Further, a UR Organization may eliminate certain determination notifications by mutual agreement with the health care provider.

6. In most health benefit plans, it is the responsibility of the enrollee or covered patient to appeal. UR Organizations should routinely allow the attending physician to initiate an expedited appeal on behalf of a patient. Hospitals, other health care providers or a representative may assist the enrollee or covered person in an appeal. It is important to emphasize that the decision as to what treatment to prescribe for an individual patient remains that of the physician and his or her patient or their representative. The final decision as to whether these prescribed treatments are a covered benefit is the responsibility of the claims administrator or health benefit plan.

7. Health benefit plans operating under ERISA and state law procedures are designed to give an enrollee a full and fair review after receiving an appeal on a claim denial notice. Health benefit plan enrollees (with or without the provider's assistance) who wish to appeal a claim denial, partial payment or pending claim may utilize that health benefits plan's appeal process. Likewise, claims administrators for health benefit plans have established mechanisms for provider appeals of denied or partially paid claims. In addition, health benefit plans may include specific requirements for compliance with UR rules. The application of those requirements and the charging of any penalty or disincentive is typically a function of the claims administrator and any appeal mechanism would be specified by the health benefit plan.

8. When consistent with applicable federal and state laws, patient specific data gathered by the UR Organization which raise questions of deficiencies in quality may be shared with the hospital's or outpatient surgical facility's Quality Assurance Committee. Prior to the sharing of such information, a UR Organization may require the hospital or outpatient surgical facility to assure compliance with confidentiality requirements, to assure the appropriate review and follow-up within that hospital's or outpatient facility's Quality Assurance Committee, and to indemnify the UR Organization from inappropriate use of such information.

9. Health benefit plans and employers typically develop enrollee communications that provide information regarding UR requirements, benefits, obligations, penalties and sources for further information. UR Organizations are encouraged to take an active role in assisting health benefit plans in the development of enrollee communications and information that provides effective education of enrollees regarding the review requirements of their health benefit plan.

DEFINITIONS

For the purposes of this document, the following terms will have the following definitions:

APPEAL: A formal request to reconsider a determination not to certify an admission, extension of stay or other health care service.

ATTENDING PHYSICIAN: The physician with primary responsibility for the care provided to a patient in a hospital or other health care facility.

CERTIFICATION: A determination by a utilization review organization that, an admission, extension of stay, or other health care service has been reviewed and based on the information provided, meets the medical review requirements of the applicable health benefit plan.

CLAIMS ADMINISTRATOR: Any entity that reviews and determines whether to pay claims to enrollees, physicians, hospitals or others on behalf of the health benefit plan. Such payment determinations are made on the basis of contract provisions. Claims administrators may be insurance companies, self-insured employers, third-party administrators or other private contractors.

CLAIMANT: The enrollee or covered person who files a claim for benefits.

CLINICAL CRITERIA: The written policies, decision rules, medical protocols, or guides used by the Utilization Review Organization to determine certification [e.g., Appropriateness Evaluation Protocol (AEP) and Intensity of Service, Severity of Illness, Discharge, and Appropriateness Screens (ISD-A)].

CONCURRENT REVIEW: Utilization review conducted during a patient's hospital stay or course of treatment, sometimes called Continued Stay Review.

DISCHARGE PLANNING: The process that assesses a patient's needs for treatment after hospitalization in order to help arrange for the necessary services and resources to effect an appropriate and timely discharge.

ENROLLEE: The individual who has elected to contract for, or participate in, a health benefit plan for either him or herself and/or his or her dependents.

HEALTH BENEFIT PLAN: Any public or private organization's written plan that insures or pays for specific health care expenses on behalf of enrollees or covered persons.

PROSPECTIVE REVIEW: Utilization review conducted prior to a patient's hospital stay or course of treatment.

PROVIDER: A licensed health care facility, physician or other health care professional that delivers health care services.

QUALITY ASSESSMENT PROGRAM: A structured mechanism which, at a minimum, monitors and evaluates a UR Organization's program and provides management intervention, as needed, to support compliance with these standards.

RECONSIDERATION: An initial request by telephone for additional review of a UR organization's determination not to certify an admission, extension of stay, or other health care service. A reconsideration may be called an expedited appeal by some UR Organizations.

UTILIZATION REVIEW: Evaluation of the necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities.

UTILIZATION REVIEW ORGANIZATION: An entity which conducts utilization review and determines certification of an admission, extension of stay or other health care service.

Commentary

Should We Regulate 'Utilization Management?'

by Marilyn J. Field and Bradford H. Gray

Calls for regulation are a familiar response to change. Recently, this response has been evident in proposals to regulate private organizations that provide utilization management services for employers and other sponsors of health benefit plans. Several states have passed legislation to regulate utilization management, and others are considering it. The American Medical Association's (AMA's) House of Delegates has directed AMA staff to develop model legislation, and the American Medical Peer Review Association devoted a session at its October 1989 meeting to the question. Given this upsurge in interest and activity, an analysis of the pros and cons of regulation is timely.

In October 1989, the Institute of Medicine's (IOM's) Committee on Utilization Management by Third Parties issued its report on how utilization management works, what its effects appear to be, and what role it should play in the future.[1] Although much of the activity and interest in regulating utilization management became apparent after the committee's last formal meeting in February 1989, growing pressure for regulation was becoming apparent, and most of the basic approaches were known. This Commentary summarizes the IOM committee's analysis of the question, "Is public regulation of utilization management desirable and feasible now?" and explains why its answer is "No."

The Rise Of Utilization Management

Definition. The IOM committee adopted a relatively narrow definition of utilization management as "a set of techniques used by or on behalf of purchasers of health benefits to manage health care costs by influencing patient care decision-making through case-by-case assessments of the appropriateness of care prior to its provision." Although benefit design,

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financial incentives, and other strategies can influence medical decisions, the committee focused on prospective case-by-case approaches because of the significant change they entail in the way that patient care decisions are made and because they have been adopted rapidly with little systematic study. The major forms of utilization management are (1) prior review of proposed medical services through such means as preadmission or admission review for elective or emergency hospital admissions, continued stay review for hospitalized patients, and preprocedure review for selected inpatient and outpatient services; and (2) high-cost case management. To date, programs have been aimed at the site, timing, and duration of care, focusing on hospital use. Recently, the focus has begun to include case-by-case assessments of the medical need for particular procedures.

Development. Although some prior review dates back to the 1960s and before, initial efforts to avoid payment for unnecessary services emphasized review after care had been provided or even after it had been reimbursed. Such efforts have serious limitations as ways to influence medical decisions and control costs. First, most private health plans lack the power to deny payment to a physician or institution when the "unnecessary" services had already been provided—although the growth of contracting arrangements with providers has altered the situation somewhat. Absent such contracts, the burden of payment denials falls on the health plan member. Complaints by individuals faced with such unexpected expenses create employee relations problems for purchasers and public relations and marketing problems for review organizations. The risk of litigation also weakens the will to apply retrospective review vigorously. Furthermore, although one could deny payment for inappropriate care after the fact, the patient would already have undergone the service's risk and inconvenience. In theory, all parties would benefit if such care were avoided in the first place.

Virtually all insurers and third-party administrators and many health maintenance organizations (HMOs) and preferred provider organizations (PPOs) now offer some utilization management services.[2] Many statewide peer review organizations (PROs) that monitor utilization and quality of care for Medicare beneficiaries have private clients. Dozens of independent companies provide utilization management services. Surveys by benefit consulting firms show that one-half or more of large employers include utilization management provisions in their health benefit programs, up from as few as 5 percent in 1984.[3] The American Hospital Association (AHA) reports that individual hospitals may now deal with 50 to 250 different review organizations.[4] As recently as 1984, the Mayo Clinic worked with just one prior-review program administered by the Minnesota PRO for Medicare. Now it faces over 1,000 programs, many de-

veloped by review organizations to meet individual employers' demands.

Process and impact. The utilization management programs are far from uniform. However, they tend to share certain basic features. The initial contact with the organization may be made by the patient, the physician's office, or the hospital. Registered nurses generally collect information from these sources and, for prior review cases, make the initial evaluation of whether the proposed services meet medical necessity requirements for coverage under the patient's health plan.[6] If the nurse reviewer cannot certify the care as clinically necessary or appropriate based on the organization's review criteria, then the case is referred to a staff or consultant physician for final determination, often after discussion with the patient's physician. The emphasis seems to be on changing behavior through education, persuasion, and negotiation, and it appears uncommon for the process to end with refusal to certify the necessity of services that the patient's physician adamantly contends are needed. For high-cost case management, the focus is on evaluating alternative treatment approaches that could reduce costs for patients who are embarked on a very expensive course of care, and then—if the patient, family, and attending physician agree—coordinating implementation of the alternatives. Less costly services not normally covered by the health plan (such as intensive home care) may be approved if appropriate. The IOM report describes the operational elements and variations in utilization management at considerable length.

The rise of utilization management has been fueled by purchasers' frustration with ever-increasing health care costs and by the perception, backed by growing evidence, that many services may be unnecessary and inappropriate. This was fertile ground for early reports—disseminated widely by the trade press, conferences, consulting firms, and utilization management companies—that suggested that utilization management could cut hospital use and costs. As the IOM report describes, the early evidence was methodologically weak, and many expectations were overblown. Yet, utilization management quickly became a routine part of the health care system. Research evidence is still limited and flawed, but after evaluating it, the IOM committee concluded that utilization management has affected use and costs. Its effects on the quality of care and on providers' costs have not been documented, but it is clear that a significant change has taken place in the autonomy of practicing physicians.

Current Regulation And Oversight

Utilization management in the private sector has developed largely free from systematic oversight or government regulation. Today's operat-

ing environment is governed largely by market forces with backup from a scattering of judicial decisions and voluntary standards.

The market. Purchasers exercise varying degrees of control over utilization management in their decisions to select, continue, or replace particular programs or organizations. Recognizing employers' influential position, the IOM committee offered suggestions on how employers could better fulfill their roles as responsible and informed purchasers. However, not all employers have the resources or the inclination to make truly educated evaluations, and clear, evidence-based standards for distinguishing good performers from bad do not exist. A few private firms offer to evaluate review organizations for purchasers but are used by only larger and more committed employers or review firms.

Voluntary standards. For the utilization management industry, no voluntary organization analogous to the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) or the medical specialty boards exists to set standards or certify organizational adherence to standards. A limited first step toward voluntary standards went public this past summer when the AMA, the Blue Cross and Blue Shield Association, and the Health Insurance Association of America (HIAA) published eight broad guidelines for the conduct of utilization management programs. Several state hospital associations have also proposed guidelines for outside review organizations.

Case law. Although state and federal courts have faced few cases dealing explicitly with utilization management, these cases—combined with a much larger array of decisions relating generally to insurance and health plan administration—have created a broad, but incomplete, picture of the responsibilities and potential liability of review organizations and their clients. On the one hand, purchasers do have the right to evaluate and challenge the medical appropriateness of an attending physician's decisions about services that their health plans are expected to cover.[2] On the other hand, review organizations are then potentially liable for "defects in the design and implementation of cost containment mechanisms" that cause medically necessary services to be denied.[3] Such defects could include sloppy program design, incompetent management and monitoring, inadequate documentation, bad faith, and poor judgment about clinical or other patient circumstances.

State regulation. Maryland and Arkansas are establishing registration and certification processes that require review organizations to submit data on such matters as confidentiality policies, clinical criteria used for review, staffing, provisions for appeals of negative decisions, and accessibility (for example, business hours).[4] North Carolina authorizes the state insurance commissioner to adopt similar regulations and to require the

use of a standardized form for preadmission certification (most reviews are telephone-based). Maine limits its requirements for annual information reports to insurers operating prior review programs. Louisiana requires that review decisions be communicated within two business days unless special circumstances warrant a longer period, and Minnesota requires a decision within ten days after the review organization has received all necessary information. Louisiana also requires—without giving specifics—that decisions be based on "nationally accepted current medical criteria." Other states have considered, but not passed, legislation requiring that physician reviewers for utilization management organizations be licensed within the state, that no penalties be imposed on patients or providers for ignoring review requirements, and that all reviews, including those now performed by nurses, be defined as the practice of medicine and be done by physicians.

Federal action. PROs responsible for reviewing the appropriateness of care provided to Medicare beneficiaries are subject to extensive and frequently revised regulation, some of which—as a matter of convenience if not mandate—will affect their review programs for private clients. Although the federal government regulates PROs in great detail in many areas, it has explicitly refrained from requiring common clinical criteria for prior and retrospective review. A study commissioned by the Prospective Payment Assessment Commission (ProPAC) found great variation in the substance and specificity of criteria used by PROs.[10]

Emphases of regulation. Regulatory approaches fall into two broad categories. Some focus on information development through organizational disclosure of operating procedures, review criteria, and so forth, or through standardization of data used for evaluation and reporting. Other regulations try to protect consumers and providers by subjecting organizations to general oversight and approval, or by specifically prescribing or prohibiting certain practices (such as requiring a standard information form or forbidding use of nurse reviewers).

The Case For Regulation

The case for public regulation of utilization management rests on several points. First, neither administrative processes nor clinical criteria for review are highly standardized, and a number of shortcomings in common review mechanisms may hurt patients and overload providers. Proponents of regulation argue that only government action, rather than market or voluntary mechanisms, offers achievable and acceptable protection against inadequate or unscrupulous review organizations.

Site visits by the IOM committee to a dozen organizations that provide

utilization management services showed that they have some broad operating practices in common but differ on many specifics. These include the clinical criteria for assessing the appropriateness of specific services; the qualifications, training, and supervision of review nurses and physicians; the links to claims administration processes; the extent of computerization; and the procedures for appealing unfavorable decisions. Most organizations say their criteria are adapted from either the Appropriateness Evaluation Protocol or the Intensity Severity Discharge and Appropriateness screens—both widely known. Still, the individual adaptations may vary considerably, and no systematic inventory of criteria exists. The uncertainty about the quality of review criteria was a major concern of the IOM committee.

Physicians have complained that utilization management organizations refuse to disclose their decision-making criteria, although it is difficult to know how widespread this may be. Certainly, some organizations consider certain review criteria proprietary and will not disclose them in full. Other shortcomings identified by the committee include the lack of rigorous evaluation of utilization management techniques and variations; the absence of standard operating procedures for review organizations when they uncover quality-of-care problems; and vagueness, inconsistency, unfairness, or undue complexity in procedures for patients or providers to appeal unfavorable review decisions. Another criticism is that there are only informal mechanisms to press utilization management organizations to weigh the costs that their activities impose on providers of care, particularly those who are willing to appeal decisions with which they disagree. Some firms survey patients about their experiences with utilization management, but the committee found no parallel mechanism for physicians and hospitals.

The current conduct of utilization management may put an unfair burden on physicians to discover the basis for a review organization's decision, find out how the decision may be appealed, and then pursue the appeal. This generates costs—time, money, and stress—for practitioners and their staffs. However, if physicians do not contest ill-considered review decisions and do change their plan of treatment to conform, they may be legally liable should subsequent harm befall their patients.

Relying on the market to weed out poor vendors and procedures could be unsatisfactory because some of the parties most affected are not involved directly in decisions to purchase utilization management services. Moreover, many purchasers know little about what they are buying. Also, the varied contexts in which utilization management is carried out make it potentially subject to the hodgepodge of regulatory frameworks that cover insurance companies, HMOs, PPOs, and em-

ployee benefits. The likelihood of inconsistency, overlaps, and gaps is high. In sum, the case for regulation rests on the perception that serious problems exist and that government regulation can solve these problems.

The Case Against Regulation

Arguments against government regulation of utilization management do not deny that current approaches are variable and suffer from inadequacies. Nonetheless, it is one thing to identify a problem and another to find a satisfactory solution. Those who now oppose regulation emphasize three general points: (1) the lack of knowledge about what and how to regulate; (2) the potential for harm from ill-conceived regulation; and (3) the lack of documented evidence of harm to patients.

The utilization management industry has been called a moving target, so dynamic that it is difficult to crystallize meaningful and responsible rules to fit the activities of a variety of organizations with different objectives, structures, and incentives. The modest available evidence about the effectiveness of particular review strategies appears to some observers to be a rationale for regulation, but others contend that we do not know enough about what works and does not work (and under what conditions) to entrench our suppositions in regulation. They suggest that self-regulation by utilization management organizations is a reasonable first step, though recognizing that self-regulation often lacks public accountability and that no organizational umbrella currently covers all or even most review firms.

Poorly conceived government regulation could lead to premature rejection of utilization management, thereby encouraging further adoption of cost containment methods—such as coverage restrictions and economic incentives—that take less cognizance of the needs of individual patients and that are not designed to affect inappropriate care selectively. Moreover, little or no evidence suggests that utilization management harms patients. In fact, since utilization management aims to eliminate inappropriate services, it may benefit patients—although neither clinical benefit nor harm has been documented. Review programs do generate extra costs and aggravation for health care practitioners and institutions, and their calls for more standard operating methods and review criteria are understandable. However, some would argue that certain regulatory proposals—for example, those to restrict who can do prior review—look more like professional protectionism than efforts to save patients from harm and practitioners from unreasonable red tape.

Overall, the IOM committee concluded that the need for regulation seems not so urgent as to outweigh the need to understand well how to

act. The sophistication with which utilization management is carried out is increasing, and voluntary standards are being developed. Regulations might freeze certain methods in place before better approaches can be substituted. Or they might render ineffective and infeasible one of the few cost containment strategies designed to be sensitive to individual patients' circumstances.

Nonregulatory Directions For Utilization Management

Although the IOM committee did not endorse regulation, it did identify areas in which more standardization is desirable and should be encouraged by purchasers of review services, relevant professional associations, and consumer groups. Such areas include knowledge development, information disclosure, and procedural matters.

Knowledge base. The IOM committee saw clinically validated utilization management criteria as a public good that should be developed through rigorous processes that take into account the scientific literature and reflect a credible professional consensus. No utilization management organization can surmount the limits of medical knowledge and the lack of national consensus that now exists regarding many medical services. In addition, systematic empirical evaluation of different utilization management strategies probably requires some public investment, since broad-based and rigorous research may be beyond the capability and objectives of most individual organizations. Unfortunately, the building of broader clinical and management knowledge bases will not be a quick or comprehensive process. Research takes time, faces ethical constraints in some areas, applies imperfectly to varied real-world settings, and provokes disagreements over interpretation.

Disclosure of review criteria. Whereas the call for more research was easy for the IOM committee to reach, the conclusion that review criteria should be publicly accessible rather than secret or proprietary was less readily achieved. The arguments in favor of disclosure were several. Certainly, it seems only fair that practitioners and patients should know the basis for decisions about whether expensive health services are deemed appropriate for payment. Moreover, disclosing review criteria will expose them to more critical scrutiny. It may also increase the educational impact of review on providers and patients, perhaps improving quality of care. In general, more disclosure should help broaden the path from clinical research to applications.

In the committee's view, utilization management organizations should compete on the basis of data systems, efficiency, and performance, not on the basis of "secret" criteria. It may be argued that disclosure is unfair to

firms that have invested in criteria development and that it will discourage such efforts because firms will not be able to capture fully the benefits of their investment but will have to share them with free riders. This point has some merit, although the most noteworthy investments by review organizations appear to be less in developing criteria than in devising software to make their use practical and efficient.

Disclosure of criteria may also facilitate gaming by practitioners and reduce the cost-effectiveness of utilization management by making it easier for physicians to gain approvals and by adding more costs for monitoring. The committee believes that the appropriate response to this concern is not secret criteria but rather the development of greater consensus about appropriate care and better means for verifying information provided during the review process.

Other issues. Since overly burdensome or obscure appeal processes could discourage physicians from challenging questionable decisions by review organizations, there is much to commend more standard appeals mechanisms and better materials to explain them. With respect to procedures for organizations to follow when they identify serious quality-of-care problems, the immediate need is not for uniformity but rather for organizations to adopt explicit policies in the first place. Finally, more standardization in data collection and reporting is needed in both utilization management and other aspects of the health care system.

Conclusion

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.

The authors wish to acknowledge their equal contribution to this Commentary and note that their names are in alphabetical order. Members of the Institute of Medicine Committee on Utilization Management by Third Parties are: Jerome H. Grossman (chairman), Howard L. Bailit, Robert A. Berenson, John M. Burns, Richard H. Egdahl, John M. Eisenberg, Deborah Anne Freund, Paul M. Gertman, Alice G. Gosfield, Michael E. Herbert, Nathan Hershey, Neil Hollander, Karen Ignani, Carol Ann Lockhart, Arnold Milstein, Alan R. Nelson, Robert Patricelli, Cynthia L. Polich, Donald M. Steinwachs, and Bruce S. Wolff.

NOTES

1. Institute of Medicine Committee on Utilization Management by Third Parties, *Controlling Costs and Changing Patient Care? The Role of Utilization Management*, ed. B.H. Gray and M.J. Field (Washington, D.C.: National Academy Press, 1989).
2. Various trade sources list different numbers of utilization management organizations. The 1987 directory published by McGraw-Hill listed 158 utilization management companies, including many PROs. *Business Insurance* listed approximately 125 organizations in 1989, including only a few PROs.
3. Corporate Health Strategies, *The Health Poll*, Fall 1988, 1; J. Gabel et al., "Employee-Sponsored Health Insurance in America," Research Bulletin of the Health Insurance Association of America (Washington, D.C.: HIAA, January 1989); and Health Care Benefits Survey, 1987 and 1988 ed. (New York: Foster & Higgins, 1987 and 1989).
4. American Hospital Association, *Private Utilization Review*, State Issues Forum Monograph Series (Chicago: AHA, August 1989).
5. Mayo Clinic, "The Cost of Effective Utilization Review Programs," statement for the IOM Committee on Utilization Management by Third Parties, 19 May 1988.
6. Although terms such as prior review and prior authorization are often used interchangeably, the approval of benefits in advance of service provision may be contingent rather than final. Retrospective claims review will verify patient eligibility under the health plan, coverage for the category of service provided, and, to a lesser extent, accuracy of information supplied during prior review.
7. *Sarchett v. Blue Shield of California*, 43 Cal. 3d 1, 233 Cal. Rptr. 76, 729 P. 2d 267 (1987), which involved a retrospective judgment of the medical necessity of hospital care, is a key case involving the right of payers to review physician judgments. *Varol v. Blue Cross and Blue Shield of Michigan* reached a similar conclusion in a case involving prior review. See also W.A. Helvestine, "Legal Implications of Utilization Review," in *Controlling Costs and Changing Patient Care*, ed. Gray and Field, Appendix A.
8. *Wickline v. California*, 192 Cal. App. 3d 1630, 239 Cal. Rptr. 810 (1986). For discussion, see Helvestine, "Legal Implications of Utilization Review."
9. H. Meyer, "Two States Lead Move to Regulate Utilization Review," *American Medical News*, 21 April 1989, 1, 45. See also AHA, *Private Utilization Review*; and Helvestine, "Legal Implications of Utilization Review."
10. Project HOPE, Center for Health Affairs, *A Study of the Preadmission Review Process*, prepared for the Prospective Payment Assessment Commission (Washington, D.C.: ProPAC, November 1987).

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best's review

Volume 90 No. 11

Life/Health Insurance Edition

Does Mr. Jones Need Bypass Surgery?

BY IRENE SCHEIBNER AND CONSTANCE M. WINSLOW

Computerization of claim processing, billing and many previously manual processes has become an accepted way to enhance customer service and cut the costs of doing business. On the leading edge of trends in automation, however, are applications of technology that go beyond streamlining standard processes to make possible new products, services and programs that were inconceivable in a manual environment.

Today, Aetna Life and Casualty is applying knowledge-based systems technology to manage health care delivery more efficiently and effectively. The company's new protocol-based programs use special software to represent the decision logic used in determining the medical necessity of specific health care services.

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There is mounting evidence that suggests patients may be getting health services they do not need. A study by the RAND Corp. showed that between 17% and 32% of three frequently used procedures—coronary angiography, carotid endarterectomy, upper GI endoscopy—were performed for inappropriate reasons (*Journal of the American Medical Association*, November 13, 1987). The researchers defined "appropriate" as when the benefit to the patient clearly outweighs the risk. In a subsequent study of three hospitals in a western state, 14% of the coronary artery bypass surgeries reviewed were deemed inappropriate (*JAMA*, July 22/29, 1988).

Prompted by the results of these and other studies, we undertook the development of specific utilization management programs that could avert the unnecessary use of health services in both inpatient and outpatient settings. The programs are designed to prospectively review for the medical necessity (clinical appropriateness) of selected procedures using scientifically based clinical protocols, or practice guidelines. The company's Employee Benefits Division has been operating these programs since 1987 with more than 500,000 lives. Program results are promising and indicate that we effectively can reduce the use of unnecessary, and sometimes harmful, medical procedures.

Clinical decision making is complex, but researchers are developing methodologies to simplify our understanding of the process. Nationally recognized medical research groups developed the clinical decision logic used to screen for unnecessary or clinically inappropriate treatments or surgeries. The protocol logic is based on an extensive review of the medical literature, recommendations of medical specialty societies, and final review by an expert panel of physicians.

The resultant protocol consists of clinical decision logic and the expert panel's ratings of appropriateness. The protocols vary in complexity, depending on the underlying medical decision logic for each procedure. Outpatient procedures such as bunionectomy or tympanostomy tube insertion are not as complex as hysterectomy, for example, which has more than 2,000 indications for use. Other procedures included in the review process include cataract removal, knee arthroscopy, septoplasty/rhinoplasty, tonsillectomy,

carpal tunnel release, prostatectomy and laminectomy, among others.

The procedures are carefully selected for inclusion in the review program. The basic criteria for selection are as follows:

- Information about the effectiveness of the procedure needs to be available in the medical literature.
- The frequency and cost of the procedure must be high enough to make prospective review cost effective.
- Inappropriate use must be suspected.

The clinical protocols developed for selected procedures can then be incorporated into utilization management and quality assurance programs. Both the Outpatient Precertification program and the Managed Second Opinion program, which targets inpatient procedures, are prospective and require that patients precertify selected procedures by calling the company's utilization review nurse, who collects the pertinent clinical information from the patient and the attending physician. Through the use of the protocols, the nurse identifies cases in which a procedure may not be medically necessary and refers such cases to the company's review physician.

To minimize operational costs and to make efficient use of the patient and attending physician's time, we used knowledge-based systems software to represent the clinical logic. The knowledge-based system assists the nurse in reaching a decision to certify or refer the case, based on the clinical logic of the protocol.

Using the computerized system, the nurse is required to collect only the pertinent clinical information and can proceed through the certification interview without having to remember the logic of the protocol—the sequence of questions is built into the system. In addition, the system enables the nurse to keep the interview with the attending physician within a desired five to seven minutes.

The outpatient system is based on a new technology, hypertext technology, and is written in Apple's HyperCard software running on a Macintosh computer. The hypertext software models the human reasoning process and supports automated representation of the clinical protocol logic by linking successive questions and logic paths.

COMPLEX PROTOCOL LOGIC

The managed second opinion program operates in much the same way as the outpatient program by addressing review of selected inpatient surgical procedures. The Healthline nurse uses protocol logic to certify medical necessity and screen selected cases for the physicians' review. The program eliminates second opinions for patients whose procedure or admission is completely appropriate and focuses review efforts on cases in which the procedure or treatment may not be medically necessary. The review physician determines when a second examination is required and finalizes determination of the medical necessity of a procedure.

The difference between the outpatient precertification and managed second opinion programs lies in the complexity of the protocol logic for inpatient cases, such as hysterectomy, cardiac bypass and prostatectomy. An inpatient protocol can consider more than 1,000 clinical indications and is much more complex than the clinical logic in an outpatient protocol.

A more sophisticated knowledge-based technology was necessary to implement the managed second opinion protocols. To help streamline the extensive clinical questioning logic, newly available artificial intelligence technology, called induction technology, was used. To speed up system support for the questioning process, screen windows and button-choice features assist the nurse by clarifying definitions of the medical indications and tracking the clinical logic to facilitate the task. Further technical programming enhancements bring system performance speed to the level necessary to implement the program.

The nurse uses protocol logic to certify medical necessity and screen selected cases for the physicians' review.

Future development of these review programs will focus on further reducing administrative costs through the continued application of new technologies and by expanding the use of these programs to other areas, such as hospital ancillary services. As the cost of delivering health services continues to rise, employers will continue to demand programs that can reduce health care costs. Reducing costs, however, does not necessarily mean sacrificing needed patient care. The protocol-based programs selectively reduce the use of unnecessary procedures with consequent cost savings.

Knowledge-based technologies make it possible for us to implement utilization management programs that would not be possible with conventional technologies or in manual environments. The future of health care utilization management depends on a close, collaborative effort between informations systems technology development and the application of health services research.

UTILIZATION REVIEW ACCREDITATION COMMISSION
NATIONAL UTILIZATION REVIEW STANDARDS
JUNE 1991

Comments or recommendations regarding these Standards should be submitted to the Utilization Review Accreditation Commission, Inc., 1227 25th Street, NW, Suite 610, Washington, DC 20037

NATIONAL UTILIZATION REVIEW STANDARDS

Overview

A. Introduction

These standards for utilization review were developed and approved by the Utilization Review Accreditation Commission (URAC) which was established to encourage efficient and effective UR processes and provide a method of evaluation and accreditation of utilization review programs. These standards will be used by URAC to credential Utilization Review (UR) Organizations which apply for voluntary accreditation.

These standards were developed as guidelines for the evolving UR industry and are not intended to discourage the further development of effective, efficient, and innovative methods to promote quality care and decrease the rate of growth in health care expenditures.

B. Purpose of the Utilization Review Standards

The purpose of these standards is to encourage the availability of effective, efficient, and consistent utilization review of health care services throughout the United States. These standards accomplish that purpose through the following objectives:

- encouraging consistency in the procedures for interaction between UR Organizations and providers, payors, and consumers of health care;
- establishing UR processes that cause minimal disruption to the health care delivery system;
- establishing standards for the procedures used to certify health care services and to process appeals of utilization review determinations;
- providing the basis for an efficient process for credentialling and accrediting UR Organizations; and,
- providing consistent standards and an accreditation mechanism that can be applied efficiently nationwide for those states which choose to regulate UR Organizations.

UTILIZATION REVIEW STANDARDS

I. Scope of the Utilization Review Standards

A. These standards apply to prospective and concurrent utilization review for inpatient admissions to hospitals and other inpatient facilities as well as to outpatient admissions to surgical facilities.[2]

B. "Inpatient admissions to hospitals" as used in these standards, includes admissions to all acute medical, surgical, obstetrical, psychiatric and chemical dependency inpatient services at a licensed hospital facility, as well as other licensed inpatient facilities such as skilled nursing facilities, residential treatment centers and free standing rehabilitation facilities.

II. Responsibility for Obtaining Certification

Health benefit plans which include utilization review requirements typically specify the individual(s) responsible for notifying the UR organization in a timely manner and obtaining certification for health care services. A UR Organization shall allow any licensed hospital, physician or responsible patient representative, including a family member, to assist in fulfilling that responsibility.[3]

III. Information Upon Which Utilization Review is Conducted

A. When conducting routine prospective and concurrent utilization review, UR Organizations shall collect only the information necessary to certify the admission, procedure or treatment and length of stay.

1. UR Organizations shall not routinely require hospitals and physicians to supply numerically codified diagnoses or procedures to be considered for certification. UR Organizations may ask for such coding, since if it is known, its inclusion in the data collected increases the effectiveness of the communication.

2. UR Organizations shall not routinely request copies of medical records on all patients reviewed. During prospective and concurrent review, copies

Diagnosis/Treatment Information

Primary Diagnosis (with associated ICD or DSM Coding, if available)
Secondary Diagnosis (with associated ICD or DSM Coding, if available)
Tertiary Diagnoses (with associated ICD or DSM Coding, if available)
Proposed Procedure(s) or Treatment(s) (with ICD9 or associated CPT Codes, if available)
Surgical Assistant Requirement
Anesthesia Requirement
Proposed Admission or Service Date(s)
Proposed Procedure Date
Proposed Length of Stay

Clinical Information

Sufficient for support of appropriateness and level of service proposed
Contact Person for detailed clinical information

Facility Information

Type (such as in-patient, out-patient, special unit, SNF, rehab., office/clinic)
Status (licensure/certification status and DRG exempt status, as needed)
Name
Address
Phone Number
Tax ID No. or Other ID No.

Concurrent (Continued Stay) Review Information

Additional Days/Services/Procedures Proposed
Reasons for Extension, including clinical information sufficient for support of appropriateness and level of service proposed
Diagnoses (same/changed)

For Admissions to Facilities other than Acute Medical/Surgical Hospitals, Added Information On:

History of Present Illness
Patient Treatment Plan and Goals
Prognosis
Staff Qualifications
24 Hour Availability of Staff

For Special Situations

Additional information may be required for other specific review functions such as discharge planning or catastrophic case management. Second Opinion Information may also be required, when applicable, sufficient to support benefit plan requirements.

CORRECTION

THIS DOCUMENT
HAS BEEN REPHOTOGRAPHED
TO ASSURE LEGIBILITY

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- providing the basis for an efficient process for credentialling and accrediting UR Organizations; and,
- providing consistent standards and an accreditation mechanism that can be applied efficiently nationwide for those states which choose to regulate UR Organizations.

These standards apply to all organizations offering UR services which apply for accreditation. Health Maintenance Organizations, Preferred Provider Organizations and other such managed care systems that contract directly with health care providers may vary from these standards to the extent that the variance is addressed in the provider contract or in the terms of the health benefit plan and is consistent with the objectives of these standards. UR services for health care benefits provided through certain governmental programs such as Medicare, Medicaid and through Workers' Compensation and certain Automobile Medical Payment coverages may vary from these standards to the extent that the variance is required by statute.[1]

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2. UR Organizations shall not routinely request copies of medical records on all patients reviewed. During prospective and concurrent review, copies

of medical records should only be required when a difficulty develops in certifying the medical necessity or appropriateness of the admission or extension of stay. In those cases, only the necessary or pertinent sections of the record should be required.

3. UR organizations may request copies of medical records retrospectively for a number of purposes, including auditing the services provided, quality assurance, evaluation of compliance with the terms of the health benefit plan or UR provisions. With the exception of the reviewing of records associated with an appeal or with an investigation of data discrepancies and unless otherwise provided for by contract or law, health care providers should be reimbursed the reasonable direct costs of duplicating requested records for retrospective review.

B. Except as otherwise provided in these standards, a UR Organization should limit its data requirements to the following elements:[4],[5]

Patient Information

Name
Address
Date of Birth
Sex
SS No. or Patient ID No.
Name of Carrier or Plan, including Plan Type
Plan ID No.

Enrollee Information

Name
Address
SS No. or Employee ID No.
Relation to Patient
Employer
Health Benefit Plan
Group Number/Plan ID No.
Other Coverages Available (Workers Comp., Auto, CHAMPUS, Medicare, Other)

Attending Physician/Practitioner Information

Name
Address
Phone Numbers
Degree
Specialty/certification status
Tax ID or other ID No.

Diagnosis/Treatment Information

Primary Diagnosis (with associated ICD or DSM Coding, if available)
Secondary Diagnosis (with associated ICD or DSM Coding, if available)
Tertiary Diagnoses (with associated ICD or DSM Coding, if available)
Proposed Procedure(s) or Treatment(s) (with ICD9 or associated CPT Codes, if available)
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Prognosis
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24 Hour Availability of Staff

For Special Situations

Additional information may be required for other specific review functions such as discharge planning or catastrophic case management. Second Opinion Information may also be required, when applicable, sufficient to support benefit plan requirements.

C. Information in addition to that described in this section may be requested by the UR Organization or voluntarily submitted by the provider, when there is significant lack of agreement between the UR Organization and health care provider regarding the appropriateness of certification during the review or appeal process. "Significant lack of agreement" means that the UR Organization:

1. has tentatively determined, through its professional staff, that a service cannot be certified;

2. has referred the case to a physician for review; and

3. has talked to or attempted to talk to the attending physician for further information.

D. A UR Organization should share all clinical and demographic information on individual patients among its various divisions (e.g., certification, discharge planning, case management) to avoid duplicate requests for information from enrollee or providers.

IV. Procedures for Review Determination

A. Each UR Organization shall have written procedures to assure that reviews are conducted in a timely manner.

1. Each UR Organization shall make certification determinations within two working days of receipt of the necessary information on a proposed admission or service requiring a review determination. Collection of the necessary information may necessitate a discussion with the attending physician or, based on the requirements of the health benefit plan, may involve a completed second opinion review.

2. UR Organizations may review ongoing inpatient stays, but shall not routinely conduct daily review on all such stays. The frequency of the review for extension of the initial determination should vary based on the severity or complexity of the patient's condition or on necessary treatment and discharge planning activity.

B. Each UR Organization shall have in place written procedures for providing notification of its determinations regarding all forms of certification in accordance with the following:

1. When an initial determination is made to certify, notification shall be provided promptly either by telephone or in writing, to the attending physician. The notification should be transmitted in writing to the hospital and attending physician, as well as to the enrollee or patient, within two working days of the determination.[6],[7]

2. A determination to certify an extended stay or additional services resulting from concurrent review should be transmitted to the attending physician by telephone or in writing within one working day of receipt of all information necessary to complete the review process or prior to the end of the current certified period.

3. If a UR Organization transmits written confirmation of certification for continued hospitalization, that notification should include, when possible, the number of extended days or next review date, the new total number of days approved and the date of admission.

4. When a determination is made not to certify a hospital or surgery facility admission or extension of a hospital stay, or other service requiring review determination, within one working day the attending physician shall be notified by telephone and a written notification shall be sent to the hospital, attending physician and the enrollee or patient.[6] The written notification should include the principal reason(s) for the determination and the way to initiate an appeal of the determination. Reasons for a determination not to certify may include, among other things, the lack of adequate information to certify after a reasonable attempt has been made to contact the attending physician.

C. UR Organizations shall have in place written procedures to address the failure of a health care provider, patient or their representative to provide the necessary information for review. If the patient or provider will not release the necessary information to the UR Organization, the UR Organization may deny certification in accordance with its own policy or that of the health benefit plan.

V. Appeals of Determinations Not to Certify

Each UR Organization shall have in place procedures for appeals of determinations not to certify an admission, procedure, service or extension of stay. The right to appeal shall be available to the patient or enrollee, and to the attending physician.[8] The procedures for appeals shall include at a minimum the following:

A. Expedited appeal

When an initial determination not to certify a health care service is made prior to or during an ongoing service requiring review, and the attending physician believes that the determination warrants immediate appeal, the attending physician shall have an opportunity to appeal that determination over the telephone on an expedited basis. Each UR Organization shall provide for reasonable access to its consulting physician(s) for such appeals. Both providers of care and UR Organizations should attempt to share the maximum information by phone, FAX or otherwise to resolve the expedited appeal (sometimes called a reconsideration request) satisfactorily. Expedited appeals which do not resolve a difference of opinion may be resubmitted through the standard appeal process.

B. Standard appeal

The UR Organization shall establish procedures for appeals to be made in writing and/or by telephone.

1. Each UR Organization shall notify in writing the enrollee or patient, attending physician and claims administrator of its determination on the appeal as soon as practical, but in no case later than 60 days after receiving the required documentation on the appeal.

2. The documentation required by the UR Organization may include copies of part or all of the medical record and/or a written statement from the health care provider.

3. Prior to upholding the original decision not to certify for clinical reasons, the UR Organization shall conduct a review of such documentation by a physician who did not make the original determination not to certify.

4. The process established by a UR Organization may include a period within which an appeal must be filed to be considered.

5. An attending physician who has been unsuccessful in an attempt to reverse a determination not to certify shall be provided the clinical basis for that determination upon request.

6. In cases where an appeal to reverse a determination not to certify for clinical reasons is unsuccessful, the UR Organization should assure that a physician in the same or a similar general specialty as typically manages the medical condition, procedure or treatment under discussion is reasonably available to review the case as mutually deemed appropriate.

C. Notification to the claims administrator

Each UR Organization shall forward electronically or in writing, a notification of certification or determination not to certify to the appropriate claims administrator for the health benefit plan.[9]

VI. Confidentiality

A. Each UR Organization shall have written procedures for assuring that patient-specific information obtained during the process of utilization review will be:

1. kept confidential in accordance with applicable federal and state laws;

2. used solely for the purposes of utilization review, quality assurance, discharge planning and catastrophic case management; and

3. shared with only those agencies (such as the claims administrator) who have authority to receive such information.[10]

B. Summary data shall not be considered confidential if it does not provide sufficient information to allow identification of individual patients.

VII. Staff and Program Qualifications

Each UR Organization shall have utilization review staff who are properly trained, qualified, supervised and supported by written clinical criteria and review procedures. Clinical criteria and review procedures shall be established with appropriate involvement from physicians.

A. Nurses, physicians and other licensed health professionals conducting reviews of medical services, and other clinical reviewers conducting specialized reviews in their area of specialty shall be currently licensed or certified by an approved state licensing agency in the United States.

B. A physician shall review all cases in which the UR Organization has concluded that a determination not to certify for clinical reasons is appropriate. The physician should be reasonably available by telephone to discuss the determination with the attending physician.

C. UR Organizations shall utilize:

1. Written clinical criteria, as needed, for the purpose of determining the appropriateness of the certification; such criteria shall be periodically evaluated and updated.

2. Physician consultants, including, as needed and available, specialists who are board certified or board eligible and working towards certification in a specialty board approved by the American Board of Medical Specialists or the American Board of Osteopathy from the major areas of clinical services.

3. A formal program for orientation and training of UR staff.

4. Written documentation of an active Quality Assessment Program.

VIII. Accessibility and On-Site Review Procedures

A. Each UR Organization shall provide access to its review staff by a toll free or collect call phone line, at a minimum, from 9:00 am to 4:00 pm of each normal business day in the provider's local time zone in which the UR Organization routinely conducts review. Each UR Organization shall also have a mechanism to receive timely call-backs from providers and shall establish written procedures for receiving or redirecting after-hour calls, either in person or by recording.

B. Each UR Organization shall conduct its telephone reviews, on-site information gathering reviews, and hospital communications during hospitals' and physicians' reasonable and normal business hours, unless otherwise mutually agreed.

C. Each UR Organization's staff shall identify themselves by name and by the name of their organization and, for on-site reviews, shall carry picture identification and the UR Organization's company identification card. On-site reviews should, whenever possible, be scheduled at least 1 business day in advance with the appropriate hospital contact. If requested by a hospital or in-patient facility, UR Organizations should assure that their on-site review staff register with the appropriate contact person, if available, prior to requesting any clinical information or assistance from hospital-staff and shall wear appropriate hospital supplied identification tags while on the premises.

D. UR Organizations shall agree, if so requested, that the medical records remain available in designated areas during the on-site review and that reasonable hospital administrative procedures shall be followed by on-site review staff so as to not disrupt hospital operations or patient care. Such procedures, however, should not limit the ability of the UR Organizations to efficiently conduct the necessary review on behalf of the patient's health benefit plan.

E. UR Organizations should verbally inform, upon request, designated hospital personnel and/or the attending physician of the utilization review requirements of the specific health benefit plan and the general type of criteria used by the review agent. UR Organizations should also verbally inform, upon request, hospitals, physicians and other health care professionals of the operational procedures in order to facilitate the review process.[11]

IX. Accreditation Process

A. URAC will update policies and procedures for accrediting UR Organizations to assess compliance with these standards on an ongoing basis. An Application Form and a copy of these procedures will be made available to any UR Organization upon request.[12]

B. URAC has established policies and procedures for providing confirmation of accreditation status, upon request, to health care providers, state regulatory agencies and other appropriate parties.

C. Only those UR Organizations which have formally applied for and have received a current accreditation from URAC may make any claim to be accredited pursuant to these standards.

NOTES

1. Consideration should be given in the application of these standards to UR services in certain governmental programs such as Medicare, Medicaid and in Workers' Compensation and certain Automobile Medical Payment coverages. For example, in Workers' Compensation coverage, there is technically no enrollee, only a claimant. Under these coverages, the responsibility for obtaining certification is not usually the claimant's. The notification requirements, access to the claimant and appeal procedures may be governed by statute.

2. Retrospective review usually refers to a review of services provided or medical claims review performed after the discharge of the patient and/or after receiving the bill for payment.

   In situations where the enrollee or patient is unconscious or otherwise unable to provide notification, or where there was inadequate provider notification or response, review which should have been prospective might be conducted concurrently during treatment or retrospectively soon after treatment is completed. This delayed review usually follows the same general process as described for prospective and concurrent review in these Standards.

3. The timeliness of notification to a UR Organization of an admission or proposed admission is determined by the terms of the applicable health benefit plan.

   a. In general and in the absence of contractual agreements to the contrary, notification should be considered timely if made a minimum of three working days prior to admission for routine or elective admissions and within two working days after emergency admissions.

   b. In cases involving a second opinion, proper notification should be considered seven working days, unless otherwise provided for in the enrollee's health benefit plan.

   c. Hospitals and physicians should notify the UR Organization prior to actual admission, whenever possible, on cases where it is uncertain whether the admission would be defined as an emergency.

4. Hospitals and physicians are encouraged to assist in providing information to UR Organizations by telephone and otherwise. Health benefit plans and claim administrators are also encouraged to make information available to UR Organizations to facilitate enrollee identification. Review determinations by UR Organizations are based on the information provided. Health care providers and UR Organizations are encouraged to develop more efficient and cost effective forms of communicating the information in a timely and confidential fashion.

5. The information release forms signed by or on behalf of a patient at the time of treatment by hospital or physician should include language, as needed, to clarify that providers have the right to release information by telephone and in writing for utilization review purposes. Hospitals and physicians may reserve the right to discuss the release of sensitive information to a UR Organization with the patient.

6. In those health benefit plans where the enrollee or patient incurs no financial liability for failing to obtain certification, the UR Organization is not required to notify the enrollee or patient of their determination. Further, a UR Organization may eliminate certain determination notifications by mutual agreement.

7. Mail-in and telephonic certification programs for services which may be provided 30 or more days following the request for authorization (such as anticipated normal childbirth or certain elective surgeries) may be allowed reasonable latitude from the times for notification of certification otherwise required by the Standards.

8. In those health benefit plans where it is the responsibility of the enrollee or covered patient to appeal, UR Organizations should allow the attending physician to initiate an expedited appeal on behalf of a patient. In those health benefit plans which place responsibility for notification and appeal on the attending physician, UR Organizations should allow the attending physician to appeal directly on his or her own behalf. Hospitals, other health care providers or a representative of the enrollee or covered patient may assist in an appeal.

   It is important to emphasize that the decision as to what treatment to prescribe for an individual patient remains that of the physician and his or her patient or their representative. The final decision as to whether these prescribed treatments are a covered benefit is the responsibility of the claims administrator or health benefit plan.

9. Health benefit plans operating under ERISA and state law procedures are designed to give an enrollee a full and fair review after receiving an appeal on a claim denial notice. Health benefit plan enrollees (with or without the provider's assistance) who wish to appeal a claim denial, partial payment or pending claim may utilize that health benefit plan's appeal process. Likewise, claim administrators for health benefit plans have established mechanisms for provider appeals of denied or partially paid claims. In addition, health benefit plans may include specific requirements for compliance with UR rules. The application of those requirements and the charging of any penalty or disincentive is typically a function of the claims administrator and any appeal mechanism would be specified by the health benefit plan.

10. When consistent with applicable federal and state laws, patient specific data gathered by the UR Organization which raise questions of deficiencies in quality may be shared with the hospital's or outpatient surgical facility's Quality Assurance Committee. Prior to the sharing of such information, a UR Organization may require the hospital or outpatient surgical facility to assure due care in complying with confidentiality requirements, to assure the review and follow-up within that hospital's or outpatient facility's Quality Assurance Committee, and to indemnify the UR Organization from any inappropriate use of such information by the hospital or outpatient facility.

11. Health benefit plans and employers are encouraged to develop enrollee communications that provide information regarding UR requirements, benefits, obligations, penalties and sources for further information. UR Organizations are encouraged to take an active role in assisting health benefit plans in the development of enrollee communications and information that provides effective education of enrollees regarding the review requirements of their health benefit plan.

12. These standards are intended to encourage efficient and effective UR processes as well as to provide a basis for an accreditation process for UR Organizations. The terms "shall" and "should," as used in this document and as used as a measure of compliance within the accreditation process, have the following definitions:

"Shall" means that the UR Organization is required to carry out the action of the direction as stated.

"Should" means that while the UR Organization can be expected to carry out the action as stated, there may be reasons, based on the individual organization's circumstances, where the organization will not perform the direction. In those instances where the UR Organization does not presently carry out the stated action, the organization may choose to implement the direction as a future objective.

DEFINITIONS

For the purposes of this document, the following terms have the following definitions:

APPEAL: A formal request to reconsider a determination not to certify an admission, extension of stay or other health care service.

ATTENDING PHYSICIAN: The physician with primary responsibility for the care provided to a patient in a hospital or other health care facility.

CERTIFICATION: A determination by a utilization review organization that, an admission, extension of stay, or other health care service has been reviewed and based on the information provided, meets the medical review requirements of the applicable health benefit plan.

CLAIMS ADMINISTRATOR: Any entity that reviews and determines whether to pay claims to enrollees, physicians, hospitals or others on behalf of the health benefit plan. Such payment determinations are made on the basis of contract provisions. Claims administrators may be insurance companies, self-insured employers, third-party administrators or other private contractors.

CLAIMANT: The enrollee or covered person who files a claim for benefits.

CLINICAL CRITERIA: The written policies, decision rules, medical protocols, or guides used by the Utilization Review Organization to determine certification.

CONCURRENT REVIEW: Utilization review conducted during a patient's hospital stay or course of treatment, sometimes called Continued Stay Review.

DISCHARGE PLANNING: The process that assesses a patient's needs for treatment after hospitalization in order to help arrange for the necessary services and resources to effect an appropriate and timely discharge.

ENROLLEE: The individual who has elected to contract for, or participate in, a health benefit plan for either him or herself and/or his or her dependents.

HEALTH BENEFIT PLAN: Any public or private organization's written plan that insures or pays for specific health care expenses on behalf of enrollees or covered persons.

PROSPECTIVE REVIEW: Utilization review conducted prior to a patient's hospital stay or course of treatment.

PROVIDER: A licensed health care facility, physician or other health care professional that delivers health care services.

QUALITY ASSESSMENT PROGRAM: A structured mechanism which, at a minimum, monitors and evaluates a UR Organization's program and provides management intervention, as needed, to support compliance with these standards.

RECONSIDERATION: An initial request by telephone for additional review of a UR organization's determination not to certify an admission, extension of stay, or other health care service. A reconsideration may be called an expedited appeal by some UR Organizations.

UTILIZATION REVIEW: Evaluation of the necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities.

UTILIZATION REVIEW ORGANIZATION: An entity which conducts utilization review and determines certification of an admission, extension of stay or other health care service.

SB 239, relating to private health care review agents, was next to come before the committee members. CHAIRMAN STURGULEWSKI explained that what is being dealt with is a process that is being utilized more and more by insurance companies called utilization review. What that means is that the insurance companies get pre-approval of medical treatment for the insured. The legislation would require a utilization review board to obtain a license from the Department of Commerce and Economic Development. Under Title 8, it would require an applicant to submit an application with the utilization review plan that includes a number standards it sets out in the policies and procedures, qualifications of personnel employees, assurances that a determination of medical inappropriateness won't be rendered except in writing, and procedures to ensure confidentiality of confidential medical records. She explained that the committee was asked to introduce the legislation by those facilities that offer drug and alcohol treatment, and psychiatric and psychological counselling. Chairman Sturgulewski noted that there is also interest on the part of the medical community.

Number 189

The first person to speak on the measure was DR. HOWARD FAGIN, Health Care Consultant, Atlanta, Georgia. He informed committee members of his qualifications. Mr. Fagin said he supports SB 239 as it encourages greater coordination between payers and providers, protects the rights of patients, ensures private agents are qualified to perform utilization review, and ensures confidentiality of patient medical records. He explained that there have been some isolated instances where there were some unnecessary admissions, services preformed, and the length of stays have been longer than desired in hospitals. In some cases services were delivered in less than the most efficient setting. He noted these problems do not mean that all providers are unable or are unwilling to provide appropriate services. Providers do have an ultimate legal responsibility for patient care, Dr. Fagin noted. Reviewers of patient care may cause problems for patients since the primary motive for most utilization review firms is cost containment rather than patient care. Just as the IRS should not assume that all tax payers are criminals, utilization review firms should not assume all providers attempt to provide unnecessary services.

Dr. Fagin referred to the development of utilization review firms and said frustration has occurred by many U.S. corporations with respect to the cost of health care and their desire to have an active involvement. They are not concerned about just paying health insurance premiums, but are trying to reduce costs for their corporations. Private insurance companies are beginning to relax to this corporate pressure and the corporations are hiring the new utilization review firms to develop programs that review claims for payments. Dr. Fagin said there have been several positive results of the new firms such as health care cost reduction

in excess of the costs expended, decreases in hospital admissions for procedures that normally can be done on an outpatient basis, reduced lengths of stays for hospitalized cases, increased attention by providers to outcome analysis justifying inpatient care for certain types of patients where they are necessary, increased hospital cooperation with managed care firms, and desire to develop designated hospital staff contacts to facilitate the review process. Dr. Fagin said there have been many negative results from the implementation of utilization review: (A) There have been cases where reviewers demand hospital discharge of patients too early in the treatment process; (B) There have been cases where patients leave the hospital against medical advice, when a reviewer indicates treatment is not covered; (C) There have been cases where the reviewer, not the physician, makes the decision to admit the patients by pre-admission criteria; (D) There has been denial by reviewers of recommended ancillary health services or diagnostic evaluations for patients; (E) Cases when reviewers refuse to communicate with hospital utilization managers and page physicians to answer routine inquires; (F) Cases where reviewers (including nurses clerks, social workers or sometime computer answering devices) are evaluating medical cases without physicians involvement; (G) Cases where clinical reviewers lack experience in the field where reviewers are necessary; and (H) Cases where utilization management firms do not explain their criteria or apply criteria consistently.

Dr. Fagin said denial by physicians is essential if the utilization review firm is not going to approve a particular claim. Since the utilization firm is, in fact, setting itself up in the practice of medicine, it is only reasonable that the practice of medicine is left to physicians. Mr. Fagin continued discussing negative results regarding implementation of utilization review.

Number 302

Dr. Fagin explained that there are at least ten states that have enacted legislation relating to the practice of private utilization review agents. Prior to 1990, Maryland, Arkansas, Maine, and New Jersey had enacted legislation, and in 1990, Georgia, Florida, Mississippi, South Carolina, Virginia and Kentucky enacted legislation. He noted that legislation has been introduced in Missouri Kansas, Pennsylvania, Illinois, Texas Massachusetts and Alaska. Dr. Fagin referred to information in the committee member's packets and continue to discuss the characteristics of the legislation:

A. Companies conducting utilization review must obtain certification from either the State Department of Health or the Commissioner of Insurance.

B. Utilization review firms must submit information describing:

1. review criteria and procedures to be used in evaluating hospital and medical care;

2. the type and qualifications of personnel performing utilization review;

3. procedures and policies ensuring that a private review agent is "reasonably accessible" to patients and providers during normal business hours;

4. policies and procedures ensuring that applicable state and federal laws protecting confidentiality of individual medical records are followed; and

5. procedures by which insurers, patients or providers may seek reconsideration of adverse decisions.

C. Statements affirming availability of appropriate medical care providers when utilization review agent questions the medical necessity or appropriateness of care. The patient's attending physician or health care provider must be able to discuss the case with an identified health care provider trained in a related specialty.

Dr. Fagin explained that he has discussed SB 239 with Kathy Cronen, Administrator of Charter North Hospital. In response to a previous presentation by representative of AETNA, Ms. Cronen contacted representative at Human Affairs in Anchorage. Charter North hospital is concerned about the cost of health care, cost containment, and not unnecessarily increasing the costs to the patient. As a strong advocate of the bill, they are willing to discuss specific concerns about the legislation, versus general observations that may objectional to the organization. Dr. Fagin said Charter North is concerned that all involved understand the specific situations in Alaska including limited availability of resources as well as alternative delivery systems, and the great distances that many patients must travel to reach appropriate health providers.

CHAIRMAN STURGULEWSKI thanked Dr. Fagin for his testimony. She asked Ann Boudreaux to comment on the legislation.

ANN BOUDREAUX, Director, Division of Occupational Licensing, Department of Commerce and Economic Development, said the department agrees that there is probably a need to make sure that health care providers are not doing unnecessary procedures or are requiring a longer than necessary stay. She said a concern to her, as an individual, is if a patient is given more treatment than necessary. The department wants to make sure that the utilization review is acting in an appropriate manner. There have been complaints from state employees about delays in getting procedures approved and some rudeness when inquiring about care.

Ms. Boudreaux referred to the legislation and said a concern is that what is proposed seems to be more of a registration than a licensing. They are required to file a plan, but there are not enough specifics of following the details of that plan. It would appear that a lot of discretion is being given to the department to try and set some regulations. She said that is more than what the department wants to take on as they are not professional medical personnel.

Ms. Boudreaux referred to the legislation mentioning using a physician licensed in the state, and said she presumes that means the State of Alaska. She said the department agrees that licensed medical personnel should be used and said it may be too restrictive on the utilization review firm if it would have to be someone licensed in Alaska. Ms. Boudreaux said the language says "physician or nurse," and the department thinks that it may be more appropriate to say, "the appropriate health care practitioner" since often it could be chiropractor, naturalpath, physical therapist, etc. She referred to page 4, lines 27 through 30, which speaks to revocation of licenses, that after the word "revoke" add "," and add wording for either suspension or placing on probation of the license. She referred to page 5, lines 13 through 15, which says "the department fails to render a

decision on a complaint brought by a patient or provider within ninety days, the patient or provider shall have the right to bring suit in Superior Court to compel the department to take an action specified in this section," and said the department would have to hire an investigator that did nothing but utilization care review. Presently, there are seven investigators for all the license categories. She noted that investigations are not always complete within ninety days. Currently, there would be difficulty in meeting that requirement. Ms. Boudreaux said the department supports the intention to have some measure of control over the utilization review firms, but would request that they be compelled to be more specific in their plan.

CHAIRMAN STURGULEWSKI asked Ms. Boudreaux to submit her concerns in writing.

Number 427

HAWLEY FOUSE, Vice President, AETNA Life Insurance Company, discussed his qualifications as a board certified physician who practices actively in different parts of the country. He said he has been a consultant in cost containment and utilization management for about thirteen years. Mr. Fouse said he joined AETNA in 1987, to direct the activity of the company's physician and dental staff, to oversee the training of nurse reviewers, and to set general clinical policy regarding utilization review programs. He spoke to the goals of clinical utilization review. Utilization review required as much flexibility in its administrative and clinical applications as does the provisions of medical services. Mr. Fouse referred to the utilization review

legislation, if it is necessary at all, requires a balanced cooperation between providers and utilization review companies. That balance is missing in SB 239. The performance of certain types of procedures can vary from region to region within a single state. He asked if practices which are more scientifically sound, efficient, and provides optable outcomes for patients could be identified. There are considerable risks to unnecessary and inappropriate care. There are risks of health care systems causing infections, hemorrhage, adverse medication reactions, etc. More services does not mean quality care. Utilization review asks physicians to carefully examine their practices and to break out of the mold of practicing medicine as to what it does solely to their training and other aspects of their experiences that may have occurred, for example, twenty years prior.

Mr. Fouse said utilization review asks doctors to perform a careful analysis of the standard way they treat patients and it encourages them to consider alternatives which they may not be familiar with, but it may be just as effective in allowing a patient to achieve an optable outcome. He continued to discuss his views and the benefits regarding utilization review. Mr. Fouse said while the legislation requires utilization review licensure, the legislation should also include some protections for utilization review activities performed by licensed utilization review companies such as providers must be available to discuss cases with utilization review agents and provide needed information within reasonable periods of time upon initial contact by the utilization agent. He said he believes SB 239 moves in the opposite direction. Providers should ensure that whenever they go on vacation or off duty, they have other knowledgeable physicians who will cooperate with the utilization review process.

Mr. Fouse said hospitals and other inpatient facilities need to allow on-site concurrent review by qualified utilization review personnel. For the State of Alaska, on-site review has saved 11.8 percent of medical submitted expenses from December, 1988, through November, 1990.

Another concern, Mr. Fouse continued, is that providing false or misleading information to a utilization review agent should be defined as fraudulent, in appropriate Alaska statutes, with the same penalties as any other prosecution for fraud. He indicated he would submit a written statement to elaborate on his testimony.

CHAIRMAN STURGULEWSKI announced the legislation would be scheduled again at a later date.

SB

242

FISCAL NOTE

STATE OF ALASKA
1991 LEGISLATIVE SESSION

BILL NO. SB 242

Revision Date: 4/5/91
Department Affected: Commerce & Economic Dev.
Title: An Act relating to health insurance for small employers
BRU: Insurance
Component: Operations
Sponsor: Senator Collins
Requestor: Senator Collins
COMPONENT SERIAL NO. 0354

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY 92	FY 93	FY 94	FY 95	FY 96	FY 97
PERSONAL SERVICES	0					
TRAVEL	6.0	1.5	1.5	1.5	1.5	1.5
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	6.0	1.5	1.5	1.5	1.5	1.5
CAPITAL						
REVENUE						

FUNDING: (Thousands of Dollars)

GENERAL FUND						
FEDERAL FUNDS						
OTHER						
TOTAL						

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

Estimate of current year impact:

ANALYSIS: (Attach a separate page if necessary.)

In the first year, a substantial number of meetings with industry will be required to assure that the operations of the association are satisfactorily established. Eight meetings are anticipated in the first year and two per year thereafter.

Prepared By: Donald P. Koch, Chief of Market Surveillance Phone: 465-2577
Division: Insurance Date: 4/18/91
Approved by Commissioner: Glenn A. Olds Asst. Comm.
Agency: Department of Commerce & Economic Development Date: 4-18-91

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

FISCAL NOTE

Bill Version: SB 242

(S) Publish Date: 4/19/91

STATE OF ALASKA
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Alaska State Legislature

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Senator Virginia Collins

MEMORANDUM

TO: Senator Arliss Sturgulewski, Chair
Senate Health & Social Services Committee

FROM: Senator Virginia Collins VC

DATE: September 10, 1991

RE: September 17th committee hearing

My office was informed last week that a hearing on SB 242 had been set for the 17th.

Since I am scheduled to meet with a number of people from HIAA in Chicago on the 23rd through the 25th of September and intend to discuss SB 242 and health care issues, it occurred to me that the bill should be heard in your committee after I have had this meeting.

I respectfully request that SB 242 be postponed until a later date during the interim.

Please call me at 561-2040 if you have any questions.

SENATE BILL 242

"An Act relating to health insurance for small employers; and providing for an effective date."

CONTENTS

Alaska State Legislature

SENATE

Official Business

SENATOR VIRGINIA COLLINS

P.O. Box V
State Capitol
Juneau, Alaska 99811

SPONSOR STATEMENT

Senate Bill 242

Senate Bill 242, "An Act relating to health insurance for small employers; and providing for an effective date."

As the cost of health care has increased, an unacceptable number of Alaska residents are currently without appropriate health care coverage. Small employers find it very difficult to obtain affordable coverage, if any coverage at all. Over 90% of the businesses in Alaska are considered small businesses, having 25 or fewer employees.

The Health Insurance Association of America, an association of 300 private health insurance companies providing insurance for 95 million Americans, developed a model bill to address the issue of small employer health insurance coverage. Senate Bill 242 is HIAA's model bill.

The focus of the bill is to make certain changes in the small employer insurance market to provide more accessibility, renewability, predictability, and stability for the small employer who has 3 to 25 employees.

This bill creates the Small Employer Health Reinsurance Association, a private nonprofit legal entity. All insurers in the small employer insurance market make up the membership. The Association allows insurers to treat all individuals in a group the same way. High risks are spread broadly through the market rather than concentrated in one small employer group. Managed care and other cost containment provisions may be incorporated into the small employer health plans. Once someone with a preexisting condition satisfies the preexisting condition restriction, he or she is not required to satisfy requirements again when changing jobs or when the employer changes insurers. Premium costs are capped and reinsurance association loss assessments are capped.

The Small Employer Health Reinsurance Association is a self-supported association. The only cost to the State is for travel by the Director of the Division of Insurance. That cost is minimal.

Your support and co-sponsorship of Senate Bill 242 would be appreciated.

LIST OF BILL SECTION HEADINGS

SB 242

DIVISION OF LEGAL SERVICES

LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

P.O. Box Y, Juneau, Alaska 99811
(907) 465-3867 or 465-2450
FAX (907) 465-2029

Deliveries to: 240 Main Street
Court Plaza, Room 500
Mail Stop 3101

MEMORANDUM April 12, 1991

SUBJECT: Small employer health insurance - (SB 242)

TO: Senator Virginia Collins

FROM: Michael F. Ford
Legislative Counsel

The following is a section by section analysis of SB 242:

Section 1 - Findings.

Section 2 -

Sec. 21.55.010 - Establishes the Small Employer Health Reinsurance Association and requires certain insurers to be members.

Sec. 21.55.020 - Establishes the board of directors of the association and provides for specific board representation and organization.

Sec. 21.55.030 - Establishes the general powers of the association.

Sec. 21.55.040 - Requires the association to submit a plan of operation to the director of the division of insurance. Allows the director to adopt regulations to implement AS 21.55 if the association fails to submit a suitable plan of operation. Requires members to comply with the plan and establishes specific components of the plan.

Sec. 21.55.050 - Establishes specific provisions that apply to reinsurance provided by a member to employees or dependents of employees of a small employer. Imposes certain restrictions on reinsurance of group plans other than small employer health benefit plans and establishes limits for premiums charged for reinsured coverage and for coverage provided by a health maintenance organization. Provides for member assessments, by the administering insurer.

Sec. 21.55.060 - Exempts the association from the Administrative Procedure Act.

Sec. 21.55.070 - Exempts the association from payment of taxes, except for real or personal property taxes.

Sec. 21.55.080 - Provides immunity from civil actions filed against a member of the association for a negligent act on behalf of the association.

Sec. 21.55.100 - Establishes when an individual or group health benefit plan is subject to AS 21.55 and provides that other laws requiring coverage, reimbursement, utilization, or consideration of a specific health care provider do not apply to a health benefit plan provided to a small employer. Exempts a health benefit plan offered to a small employer from certain restrictions contained in other laws.

Sec. 21.55.110 - Establishes underwriting and rating requirements applicable to health benefits plans covering small employers.

Sec. 21.55.120 - Requires a guaranteed issue insurer to offer at least one small employer health benefit plan and that the plan provide certain coverage. Allows a guaranteed issue insurer to reinsure, make special premium arrangements, or appeal unfair administrative or credit risk.

Sec. 21.55.130 - Requires the board to design small employer health benefit plans that are eligible for reinsurance by the association, including the form and level of coverage. Provides that a plan may include certain cost containment features. Requires the plan be submitted to the director of the division of insurance for approval.

Sec. 21.55.140 - Establishes certain conditions that must be met before an insurer or welfare arrangement may cease doing business in the small employer market.

Sec. 21.55.250 - Definitions.

Section 3 - Provides that a health maintenance organization is subject to the small employer health insurance provisions contained in AS 21.55.

Section 4 - Provides that a hospital or medical service corporation is subject to the small employer health insurance provisions contained in AS 21.55.

Section 5 - Transition section.

Section 6 - Effective date.

MFF:plm
91-250.plm

SENATE HEALTH, EDUCATION, AND SOCIAL SERVICES
COMMITTEE
NOTES AND QUESTIONS TO SB 242
16 September 1991

*1 - See attached definition.

*2 - Does the legislature wish, as a matter of public policy, to allow the association to design health coverage products or does the Legislature wish to examine models that set out basic health care plans and incorporate them into the bill. (i.e., the National Association of Insurance Commissioners will be making public a model bill in December)

*3 - The director of the division of insurance is required to approve the plan of operation for the Association. However, if the Association does not submit a plan, the director is required to adopt regulations governing the operation of the association.

Should the director be required to take action that the Association fails to take?

While the association is made exempt from the Administrative Procedures Act, the director of the division of insurance is not, therefore regulations that the director is required to adopt under this section still must go through the administrative process.

If the director adopts regulations, then the association can modify them by submitting a new plan to the director. That new plan must then be approved by the director again. Should it be made clear in the legislation than action taken by the director as regards the association is subject to the APA, even though the bill exempts the association itself from the APA.

*4. Should the director be an arbiter for the association? The bill provides that a member may appeal to the director from association action or decision.

*5. Is there an industry standard for poor credit risks? What does this mean?

*6. Under what circumstances does the bill envision a guaranteed issue insurer would not be required to write business received from a particular agency or broker?

*7. What kind of plan does the bill envision being reinsured here.?

*8. Should the legislature, as a matter of public policy, enumerate a standard of cost-containment beyond which the association may not go. i.e., can the association limit choice of physicians?

*9. , *10,*11 - see footnote #5 in sectional analysis.

*12. Should the bill cap the amount of the deductible or should be board be able to change the amount? Does this section authorize the board to change the amount of the deductible without going through the director?

*13. Are the premium rates in this section the rates charged by the reinsurance association to the insurer or the rates charged by the insurer to the employer?

*14. Who is responsible for paying for the program if the costs exceed the four percent assessments to the members? NOTE: Connecticut adopted a five percent assessment as well as a provision for an additional assessment if the five percent is insufficient.

*15. Should the director, rather than the board, be allowed to grant deferments. Does this create liability on the part of the state to make up the difference if the insurer doesn't pay?

*16. Does the Legislature wish to use this standard of proof for exempting from liability for acts or omissions on the part of a member of the association?

*17. Does the Legislature intend to exempt current statutory requirements for services and payments to providers from this bill? See Footnote 7.

*18. Does the Legislature wish to give the Association the

authority to limit access to providers by insured?

*19 The effect of this section may be to prevent persons from seeking medical care in the six months prior to being covered.

*20. Should pregnancies be exempt from coverage? A consensus of public policy is that pregnant women who receive medical care during pregnancy have healthier babies for a much lower long-term cost of care.

*21. This subsection does not make it clear if a plan may be changed at any time or only upon renewal.

* 22. An example of possible premium spread among individuals with similar case characteristics under this bill is as follows:

Allowable variation in monthly premium based on industry classification (15 percent variation) - low, $127.50; midpoint $150.00; high $172.50. Highest possible premium (35 percent above high risk business group midpoint) - $232.87. Lowest possible premium (35 percent below low risk business group midpoint) - $82.87. Spread between lowest premium and highest premium among individuals with similar case characteristics - 280 percent. (From National Academy for State Health Policy Access and the Uninsured: A guide for the States)