MICROFILM DIVIDER

OMB/RECORDS MANAGEMENT DIVISION
SFN 2053 (2/85) 5M

ROLL NUMBER

DESCRIPTION

2282

2005 SENATE INDUSTRY, BUSINESS AND LABOR

SB 2282

2005 SENATE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. SB 2282

Senate Industry, Business and Labor Committee

☐ Conference Committee

Hearing Date 1-25-05

Tape Number	Side A	Side B	Meter #
1		xx	4200-end
2	xx		96-2811
Committee Clerk Signature	Jo Ann VanBerkom		

Minutes: **Chairman Mutch opened the hearing on SB 2282. All Senators were present.**

SB 2282 relates to minimum standards of utilization review agents and Workforce, Safety and Insurance procedures for dispute resolution; and to provide an effective date.

Senator Brown introduced the bill.

Senator Brown: This bill deals with utilization review and other issues by the North Dakota Health Care Associations. I will now turn this over to Chip Thomas.

Arnold Thomas, President of the North Dakota Healthcare Association, spoke in support of the bill. See attached testimony.

Senator Espegard: Is there still a process where the hospital would have to call the payor to get approval to do these extra services?

Arnold: It depends on what the provisions are from the payor, with respect to prior approvals.

Senator Nething: We are talking here about a determination in so far as health care treatment is concerned. Insurance Commissioner deals primarily with business decisions. I realize the

relationship after the health decision is made. Wouldn't we be better off to change this bill to have it go into the health department, than into the insurance department where we have a medical director in charge?

Arnold: The dominant entity with which we are familiar in terms of addressing this issue is Medicare. Currently, if we have a dispute regarding a payment under the Medicare program, we appeal to an external entity which happens to be in Minot, ND. They convene a variety of reviewers to look at all of the issues that are in dispute.

Senator Nething : Is the Insurance Commissioner in charge of that review program?

Arnold: No, that is set up by the Federal Government.

Bruce Levi, Representative of the North Dakota Medical Association, spoke in support of the bill. See written testimony.

Senator Nething : Of these other forty two states that you have listed here, what is the focal point of authority in those states? Insurance Commissioner, health department, what is it?

Bruce: There are a variety of focal points. I think in some states they simply require the insurer to develop an external review process. In some states, it's the insurance commissioner. I can get that information for you.

Senator Nething : I think that information would be important if we are going to be going ahead with this.

Tim Wahlin, staff counsel for Workforce Safety and Insurance, proposed amendments to the bill. See attached testimony.

Senator Heitkamp : Did you talk to the sponsor of this bill about the amendments?

Tim: Yes, we have.

Senator Klein : So you have your own review group who resolves those issues?

Tim: That's exactly it.

Chairman Mutch allowed opposition to be heard.

David Zentner, Director of Medical Services for the Department of Human Services, spoke in opposition to the bill. See attached testimony.

Dan Ulmer, Blue Cross Blue Shield, spoke in opposition. See attached testimony.

Bob Stroup, legal counsel for Blue Cross Blue Shield, spoke in opposition to the bill. See attached testimony.

Senator Nething : Did I hear you right, that of those places where an external review occurs, about fifty percent of them are overturned?

Bob: Yes.

Senator Krebsbach: You said that you are in the process of setting up an external review?

Bob: We gave assurances to the North Dakota HealthCare Association that we would review it and visit with them through 2005. That is what was presented to me by Tim Huckelman.

Senator Krebsbach: How would you perceive that as being different from what is being asked of this bill, for example in your cost areas?

Bob: I don't know that it would have an effect on the cost area. Those issues would remain the same.

Chairman Mutch : For instance, in this case, a person is disputing thirty one thousand dollar hospital bill. If you were to go to this review board, and protest, if you were not satisfied with the result of that, then you could go to court?

Bob: Yes, you would.

Mike Fix, Director of Life and Health Division and Actuary for the State Insurance Dept., spoke from a neutral standpoint on the bill.

Mike: SB 2282 does provide for the Insurance Commissioner to do some things if the bill is passed and Commissioner Poolman said that we are in a position to do those things, should the bill pass.

The hearing was closed. No action was taken.

2005 SENATE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. SB 2282

Senate Industry, Business and Labor Committee

❑ Conference Committee

Hearing Date February 15, 2005

Tape Number	Side A	Side B	Meter #
1		X	4,033-END
2	X		1-1071

Committee Clerk Signature Lisa VanBerkom

Minutes: **Chairman Mutch opened the committee meeting to discuss SB 2282, all Senators were present. Senator Nething presented written testimony that was submitted by Dennis Elbert. See attached.**

Senator Krebsbach explained the amendments to the bill. The providers are telling us there has been a problem for quite some time with the costs. The amendment would help establish an independent external review mechanism on whether the care was necessary and appropriate. The original bill was a lot more complicated, and this one removes the insurance commissioner's role completely in this situation.

Senator Nething- How can the Blue Cross Blue Shield Board (BC/BS) establish an independent external review without it coming under their own review?

Senator Krebsbach- This is giving them the authority to establish this independent review on how their board sees fit. Their board would be involved in the establishment of the board and take into consideration the concern of all parties involved.

Senator Espegaard- The insured person needs to have an understanding on what they will be billed for, it needs to be clear-cut, and not so complicated.

Senator Krebsbach- This has been an ongoing problem for a long time, 42 other states have established a mechanism to take this off the table. The amendment needs a lot of work, I would recommend it goes to the House for their consideration.

Arnold Thomas, representing the North Dakota Health Care Association - There is no timeline in the amendment and no penalty for failure to implement. It would achieve an objective of a place of neutrality.

Senator Espegaard- I have received notice from Board members that have indicated they never had the issue come before them.

Arnold- We meet with the board annually and describe what is going on in health care. We left the recommendations with them for their consideration. We presented positive suggestions to the plan, and to the providers who work with them.

Senator Klein- Do you think we have given this enough time for the board to take action? Its quite a bit of information to sort through.

Arnold- There were 7 recommendations that concluded the presentation to the board, based on our perception of the state of medical care. We have had various discussions on the plan in different levels of the organization. On this set of circumstances, utilization review and final determination of medical judgement, we haven't been able to reach an agreement.

Senator Nething- I don't know what the expectation is when it comes to immediate action from the board?

Arnold- The bill that was brought to my attention was broader than the private sector. The bill would have all claims go under an independent review. This bill was brought forth on how do we have an independent external appeal that works for all payers.

Dan Ullmer representing Blue Cross Blue Shield appeared before the committee. The hoghouse amendment singles out Blue Cross. One of the questions is what independent really means in this situation. He explained what its means to be an independent review for Blue Cross.

Senator Krebsbach- I understand that an independent external review is what they are requesting. What has been done is not working with Blue Cross.

Senator Nething- Perhaps we should study these amendments further.

Action taken:

Senator Kresbach moved a Do Pass recommendation for the amendment (50767.0103). Seconded by Senator Heitkamp. The amendment failed 2-5.

Senator Nething moved to adopt the amendment (50767.0102), which would provide an interim study on the issue. Seconded by Senator Klein. After some discussion, the amendment passed 4-3-0.

Senator Nething moved a Do Pass as amended on SB 2282. Seconded by Senator Klein. The bill as amended passed 4-3-0. Senator Nething is the carrier of the bill.

Date: 2-07-05
Roll Call Vote #: 1

2005 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2282

Senate **Industry, Business, and Labor** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken Adopt Amendments

Motion Made By Heitkamp Seconded By Klein

Senators	Yes	No	Senators	Yes	No
Chairman Mutch	X		**Senator Fairfield**	X	
Senator Klein	X		**Senator Heitkamp**	X	
Senator Krebsbach	X				
Senator Espegard	X				
Senator Nething	X				

Total (Yes) 7 No 0

Absent 0

Floor Assignment —

If the vote is on an amendment, briefly indicate intent:

Date: 2-08-05
Roll Call Vote #: 1 / (2nd Vote) Day 2.

2005 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2282

Senate **Industry, Business, and Labor** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken Do Pass As Amended

Motion Made By Heitkamp Seconded By Krebsbach

Senators	Yes	No	Senators	Yes	No
Chairman Mutch	X	X	**Senator Fairfield**	A	
Senator Klein		X	**Senator Heitkamp**	X	
Senator Krebsbach	X				
Senator Espegard		X			
Senator Nething		X			

Total (Yes) 2 No 4

Absent 1

Floor Assignment motion fails

If the vote is on an amendment, briefly indicate intent:

Date: 2-08-05
Roll Call Vote #: 2

2005 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2282

Senate **Industry, Business, and Labor** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken No recomendation

Motion Made By Krebsbach Seconded By Heitkamp

Senators	Yes	No	Senators	Yes	No
Chairman Mutch		X	**Senator Fairfield**	A	
Senator Klein	X		**Senator Heitkamp**	X	
Senator Krebsbach	X				
Senator Espegard	X				
Senator Nething	X				

Total (Yes) 5 No 1

Absent 1

Floor Assignment Heitkamp

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

SB 2282: Industry, Business and Labor Committee (Sen. Mutch, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **BE PLACED ON THE CALENDAR WITHOUT RECOMMENDATION** (5 YEAS, 1 NAY, 1 ABSENT AND NOT VOTING). SB 2282 was placed on the Sixth order on the calendar.

Page 1, line 3, replace the first comma with "and" and remove ", and 65-02-20"

Page 1, line 4, remove "and workforce"

Page 1, line 5, remove "safety and insurance procedures for dispute resolution"

Page 5, line 7, remove "<u>, including review of dispute resolution</u>"

Page 5, remove lines 8 through 10

Page 5, line 11, remove "<u>assistance program</u>"

Page 5, line 16, after "<u>medicare</u>" insert "<u>, medicaid,</u>"

Page 5, line 17, after the second underscored comma insert "<u>workers' compensation coverage,</u>"

Page 7, remove lines 12 through 31

Page 8, remove lines 1 through 8

Renumber accordingly

Date: 2-14-05
Roll Call Vote #: 1

2005 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2282

Senate **Industry, Business, and Labor** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken reconsider Action

Motion Made By Voice Vote Seconded By _____

Senators	Yes	No	Senators	Yes	No
Chairman Mutch	A		**Senator Fairfield**		
Senator Klein			**Senator Heitkamp**		
Senator Krebsbach					
Senator Espegard					
Senator Nething					

Total (Yes) _____ No _____

Absent Motion Carried

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: 2-15-05
Roll Call Vote #: 1

2005 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2282

Senate **Industry, Business, and Labor** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken 50767.0103 Adopt Amendments

Motion Made By Krebsbach Seconded By Heitkamp

Senators	Yes	No	Senators	Yes	No
Chairman Mutch		X	**Senator Fairfield**		X
Senator Klein		X	**Senator Heitkamp**	X	
Senator Krebsbach	X				
Senator Espegard		X			
Senator Nething		X			

Total (Yes) 2 No 5

Absent 0

Floor Assignment Motion Fails

If the vote is on an amendment, briefly indicate intent:

50767.0102
Title. 0200

Prepared by the Legislative Council staff for
Senator Nething
February 11, 2005

PROPOSED AMENDMENTS TO SENATE BILL NO. 2282

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to provide for a legislative council study of issues relating to health insurance external review processes for health insurance beneficiaries and for medical providers.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. LEGISLATIVE COUNCIL STUDY - HEALTH INSURANCE EXTERNAL REVIEW PROCESSES. The legislative council shall consider studying during the 2005-06 interim issues relating to health insurance external review processes for health insurance beneficiaries and for medical providers. The study must include consideration of external review issues involving the review of a claim that involves reimbursement levels, veracity of documentation, accuracy of coding, and adjudication for payment. The legislative council shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the sixtieth legislative assembly."

Renumber accordingly

Date: 2-15-05
Roll Call Vote #: 2

2005 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2282

Senate **Industry, Business, and Labor** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken 50767.0102 Adopt (Nething's)

Motion Made By Nething Seconded By Klein

Senators	Yes	No	Senators	Yes	No
Chairman Mutch		X	**Senator Fairfield**	X	
Senator Klein	X		**Senator Heitkamp**		X
Senator Krebsbach		X			
Senator Espegard	X				
Senator Nething	X				

Total (Yes) 4 No 3

Absent 0

Floor Assignment

If the vote is on an amendment, briefly indicate intent:

Date: 2-15-05
Roll Call Vote #: 3

2005 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2282

Senate **Industry, Business, and Labor** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken DPAM

Motion Made By Nething Seconded By Klein

Senators	Yes	No	Senators	Yes	No
Chairman Mutch		X	**Senator Fairfield**	X	
Senator Klein	X		**Senator Heitkamp**		X
Senator Krebsbach		X			
Senator Espegard	X				
Senator Nething	X				

Total (Yes) 4 No 3

Absent 0

Floor Assignment Nething

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

SB 2282: Industry, Business and Labor Committee (Sen. Mutch, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (4 YEAS, 3 NAYS, 0 ABSENT AND NOT VOTING). SB 2282 was placed on the Sixth order on the calendar.

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to provide for a legislative council study of issues relating to health insurance external review processes for health insurance beneficiaries and for medical providers.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. LEGISLATIVE COUNCIL STUDY - HEALTH INSURANCE EXTERNAL REVIEW PROCESSES. The legislative council shall consider studying during the 2005-06 interim issues relating to health insurance external review processes for health insurance beneficiaries and for medical providers. The study must include consideration of external review issues involving the review of a claim that involves reimbursement levels, veracity of documentation, accuracy of coding, and adjudication for payment. The legislative council shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the sixtieth legislative assembly."

Renumber accordingly

2005 HOUSE INDUSTRY, BUSINESS AND LABOR

SB 2282

2005 HOUSE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. SB 2282

House Industry, Business and Labor Committee

☐ Conference Committee

Hearing Date 3-9-05

Tape Number	Side A	Side B	Meter #
1	x		26-end
Committee Clerk Signature			

Minutes:

Chairman Keiser: Opened the hearing on SB 2282

Arnold Thomas, President of the North Dakota Healthcare Association: Appeared in support of SB 2282 and provided a written statement **(SEE ATTACHED TESTIMONY).** The committee needs to understand here, the internal mechanism that all carriers employ, works well, we do not dispute that matter of fact we support it, most of the claims disagreement are handled through that mechanism, the ones we are talking about really get down to key differences in medical judgement and then what does that mean.

Representative Amerman: Who would be this external review?

Arnold Thomas: There are a number of entities across the country, that engage in just this function, in North Dakota we have one in Minot who's primary contract is with the Federal Government.

Dan Ulmer, Blue Cross Blue Shield: I haven another amendment that addresses to Kasper's question, about applying to all companies.

Representative Kasper: How does the insured get notified of this option, if the insured is concerned, that they might like to have some opportunity to speak.

Dan Ulmer: It is in their benefit book, normally they would call and inquire about their claims and then we would guide them though the appeals process.

Bruce Levi, North Dakota Healthcare Association: Appeared in support of the bill and provided a written statement **(SEE ATTACHED TESTIMONY).**

Representative Froseth: I move to **ADOPT** both sets of **AMENDMENTS.**

Representative Ekstrom: I **SECOND** the adoption of both sets of amendments.

Motion carried voice vote.

Representative Ekstrom: I move a **DO PASS** as **AMENDED** on SB 2282.

Representative Vigesaa: I **SECOND** the **DO PASS** as **AMENDED** motion.

Motion carried **VOTE: 11-YES 0-NO 3-ABSENT (Boe, Ruby, Thorpe).**

Representative Kasper will carry the bill on the floor.

50767.0301
Title.

Prepared by the Legislative Council staff for
Representative Keiser
March 8, 2005

PROPOSED AMENDMENTS TO ENGROSSED SENATE BILL NO. 2282

Page 1, line 1, replace "26.1-12" with "26.1-36"

Page 1, line 2, replace "nonprofit mutual insurance company" with "accident and health insurance issuer"

Page 1, line 5, replace "26.1-12" with "26.1-36"

Page 1, line 7, replace "A nonprofit mutual" with "Every" and after "company" insert ", nonprofit health service corporation, and health maintenance organization"

Page 1, line 9, after "rendered" insert "under the line of insurance"

Renumber accordingly

Adopted by the Industry, Business and Labor Committee

March 9, 2005

House Amendments to Engrossed SB 2282 - Industry, Business and Labor Committee 03/09/2005

Page 1, line 1, replace "26.1-12" with "26.1-36"

Page 1, line 2, replace "nonprofit mutual insurance company" with "accident and health insurance issuer"

Page 1, line 5, replace "26.1-12" with "26.1-36"

Page 1, line 7, replace "A nonprofit mutual" with "Every" and after "company" insert ", nonprofit health service corporation, and health maintenance organization"

Page 1, line 9, after "rendered" insert "under the line of insurance"

Page 1, line 10, after the period insert "For purposes of this section, "independent external review" means a review conducted by the North Dakota health care review, inc., another peer review organization meeting the requirements of section 1152 of the Social Security Act, or any person designated by the commissioner to conduct an independent external review. A determination made by the independent external reviewer is binding on the parties. Costs associated with the independent external review are the responsibility of the nonprevailing party."

Renumber accordingly

Date: 3-9-05

Roll Call Vote #: 1

2005 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2282

House **INDUSTRY, BUSINESS AND LABOR** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken Adopt both amendments

Motion Made By Rep. Froseth Seconded By Rep. Ekstrom

Representatives	Yes	No	Representatives	Yes	No
G. Keiser-Chairman			Rep. B. Amerman		
N. Johnson-Vice Chairman			Rep. T. Boe		
Rep. D. Clark			Rep. M. Ekstrom		
Rep. D. Dietrich			Rep. E. Thorpe		
Rep. M. Dosch					
Rep. G. Froseth					
Rep. J. Kasper					
Rep. D. Nottestad					
Rep. D. Ruby					
Rep. D. Vigesaa					

Total (Yes) 11 No 0

Absent (3) Rep. Ruby, Boe, Thorpe

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: 3-9-05

Roll Call Vote #: 2

2005 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO.

House **INDUSTRY, BUSINESS AND LABOR** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number 50767.0302 .0400

Action Taken Do Pass As Amended

Motion Made By Rep. Ekstrom Seconded By Rep. Vigesaa

Representatives	Yes	No	Representatives	Yes	No
G. Keiser-Chairman	X		Rep. B. Amerman	X	
N. Johnson-Vice Chairman	X		Rep. T. Boe	A	
Rep. D. Clark	X		Rep. M. Ekstrom	X	
Rep. D. Dietrich	X		Rep. E. Thorpe	A	
Rep. M. Dosch	X				
Rep. G. Froseth	X				
Rep. J. Kasper	X				
Rep. D. Nottestad	X				
Rep. D. Ruby	A				
Rep. D. Vigesaa	X				

Total (Yes) 11 No 0

Absent 3 Ruby Boe Thorpe

Floor Assignment Rep. Kasper

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

SB 2282, as engrossed: Industry, Business and Labor Committee (Rep. Keiser, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (11 YEAS, 0 NAYS, 3 ABSENT AND NOT VOTING). Engrossed SB 2282 was placed on the Sixth order on the calendar.

Page 1, line 1, replace "26.1-12" with "26.1-36"

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Page 1, line 5, replace "26.1-12" with "26.1-36"

Page 1, line 7, replace "A nonprofit mutual" with "Every" and after "company" insert ", nonprofit health service corporation, and health maintenance organization"

Page 1, line 9, after "rendered" insert "under the line of insurance"

Page 1, line 10, after the period insert "For purposes of this section, "independent external review" means a review conducted by the North Dakota health care review, inc., another peer review organization meeting the requirements of section 1152 of the Social Security Act, or any person designated by the commissioner to conduct an independent external review. A determination made by the independent external reviewer is binding on the parties. Costs associated with the independent external review are the responsibility of the nonprevailing party."

Renumber accordingly

2005 TESTIMONY

SB 2282

NDHA
North Dakota Healthcare Association

Vision
The North Dakota Healthcare Association will take an active leadership role in major healthcare issues.

Mission
The North Dakota Healthcare Association exists to advance the health status of persons served by the membership.

Testimony on SB 2282
Chairman Mutch – Members of the Committee

My name is Arnold R. Thomas. I am President of the North Dakota Healthcare Association. I am appearing in support of SB 2282.

When a hospital provides care to a patient, depending upon the person's health care coverage program, the hospital submits a bill for payment – like Blue Cross in the commercial sector, or Work Force Safety, Human Services or Medicare in the public sector. The payer considers the bill and pays it or denies it. If the payment is denied, the hospital can appeal the denial. With Medicare and Medicaid, the appeal is first handled internally by the payer. If the disagreement is not resolved, the hospital may go to court in the case of Medicaid, or access an external appeal process in the case of Medicare. In all other cases, the appeal is handled by the entity which denied the claim in the first place.

The result is that if the final decision is no, the hospital does not get paid the amount it believes it is owed for the medical services it provided.

SB 2282 creates a new process that we believe is fair. It directs the Insurance Commissioner to establish a procedure to review differences of opinion about what was medically necessary and what should be covered under the provisions of the insurance contract. Medicare has such a system – Work Force Safety is considering such a system. We need a system.

Let me give you an example of what can happen.

John comes into the ER. He is having severe chest pains – with the pain going down his neck and left arm. He is having difficulty breathing and he is placed on a ventilator to help him breathe. A cardiologist takes John to the cardiac cath lab. A temporary pacemaker is inserted to keep John's heart beating. A balloon pump is inserted and the heart catherization is performed to determine blocked arteries. Unfortunately, despite all efforts, John dies.

The hospital sends a bill to John's insurance based on the procedures performed for "Major Cardiovascular Procedures" in the amount of $31,000. The insurance company denies the services as an inpatient claim and pays the claim as an out-patient claim in the amount of $4,400.

The insurance company has made a judgment on what it will pay. The physician has made a judgment on what treatments are necessary to address John's condition. When those judgments are not the same, to whom can we turn for an objective decision?

Similarly, Sue a 12 year old, is admitted with severe abdominal pain. The initial diagnosis is possible appendicitis. Lab work is completed and she is given a CT scan and this test indicates an ovarian cyst. Sue stays in the hospital for two days with IV pain medication and antibiotics. She is discharged and sent home with several more days of antibiotics.

PO Box 7340 Bismarck, ND 58507-7340 Phone 701-224-9732 Fax 701-224-9529

Sue's two day hospital stay is billed to the insurance company for $3,400. The entity responsible for paying for Sue thinks we should have treated her as an outpatient and pays only $849. Again, our medical judgment and that of the payer are at odds.

That's why we need an impartial appeal procedure. That's why we need this bill.

We have faith that the Insurance Commissioner understands the need for an impartial arbiter and that he will create an appeal system that will serve both providers and payers fairly and equitably.

We respectfully request a Do Pass on SB 2282.

NDHA
North Dakota Healthcare Association

Vision
The North Dakota Healthcare Association will take an active leadership role in major healthcare issues.

Mission
The North Dakota Healthcare Association exists to advance the health status of persons served by the membership.

PROPOSED AMENDMENTS TO SENATE BILL NO. 2282

Page 1, line 3, replace the first comma with "and" and remove ", and 65-02-20"

Page 1, line 4, remove "and workforce"

Page 1, line 5, remove "safety and insurance procedures for dispute resolution"

Page 5, line 7, remove "including review of dispute resolution"

Page 5, remove lines 8 through 10

Page 5, line 11, remove "assistance program"

Page 5, line 16, after "medicare" insert ", medicaid,"

Page 5, line 17, after the second underscored comma, insert "workers' compensation"

Page 7, remove lines 12 through 31

Page 8, remove lines 1 through 8

Renumber accordingly

PO Box 7340 Bismarck, ND 58507-7340 Phone 701-224-9732 Fax 701-224-9529

Summary of claims and hospital DRG inpatient claims validation reviews for 2004.

Two of the types of claims reviews that we conduct at BCBSND are: Pre-service inquiries/reviews to assure that our benefits cover the services in a claim and DRG inpatient acute hospital validation reviews that review payments we made on any given claim.

There are different levels of claims/benefit reviews and appeals. The process starts with an inquiry. If the claimant is dissatisfied with that result they can formally appeal and we internally review the claim. If they are still dissatisfied the claim can be reviewed by an appropriate provider outside of BCBSND. As the numbers indicate below most claims are resolved at the inquiry and first appeal levels when additional required information is provided.

In 2004 BCBSND had a total of 493,426 claims for service.

Of those claims
30,231 became pre-service benefit inquiries

Appeals for 2004
307 of those inquiries became internal appeals or about 1% of inquiries
152 internal appeals upheld or 49.5%

Number of appeals sent to external review in 2004
38 external appeals or 1.2%
Of these about 50% were overturned

DRG validation reviews for acute instate/inpatient hospital admission claims that received payment between 3/1/03 to 3/31/04. These reviews focus on the amount billed to us versus amount our contract with providers allows.

Number of claims paid	22,465
Number of claims audited	5,866
Number of claims disagreed with	1,424
Number of appeals on above	151
Number of appeals we agreed	43
Of 108 remaining appeals Number of 2nd level appeals	19
Number of 2nd level appeals we Agreed with provider	5

Thus of 5,866 audited claims we disagreed with the billed/coded amount and adjusted reimbursement or denied payment on 1,424 claims (24%). Of these 1,424 claims 151 were appealed and we agreed to pay 43. Of the remaining 108, 19 went onto a 2nd appeal and we agreed to pay 5 of those as billed.

Therefore of the 5,866 DRG payments reviewed 151 or 2.5% were appealed. Of the 1,424 questioned reimbursements 19 (1%) went onto a second level of appeal and 5 of those were reversed.

I strongly urge you to vote no on SB 2282.

Reasons why this bill needs further review include the following:

CONTRACTUAL This is truly a contractual issue between providers and insurers not a legislative issue. As a consumer member on the Blue Cross Blue Shield board of directors we receive annual briefings from hospital and physician representatives. In the past three years we have never discussed this issue or been asked to review such a proposal. We are more than willing to look at this, please vote no on this bill and give us a chance to review the matter.

COSTS There is a cost for external appeals. Estimates for such a review could run up to $1,000 per appeal. When citizens of North Dakota talk to me or contact me about healthcare issues as their representative on the board, the one common loud theme is the increasing costs of healthcare. SB 2282 would only increase their costs.

STUDY IN PROCESS The staff of BCBS has an agreement as of December 2004 with Altru Health Systems of Grand Forks to study the issue next year. As a former member of the Altru board, I know that the issue will be thoroughly studied and a solid set of recommendations will be forthcoming. It is my understanding that an interim study has been proposed, this I believe would be an excellent option that would be supported.

Dennis J. Elbert
09 Feb 2005

CALIFORNIA HEALTH POLICY ROUNDTABLE

ISSUE BRIEF:

Independent Review of Health Plan Decisions

State Capitol, Room 112 - Sacramento, California

1:00-3:00 p.m. - August 3, 1998

Juliette Cubanski, M.P.P., and Helen H. Schauffler, Ph.D.
University of California, Berkeley, School of Public Health

The Purpose of This Roundtable

- To inform the policy debate in California about the issues, policy options, and public and private sector initiatives in the area of independent review of health plan decisions.

Key Questions to Explore at This Roundtable

- What can California learn from the experiences of other states in establishing an independent review system for appeals of health plan decisions?
- What are the costs and benefits associated with an independent review system?
- What independent review mechanisms are currently available for health plan enrollees in California?
- What are the key elements of proposals to implement an independent review system in California?
- How does the Center for Health Dispute Resolution (CHDR) conduct independent review for Medicare?

About the Roundtable Speakers

Kevin Hanley, Director of the State of California Office of the Insurance Advisor in Sacramento, California, will discuss the position of the Wilson Administration on independent review.

Peter Lee, J.D., Director of Consumer Protection Programs at the Center for Health Care Rights in Los Angeles, California, will address the consumer protection component of independent review.

Karen Pollitz, M.P.P., Project Director at the Institute for Health Care Research and Policy at Georgetown University in Washington, D.C., will discuss the key aspects of existing state independent review programs.

David Richardson, President of the Center for Health Dispute Resolution (CHDR) in Pittsford, New York, will discuss the role CHDR plays in independently reviewing Medicare coverage decisions.

Michael Shapiro, Staff Director for the California State Senate Committee on Insurance in Sacramento, California, will discuss the existing legislative proposals to implement an independent review program in California.

Alan Zwerner, M.D., J.D., Senior Vice President and Chief Medical Officer of Health Net in Woodland Hills, California, will discuss the independent review process available to Health Net members and the view of the HMO industry on pending independent review legislation in California.

What Is Independent Review?

The current regulatory practice of most states in overseeing the health insurance industry is to require health plans to establish an internal process for the resolution of consumer complaints—be they disputes over coverage, contracts, or denials of service. Consumers in most states can appeal to the appropriate state regulatory agency for external review of health plan decisions, but this process may be informal and consumers may be unaware of their appeal rights.

Currently, there are no formal standards at the federal level or in California for the independent review of health plan decisions for enrollees who have exhausted a health plan's internal appeals process and are dissatisfied with the resolution of their grievances. Independent reviews are conducted by agencies and/or individuals that have no financial or professional affiliation with health plans and no financial or professional interest in the outcome.

Independent review of health plan decisions is one component of several health care consumer protection proposals. Both the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry and the California Managed Health Care Improvement Task Force recommended an independent system of external review of health plan decisions. Independent review is also one component of pending managed care reform proposals in Congress and the subject of California legislation.

Proponents of independent review suggest that establishing a process for independent review of health plan decisions would enhance consumer confidence in health plan decision-making, verify the accuracy of utilization reviews, and ensure that health plans are held accountable for their decisions. However, opponents of independent review suggest an independent review system would impose an administrative burden on health plans, lead to overutilization of health care services and the delivery of inappropriate care, and raise legal liability issues for health plans and independent review entities.

How Will Independent Review Affect Health Plan Premiums?

Price Waterhouse conducted an analysis, prepared for the Kaiser Family Foundation, of the benefits and costs of selected provisions of the California Managed Health Care Improvement Task Force recommendations, including the recommendation for independent review. This analysis indicated that if California established an independent review process through which consumers could appeal certain health plan coverage decisions, the estimated direct cost impact would be an increase of three cents per enrollee per month, or an increase in premiums of .03 percent.

In a separate study commissioned by the Kaiser Family Foundation, Coopers & Lybrand conducted a cost analysis of the President's Consumer Bill of Rights and the Congressional Patient Access to Responsible Care Act (PARCA).

Both proposals include provisions to allow enrollees to request an independent review of health plan service requests and utilization decisions. This analysis estimated the independent review provision would increase premiums by 2 to 16 cents per enrollee per month, or by 0.02 to 0.13 percent.

The Congressional Budget Office (CBO) prepared a cost estimate of H.R. 3605/S. 1890, the federal Patients' Bill of Rights Act of 1998. According to the CBO analysis, establishing a grievance process, including internal and external appeals of adverse determinations, would increase premiums by 0.3 percent in the 10 years following enactment of the bill.

If utilization of health care services increases as the result of independent review, premiums could increase more than these analyses reported.

What Is the Structure of Independent Review Systems in Other States?

Seventeen states have established an independent review system for enrollee appeals of health plan decisions. Key features of these systems include:

- **What parties are eligible to request an independent review?** In five states, only enrollees are eligible to appeal health plan decisions; in 12 others, an enrollee can designate a representative and/or a physician to act on his or her behalf.
- **What health plan decisions qualify for independent review?** Thirteen states allow only denials based on the medical necessity or appropriateness of a health care service to be eligible for independent review. Four states also allow enrollees to request independent review of coverage or contract disputes.
- **What entities conduct independent reviews?** Independent reviews are conducted by state insurance regulatory agencies in six states, but are more often conducted by independent review organizations (IROs) and/or by appropriately licensed or registered health care professionals (usually physicians and nurses) certified by a state to conduct reviews.
- **What entities select or contract with IROs?** In nine states, the state health insurance regulatory agency is responsible for contracting with IROs. Health plans contract with IROs in four states, and only one state allows the enrollee to choose the reviewing entity.
- **Who pays for independent reviews?** In 12 states, health plans pay most or all of the cost of reviews, either on a direct, per-review basis or indirectly through licensing fees. In six states, enrollees pay a filing fee ranging from $25 to $100. In one state, enrollees evenly share the cost with health plans.
- **What is the time allowed for the normal and expedited independent review process?** The normal independent review process ranges from 10 to 120 days, and the expedited independent review process (when the enrollee's life or health would be jeopardized) ranges from 24 hours to 45 days.
- **Are the decisions of the independent review entities binding on health plans and enrollees?** In 14 states, the decision of the independent reviewer is binding. In three states, either party can appeal the independent review decision at the judicial level.

What Independent Review Process Is Currently Available in California?

There is currently no formal process through which all insured people in California can request independent review of health plan decisions. Under the Knox-Keene Act, the California Department of Corporations (DOC) is responsible for providing an informal review process through which enrollees can file complaints against HMOs relating to grievances filed or pending with, or resolved by, HMOs.

The Friedman-Knowles Experimental Treatment Act (AB 1663 of 1996), effective July 1, 1998, allows HMO and disability insurer enrollees who have terminal conditions to request independent review of decisions to deny experimental or investigational treatment. The state has contracted with an accrediting entity that will contract with IROs to conduct these reviews.

What Are California's Proposals to Implement an Independent Review Program?

AB 1667 (Migden), SB 1504 (Rosenthal), and SB 1653 (Johnston) are the three legislative vehicles in California that would establish an independent review process for enrollees of HMOs and disability insurers.

These bills would require every HMO and disability insurer in California to provide an enrollee or insured with the opportunity to seek an independent medical review whenever health care services have been denied, significantly delayed, terminated, or otherwise limited by the plan or insurer. These bills would also require the state DOC and Department of Insurance to contract with one or more IROs to conduct independent reviews, and with a private, nonprofit organization to accredit IROs.

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Office of Policy and Representation:

State Action Kits

Health Plans Liability and State External Grievance Review (Revised 1998 Edition)

ANNOTATED BIBLIOGRAPHY ON HEALTH PLAN EXTERNAL GRIEVANCE REVIEW

"Estimated Costs of Selected Consumer Protection Proposals," prepared by Coopers & Lybrand for the Kaiser Family Foundation, April 1998

- This study estimates the projected cost impact of two leading consumer protection proposals pending in Congress: the President's Advisory Commission's Consumer Bill of Rights and the Patient Access to Responsible Care Act (PARCA). The two proposals include provisions to allow health plan enrollees to ask for an independent third party review of health plan service requests and utilization decisions. The study estimates that the cost of this provision would be $1.20 per person annually under each of the proposals.

"Key Features of State and Medicare Programs for External Review of Health Plan Decisions," prepared by the Institute for Health Care Research and Policy of Georgetown University for the Kaiser Family Foundation, forthcoming 1998

- The authors interviewed a number of state regulators, medical reviewers, and industry and consumer representatives about the status of state mandated external review programs. Comments were solicited on the experience of the programs to date (e.g., volume of appeals, nature of decision, costs of review). Respondents were also asked their views on whether mandatory external review is sound public policy. Due to the limited number of interviews conducted and the newness of many of the programs, this study offers only a brief and inconclusive profile of state external review programs.

Kilborn, "Complaints About HMOs Rise as Awareness Grows," in The New York Times, October 11, 1998

- State regulators are reporting surging numbers of formal complaints from patients and providers against managed care plans. However, state officials doubt that the rise implies a deterioration in care. They attribute much of it to greater public readiness to combat HMOs and to insurance commissioners' efforts to encourage people to file complaints. In Minnesota, where managed care is well established over time, complaints have dropped. Apparently, the more accustomed enrollees are to HMOs, the higher their satisfaction levels.

Pear, "White House Seeks to Block Care Ruling," in The New York Times, October 13, 1998

- The Clinton Administration is asking a full appeals court to overturn an August ruling that gave new rights and consumer protections to six million Medicare beneficiaries in HMOs. HHS said that it should not be held accountable for the actions of HMOs that sign contracts with Medicare. The agency complained that the ruling would provide Medicare patients with "the full panoply of hearing and appeal rights for even minor disagreements over reductions or changes in medical treatment."

Resolving Health Insurance Disputes, prepared by the National Association of Insurance Commissioners, September 1998

- This consumer action kit is a basic, practical guide on: (1) factors to consider before buying health insurance; (2) questions to ask when shopping for health care; and (3) how to make a health insurance claim and challenge a denial. The NAIC estimates that consumers will make more than 35,000 complaints during 1998 to state insurance departments about their health plans. The most frequently made complaints are those concerning claim denials, disputed claims, the speed of payments, and premium-related matters. (The action kit is available on the internet at www.naic.org.)

"What is Good for the Goose is Good for the Gander: ERISA, FEHBA and Medicare Claims Denial and Appeals Procedures and Remedies," by APPWP- The Benefits Association, June 1998

- This study concludes that ERISA is equal or superior to either Medicare or FEHBA with respect to the plan participant protections it affords. It compares and contrasts the appeals systems and available remedies in terms of timeliness, fairness, administrability and fiduciary responsibility.

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FACTS & FIGURES

American Association of HEALTH PLANS

POLICY & IMPLICATIONS

INDEPENDENT MEDICAL REVIEW OF HEALTH PLAN COVERAGE DECISIONS: EMPOWERING CONSUMERS WITH SOLUTIONS

INDEPENDENT REVIEW: A REAL SOLUTION

As special interests continue their campaign to encourage new lawsuits against health plans, a practical solution has emerged in 39 states and the District of Columbia and has proven successful: independent medical review of health plan coverage decisions.

By the end of 2000, a majority of the states[1] had adopted policies giving health plan enrollees a right to appeal plan determinations involving a denial of coverage to an independent medical review entity, such as a private organization approved by the state. Although there is significant variation among the states in the details of these laws, independent review mechanisms usually apply to coverage denials made on the basis of medical necessity criteria or a determination that the service is experimental or investigational.[2] In general, appeal mechanisms apply to a broad range of health plan types, including health maintenence organizations (HMOs) and preferred provider organizations (PPOs).[3]

STATE DATA REVEAL LOW APPEAL RATE AND EVEN SPLIT ON REVIEW DECISIONS FOR HEALTH PLANS AND ENROLLEES

The American Association of Health Plans (AAHP) analyzed publicly available independent medical review appeals and decision data from the 39 states and D.C. with laws: As of September 30, 2000, 16 of these states had data on case volume and decisions and 11 had data on appeals filed (see "Study Criteria and Metholdology" p. 3).

Two key findings were made. First, the study shows that the appeal rate was about 1.0 appeal per 14,000 enrollees. Second, the data reveal an almost even 50/50 split of independent reviews made in favor of either the health plan or

FACTS SNAPSHOT

Independent Review and Health Plan Enrollees

In 2000:

- 39 states and D.C. had independent medical review laws that applied to HMOs, PPOs, and other insurers.

Of state reporting data:

- One appeal was filed for every 14,000 enrollees.
- 51% of cases decided by independent review upheld the health plan decision.

In 1999 and 2000:

- Appeal rates were the same (0.7 per 10,000) and uphold rates were very similar (55% and 51%).

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the plan enrollee. These findings indicate that independent medical review programs are working for consumers.

A detailed analysis of the two states that had data broken down by type of insurer, and had the highest number of decided cases, shows that the "uphold" rate (percentage of cases decided by independent review where the insurer's decision was upheld) did not vary significantly by type of insurer (i.e. HMO, indemnity, other).

Independent review case volume increased in 2000, due primarily from newly established programs, longer reporting periods, and program expansions.

These independent review results for 2000 mirror results reported in an AAHP study conducted in 1999, when fewer states had review programs in operation.[4] In both years, the appeal rate was less than 1.0 per 10,000 enrollees and about 50% of decisions upheld the health plan. Reflecting the increase in the number of states with programs in 2000, longer reporting periods for some states, and changes that broadened the scope of claims eligible for review in one state, 2,567 appeals were accepted for full review in 2000, whereas 1,044 were accepted in 1999.

Highlights of Key Findings and Trends

Case Volume

In 2000, a total of 2,567 cases were accepted for full review in the 16 states reporting data and meeting this study's criteria for inclusion in the results; in 1999, 1,044 cases were accepted in 13 states.[5] (See "Study Criteria and Methodology" on page 3.) Several factors contributed to growth from 1999 to 2000:

- Most significantly, the initiation of three new state programs, in Georgia, New York, and Tennessee, accounted for almost 70% of the increase in the total number of cases accepted for full review in 2000.
- Additionally, longer data reporting periods in Florida and Pennsylvania and a new law broadening the scope of the review program in California added to the number of reported cases.

Appeal Rates

In 2000, the aggregate appeal rate was 0.7 appeals per 10,000 enrollees, or one case for every 14,000 enrollees, for the 11 states reporting data and meeting the study's criteria.[6] (See "Study Criteria and Methodology" on page 3.) This rate is the same as the previous year's, when the aggregate appeal rate was 0.7 appeals per 10,000 enrollees, for the seven states reporting data.[7]

In 2000, the aggregate appeal rate was 0.7 appeals per 10,000 enrollees, or one case for every 14,000 enrollees; the same rate was recorded in 1999.

Comparing 1999 and 2000 Findings. Of the 11 states studied in 2000, six (AZ, FL, MD, MO, NJ, TX) had data for both studies;[8] several findings are significant:

- In five states (FL, MD, MO, NJ, TX), appeal rates were under 1.0 per 10,000 in both years.
- In Arizona, the appeal rate increased slightly from 1.1 per 10,000 in 1999 to 1.4 in 2000.
- For the six states, the aggregate appeal rate was the same in both years — 0.7 per 10,000 enrollees, or about 1.0 for every 14,000 enrollees.[9]

Analyzing 2000 Findings on New Programs. Of the 11 states studied in 2000, five (CT, GA, NY, PA, TN) had data only for the 2000 analysis; several findings are significant:

- In four states (CT, GA, PA, TN), appeal rates were between 0.2 and 0.4 per 10,000 enrollees.
- In New York, the appeal rate was 1.7 per 10,000 enrollees; this state had the largest number of cases accepted for review in 2000.
- For the five states, the aggregate appeal rate was 1.0 per 10,000 enrollees.

Results of Independent Reviews

In 2000, with 16 states reporting data, 51% of cases decided by independent medical review upheld the health plan decision: 1,020 upheld the plan decision and 965 reversed the plan's decision.[10] In 1999, with 13 states reporting data, 55% of cases decided by independent review upheld the health plan decision: 596 upheld the plan decision and 498 reversed the plan's decision. Several findings are significant from the 2000 analysis:

- "Uphold" rates of decided cases varied widely across the states, from 86% in Michigan to 41% in Texas.[11]
- In 12 states, half or more of decided cases upheld plan decisions.
- In the other four states, less than half of decided cases upheld plan decisions: GA (44%), NM (46%), TN (49%), and TX (41%).

In 2000, 51% of cases decided by independent medical review upheld the health plan decision; in 1999, 55% of cases upheld the plan decision.

'Uphold' Rates by Type of Plan

In the 2000 study, AAHP found that the "uphold" rates were similar for all plan types in the two states (NY, TX) reporting data by type of insurer. These two states, which together accounted for more than half of the national total of decided cases in 2000, provided breakdowns by categories of health insurers. In New York, the state had data on HMOs, commercial insurers, and non-profit indemnity insurers. In Texas, the state had data on HMOs, a catch-all category labeled "Insurance," and two minor categories with very little volume.

In the two states with the highest number of decided cases, uphold rates were similar for all types of plans.

Study Demonstrates That as Independent Medical Review Programs Expand in Number and Scope, About Half of Plan Decisions Continue to be Upheld

The 2000 analysis helps to assess how independent medical review programs have evolved over a two-year time frame. A principal finding from the 1999 data was that independent review upheld health plan decisions in 55% of the cases. In finding that 51% of plan decisions were upheld in 2000, the most recent study shows that there has been no significant change in the overall uphold rate during the past year, despite the increases in the number of states with independent review programs and in the number of cases under review. In addition, the aggregate appeal rate was the same in both years – 0.7 per 10,000, or about one appeal for every 14,000 enrollees.

Study Criteria and Methodology

In order to assess the volume and disposition of appeals being processed by the 39 states and DC with independent medical review laws in 2000, AAHP contacted the states that had an independent appeal process in operation beginning no later than Jan. 2000. The state had to have an appeals process in operation for six months or longer and have data available on case disposition in order to be included in the 2000 study; 16 states met these criteria (AZ, CA, CT, FL, GA, MD, MI, MO, NM, NJ, NY, PA, RI, TN, TX, VT). The other 23 states and DC either did not have data available on case disposition (6 states), did not implement their review process until after Jan. 2000 (8 states and DC), or are not implementing their review process until 2001 (9 states). For the 16 states, the report gives the number of cases accepted for full review and the percentage of cases decided by independent review in which health plan decisions were upheld. Appeals rates were calculated only for states with a broad-based scope of review (see Endnote 2 and Appendix B) and more than 25 cases accepted for full review; 11 of the 16 states met these criteria (AZ, CT, FL, GA, MD, MO, NJ, NY, PA, TN, TX). The other five states, including some that enacted laws that became effective after Jan. 2000, did not meet one or the other of these two conditions. The AAHP study conducted in 1999 included independent review programs in 13 states (AZ, CA, CT, FL, MD, MI, MO, NJ, NM, PA, RI, TX, VT).

Appendices

Appendix A: State Independent Medical Review Data, 2000. This appendix contains data from 16 states on the number of cases accepted for full review, the appeal rate, the uphold rate, and related information. Reporting periods varied from 8 to 30 months (some state programs started as recently as January 2000 and other states provided cumulative data spanning a period longer than one year). In order to present appeal rates comparable across all states, it was necessary to annualize the number of cases accepted for full review. For the 11 states with broad-based programs and more than 25 cases accepted for full review, the report gives the annualized ratio of cases accepted for full review to the number of persons eligible to use the process.

Appendix B: Summary of State Independent Medical Review Programs. This appendix contains outline information on the types of plans subject to review and the issues subject to review. For a fuller summary of independent medical review provisions contained in the 39 state and DC laws, go online at www.aahp.org and click on Government & Advocacy. To download the "State Independent Medical Review Laws" chart, click on Federal & State Health Policy>Charts of Legislation>State Charts>2001 Charts.

Endnotes

1. AK, AZ, CA, CO, CT, DE, FL, GA, HI, IA, IL, IN, KS, KY, LA, ME, MD, MA, MI, MN, MO, MT, NH, NJ, NM, NY, NC, OH, OK, PA, RI, SC, TN, TX, UT, VA, VT, WA, WI
2. The scope of review for most states reporting results encompasses medical necessity determinations; however, four states (FL, GA, MD, MI) use a broader criterion of any consumer grievance or adverse outcome concerning covered services or benefits not resolved by the plan. See Appendix B for state-by-state details. During the past two years, two states (CA, VT) have changed their statutes significantly. In California, which had previously limited appeals to experimental/investigational treatments, the state broadened the scope of its review statute beginning in 2000 to cover cases involving seriously debilitating diseases. Starting in 2001, the California program extends review to all medical necessity issues. In Vermont, which had previously limited appeals to mental health and substance abuse issues, the state broadened the scope of its review statute to cover all medical necessity issues.
3. Entities affected by independent review programs vary from state to state. In addition to HMOs, they include "health carriers," "health plan companies," "utilization review agents," and "managed care entities." In general, programs include almost all non-elderly privately insured enrollees within the jurisdiction of state law. See Appendix B for state-by-state details.
4. AAHP, *Early Evidence Shows Independent Review Working for Consumers,* Washington, DC, Dec. 1999.
5. Case volume was available only for states that publicly provided appeals and decision data. See Appendix A for state-by-state breakdowns.
6. The appeal rate is expressed as the number of cases accepted for full review as a proportion of the number of persons eligible to use the appeal process. Due to the different reporting periods of various states, the data were annualized. See Appendix A for state-by-state breakdowns.
7. For the 2000 study, AAHP revised its method of calculating the number of enrollees in each state eligible to use the independent review process. See Appendix A for state-by-state breakdowns. In the 1999 study, the appeal rate was calculated by dividing the number of cases accepted for full review by the number of insured persons covered by each state's law as reported by the state's department of insurance or in the 1998 Kaiser Family Foundation/University of Georgetown report. For the 2000 AAHP study, we included only enrollees in the private market who were not members of self-funded plans exempted from the review process by ERISA. Since state review laws typically apply only to the private market, both Medicare and Medicaid enrollees were also excluded (except for New York, where Medicaid was included). We drew on the following sources: InterStudy Competitive Edge 10.1, HCFA Medicare and Medicaid enrollment reports, EBRI Health Data Book (March 1999 Current Population Survey data), and Kaiser Family Foundation/HRET 1999 Annual Report of Employer Health Benefits. All enrollment numbers are based on 1998 data, since this is the latest year for which CPS data is available. The small individual market was not separately calculated. Where comparisons are made to the 1999 report, the 1999 rate was recalculated to maintain consistency. In general, the new method of calculation, by lowering the number of eligible enrollees per state (with the exception of Texas), had the effect of making the appeal rates appear to be slightly higher. For example, the recalculated 1999 aggregate rate rose from 0.6 per 10,000 to 0.7 per 10,000.
8. In the 1999 AAHP study, Rhode Island had a sufficient number of cases (85) to calculate an appeal rate; however, for the 2000 study, the number of cases (14) fell below the cut-off criterion of a minimum of 25 cases. Consequently, no appeal rate was calculated for Rhode Island in 2000 because its case volume dropped below 25.
9. The denominator in calculating the appeal rate (the number of enrollees in each state eligible to use the process) was held constant for both the 1999 and 2000 reports because 1998 is the latest year for which CPS data is available.
10. The percentage of cases "decided" is based on the number of cases that reached final ruling either for or against the plan (excluding the small number of split decisions) and not on the number of cases accepted for review. See Appendix A for state-by-state breakdowns.
11. The uphold rate is the percentage of cases decided by independent review in which health plan decisions are upheld.

The American Association of Health Plans (AAHP) represents over 1,000 HMOs, preferred provider organizations (PPOs), and other similar health plans that provide health care to more than 150 million Americans nationwide.

APPENDIX A: STATE INDEPENDENT MEDICAL REVIEW DATA, 2000

State	Appeal Rate per 10,000 Covered Enrollees[1]	Number of Covered Enrollees	Reporting Period[2]	Cases Accepted for Full Review *Total = 2,567*	Cases Upheld[3] *Total = 1,020*	Cases Reversed *Total = 965*
Arizona[4]	1.4	1.2 mil	9/99 - 7/00	151	97 (69%)	44 (31%)
California[5]	*	na	1/99 - 6/00	154	96 (62%)	58 (38%)
Connecticut	0.3	1.0 mil	1/99 - 8/00	46	21 (51%)	20 (49%)
Florida	0.5	3.7 mil	7/99 - 6/00	220	78 (51%)	74 (49%)
Georgia	0.4	1.7 mil	2000	50	17 (44%)	22 (56%)
Maryland[6]	0.5	1.75 mil	1999	91	45 (54%)	39 (46%)
Michigan[7]	*	2.6 mil	1/99 - 8/00	29	18 (86%)	3 (14%)
Missouri	0.6	1.6 mil	6/99 - 8/00	77	32 (48%)	35 (52%)
New Jersey[8]	0.4	2.4 mil	1999	144	48 (51%)	46 (49%)
New Mexico	*	na	3/98 - 9/00	22	6 (46%)	7 (54%)
New York[9]	1.7	5.8 mil	7/99 - 6/00	979	328 (50%)	331 (50%)
Pennsylvania[10]	0.2	5.5 mil	9/99 - 8/00	54	27 (68%)	13 (32%)
Rhode Island	*	900,000	1999	14	8 (57%)	6 (43%)
Tennessee	0.7	1.3 mil	1/99 - 8/00	71	35 (49%)	36 (51%)
Texas	0.7	4.7 mil	7/99 - 8/00	455	160 (41%)	229 (59%)
Vermont	*	275,000	1/99 - 6/00	10	4 (67%)	2 (33%)

Note: This analysis presents data from 1999 and 2000 on rates of appeal and outcome percentages for all states except New Mexico, which covers 1998-2000 and not aggregateable into 1-year periods. States differed both in the starting dates for their programs (between 1998 and January 2000) and in the length of their reporting periods (from 8 to 30 months). Independent medical review appeal rates are annualized to make them comparable.

(*) AAHP did not calculate an appeal rate for states with fewer than 25 cases accepted for full review per year (MI, NM, RI, VT) or states without a broad-based program (CA) during the period studied (beginning in January 2001, CA implements a broad-based program).

Footnotes: (1) See endnote 6 to main text of report for explanation of how the rate was derived. (2) Where feasible, AAHP reports data for the latest available 12-month period (FL, MD, NJ, NY, PA, RI). In one case (GA), data is reported for less than 12 months due to the newness of the process. Other states (CA, CT, NM, TN, VT) were reporting only cumulative data for periods longer than 12 months. The reported appeal rate is annualized to compensate for this. (3) Percentages of cases upholding or reversing the plan's decision are based on the number of decided cases, not the number of cases accepted for full review. (4) AZ and other states also report other sorts of information on the number of cases filed, the number of cases pending, etc. (5) Other data: 154 cases filed. Source: California Dept. of Managed Health Care. No appeal rate is calculated since its process was limited in scope during the period covered by this study (in 1999, the program encompassed experimental treatments for the terminally ill; in 2000, it was extended to cover those suffering from a severely debilitating condition or illness; in 2001, a new broad-based program takes effect). (6) The Maryland Insurance Administration released 2000 data in Feb. 2001 showing an uphold rate of 58%. 1999 data: 1,063 cases filed; 7 cases partially overturned; in 109 cases, the plan reversed itself during the investigation; 67 cases were closed for insufficient information; 43 cases were withdrawn by the complainant; 753 cases were ineligible. Of these 753 cases, in 289 cases, the Maryland Insurance Administration lacked jurisdiction due to individuals being enrolled in a self-insured health plan; in 235 cases, an initial investigation revealed that there had been no "adverse decision" of denial of care; in another 229 cases, filings were premature, because the plan's internal review process must be completed prior to filing for external review, except in emergencies. Source: Maryland Insurance Administration's *1999 Report on The Health Care Appeals and Grievance Law*, April 2000. (7) Other data: 38 cases filed; 9 cases partly reversed; 8 cases pending; 7 cases reconsidered by the plan during review. Source: Michigan's Office of Financial and Insurance Services of the Dept. of Consumer and Industry Services which on Oct. 1, 2000, pursuant to new legislation, took over the external review process from the Dept. of Community Health. (8) Other data: 174 cases filed; 46 cases pending. Source: New Jersey Dept. of Health and Senior Services, *Legislative Report, February 2000: Independent Health Care Appeals Program* and *Legislative Report, August 1999: Independent Health Care Appeals Program*, available on the Dept.'s website. (9) Other data: 1,400 cases filed; 151 cases pending; 421 cases ineligible. The top five reasons for rejection of external appeal applications were: applicant did not provide missing information (90 cases), provider ineligible to request external appeal (74 cases), application not submitted within 45 day timeframe (58 cases), self-insured coverage (34 cases), and final adverse determination rendered prior to 7/1/99 (32 cases). Of the 979 cases accepted for full review, 169 were closed because of a health plan reversal of an adverse determination during the external appeal process. New York's Medicaid managed care population of over 600,000 enrollees is eligible to use independent review and is therefore included in the number of covered enrollees. Source: New York State Insurance and Health Departments, *External Appeals Program Annual Report, July 1, 1999 - June 30, 2000*. The full report is posted on the Dept.'s website. (10) Other data: 12 cases pending. Source: Pennsylvania Dept. of Health, Bureau of Managed Care. Under a new law, which took effect in Jan. 1999, complaints are split into two processes: one for medical necessity issues (external review) and one for all other issues.

Appendix B: Summary of State Independent Medical Review Programs

State	Effective Date*	Date Amended	Types of Entities Covered	Issues Subject to Review
Alaska	9/00		Managed care entities offering group health insurance.	Medical necessity; investigational/experimental treatment; covered benefits involving medical judgment.
Arizona	7/98	7/00	UR agents and health care insurers with UR ability to deny services.	Issues relating to determinations of medical necessity.
California	7/98	1/00; 1/01	HMOs and insurers; Medicaid excluded.	Experimental treatment for dying patients; in 2000, expanded to seriously debilitating diseases/conditions.
Colorado	6/00		Health coverage plans.	Adverse determinations based on medical necessity.
Connecticut	10/97	10/99	MCOs and UR companies.	Medical necessity, e.g., determinations not to certify admissions, services, procedures, or extension of stay.
DC	1998		Any health insurer.	Issues related to denial, termination or limitation of covered health services.
Delaware	1998	7/00	Managed care organizations.	Any UR determination resulting in a denial, termination or limitation of covered health benefits.
Florida	1985	12/98	Managed care entities.	Any grievances unresolved internally by the plan.
Georgia	7/99		Managed care entities.	Adverse outcomes concerning covered services or benefits; experimental treatments.
Hawaii	7/98	6/00	Managed care plans (defined).	Adverse decisions (not defined).
Iowa	1/00		Carriers, i.e., entities providing health insurance plans, performing UR.	Adverse coverage decisions based on medical necessity.
Illinois	1987	1/00	HMOs.	Denials of a service, treatment, or procedure based on medical necessity.
Indiana	1/00		HMOs.	Adverse UR determination.
Kansas	1/00		Health insurance companies, HMOs, fraternal benefit societies, nonprofit hospital, medical services corps.	Any final adverse determination on the grounds of "medical necessity."
Kentucky	6/00		Insurers.	Adverse determinations or coverage denials.
Louisiana	1/00		Managed care entities.	Coverage decisions based on medical necessity.
Massachusetts	10/00	1/01	Managed care organizations; UR organizations.	Adverse determinations related to medical necessity.
Maryland	1/99	6/00	Carriers, i.e., entities providing health benefit plans, including HMOs.	Complaints regarding adverse decisions concerning member.
Maine	7/00		Carriers offering health plans.	Adverse health care decisions; investigational/experimental treatments.
Michigan	1978	10/00	HMOs, alternative financing/delivery system plans.	Any "adverse determination" unresolved internally by the plan.
Minnesota	4/00		Health plan companies including managed care plans and indemnity carriers.	"Contested treatment coverage and service issues."
Missouri	8/97		Health carriers.	Adverse determinations including medical necessity, experimental treatment, related to covered services.
Montana	10/99		Health carriers, i.e., entities providing health benefit plans.	Adverse determinations.
New Hampshire	1998	5/00	Health carriers.	Adverse determinations; medical necessity.
New Jersey	3/97	2/98; 1/01	All health insurance companies.	Medical necessity, e.g. decisions to deny, reduce or terminate benefits, or coverage/network issues.
New Mexico	3/97		Managed care health plans.	UR determinations.
New York	7/99		Health care plans, including all health carriers conducting UR.	Adverse medical necessity determinations and experimental treatments.
North Carolina	1997		Health insurers.	Any decision, policy, or action of the insurer that affects the covered person.
Ohio	10/97	5/00	Health insuring corporations.	Experimental treatment for dying patients; in 2000, expanded to cases involving medical necessity.
Oklahoma	11/99		Any medical insurance coverage, including HMOs, PPOs, indemnity plans, MEWAs.	Adverse determinations based on medical necessity.
Pennsylvania	1/99		Managed care plans (HMOs and gatekeeper PPOs).	Denial of a grievance regarding medical necessity or appropriateness.
Rhode Island	1992		HMOs and UR agents.	Only prospective and concurrent "adverse determinations" and all emergency service denials.
South Carolina	7/00		All health insurance plans with UR.	Medical necessity and experimental treatment.
Tennessee	1/99		HMOs excluding TennCare.	Adverse medical necessity determinations.
Texas	9/97	8/00	Health insurance carriers, HMOs and managed care entities.	Adverse medical necessity determinations.
Utah	6/00		Insurers, HMOs, TPAs.	Grievances, to be defined by commissioner.
Virginia	5/00	7/00	All UR entities.	Adverse medical necessity determinations.
Vermont	8/95	7/99	Health benefit plans except Medicaid program.	Medical necessity, experimental treatments, pre-existing conditions.
Washington	8/00		Carriers.	Denials of coverage or payment.
Wisconsin	5/00		Insurers.	Adverse determinations or experimental treatment decisions.

*Program operational date specified in law; however, many states do not collect or release data on their programs, or have only recently begun making data publicly available.

State-Mandated External Review: Panacea, Empty Promise, or Modest Policy Success?

By Mary R. Anderlik
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In the continuing debate over how to balance cost-containment and patient protection in health care reform, external review of health plan decision making is a rare bird - a policy innovation championed by industry spokespeople and consumer advocates alike. Nearly half a decade into the experiment in the "laboratory of the states," some basis exists for a preliminary assessment.

Background

Two features of managed care were catalysts for external review. First, some health plans implemented prospective review for health plan coverage of surgeries and other expensive services, and concurrent review for extended hospitalizations. In contrast to traditional retrospective review of benefit claims, prospective or concurrent review focuses attention on the practical equivalence of third-party payment decisions and treatment decisions in an era of high-technology medicine. In many cases, an up-front denial from the health plan meant the patient could not obtain the service. Second, the prominence of cost-containment and profit motives in managed care made consumers distrustful of health plans' internal appeals mechanisms.

According to the Health Policy Tracking Service of the National Conference of State Legislatures, as of December 1999, 30 states and the District of Columbia had some form of external or independent review mandate. In addition, 10 states have passed external review laws this year, the latest being Massachusetts in a bill signed by Gov. Paul Cellucci on July 21. Key issues for drafters include:

- who controls the review process (e.g., is a state agency charged with selecting reviewers and coordinating referrals or does that power rest with the affected health plan);
- who pays for the review;
- what kinds of disputes are subject to review;
- what criteria guide or constrain reviewers (e.g., are reviewers bound by the definition of medical necessity or experimental treatment in the insurance contract);
- timetables for action, including filing deadlines and expedited review of urgent cases; and
- whether reviewers' decisions are binding.

Variation among the states on these and other particulars complicates assessment. See *External Review of Health Plan Decisions* and *External Review of Health Plan Decisions: An Update* from Kaiser Family Foundation.

Data Concerning Performance

The selection of criteria for assessment of a policy experiment is a tricky business. Even where there is agreement that something is important, measurement tools or data may be lacking. For external review, the list would likely include consumer awareness of the availability of review, actual and perceived fairness and timeliness of review, consistency of decisions across cases and with professional standards, effect of implementation on the volume of lawsuits filed

against health plans by consumers and on consumer trust in the health care system, and direct and indirect costs.

Utilization of external review by consumers has been limited to date. According to data released by the American Association of Health Plans, the appeals rate per 10,000 covered lives in states with active programs ranges from a low of 0.1 in Missouri to a high of 1.3 in Texas, with the average somewhere around 0.6. There is nothing intrinsically bad about a low rate—it could reflect an absence of disputes or health plans' readiness to reverse denials at a point in the appeals process prior to issuance of a formal reviewer opinion, among other things. Still, low utilization numbers may be an indicator of lack of awareness. In its *National Survey of Consumer Experiences with Health Plans*, Kaiser Family Foundation found considerable confusion among consumers, with substantial percentages mistaken concerning the availability of external review in their states.

Despite the many differences on specifics, most states with programs in place report that reviewers support consumers about half the time. (On July 20, Vermont officials reported that the majority of reviews in that state favored health plans, but with only 6 cases decided officials advised that any conclusions would be premature.) This result suggests success according to criteria of fairness and consistency–certainly a less balanced ratio would raise concerns that reviewers were biased in favor of one side or the other, and wildly different ratios across states might lead to skepticism about the possibility of consensus on standards of medical appropriateness. Direct costs appear reasonable, in the realm of $400-500 per case. For other areas of concern, reliable data is not yet available.

Legal and Other Challenges

The federal Employee Retirement Income Security Act, commonly referred to as ERISA, exempts employer self-insured plans from state regulation. Some health plans maintain that ERISA also blocks (in legal terms "preempts") any state law affecting benefit determinations. On July 27, the Fifth Circuit Court of Appeals affirmed its ruling that the Texas independent review organization (IRO) provisions are preempted by ERISA. At the same time, the Court hinted that it might bless some kind of anticipatory vicarious liability review: "We acknowledge that there is a powerful argument in support of an IRO procedure in which the only inquiry is whether a proposed treatment meets the standard of care demanded by Texas of physicians.... Under this view, what Texas can regulate through malpractice suits, Texas could also administratively regulate as a mandated term of insurance." *Corporate Health Insurance v. Texas Dept. of Insurance* (5th Cir. 2000) (ruling on state's petition for rehearing). A similar challenge has been leveled against the Illinois HMO Act. Somewhat ironically, Texas health plans have continued to embrace the state's IRO procedure, and at the national level accrediting agencies and trade organizations are working on their own external review requirements.

There is a possibility, now remote, that Congress will act to impose a uniform federal scheme. Otherwise, state regulators, and review panels, will need to strive for greater clarity concerning the goal of external review. As suggested in the preceding discussion, options include:

- evaluating the appropriateness a requested service for the particular patient constrained only by standards of sound medical practice, meaning that reviewers are charged with determining whether a requested service lies within the range of medically reasonable alternatives *either* without regard to contractual definitions of medical necessity and/or

experimental treatment *or* without regard to *any* term of the insurance contract (including the list of covered services and specific exclusions);

- evaluating the appropriateness of a requested service for the particular patient constrained by all the terms of the particular insurance contract as well as standards of sound medical practice; and
- testing denials against a malpractice standard, meaning that reviewers only decide against a health plan if a health care provider's failure to take action with respect to the requested service—it is unclear whether the action would be to offer, recommend, advocate for, or render the service—would constitute a breach of the applicable standard of care.

A different kind of threat is transfer of risk to physicians, a new development emanating from California. External review is a response to distrust of health plans and does little to address concerns about physicians.

Final answer? External review is a modest policy success, and much work remains to be done.

08/21/00

Testimony on Senate Bill Number 2282.

Chairman Mutch, Vice Chairman Klein, and Committee Members.

I am Bob Stroup, Deputy General Counsel at Blue Cross Blue Shield of North Dakota, and I appear this morning in opposition of Senate Bill Number 2282.

Blue Cross Blue Shield of North Dakota (BCBSND) opposes this bill at many different levels and for many reasons, but it is best to analyze the basis of its opposition within the context that in its current state, the bill will create inconsistencies with current law and procedures, the proposed bill is fraught with uncertainty and, finally, there are not insignificant costs associated with the bill.

In its current form, this bill adds a new level and layer of review to the claims process within an insurance company that will affect not only providers but applies to the interrelationships with consumers and members as well.

Consistency.

BCBSND established and updated its current claims and appeal processes in 2000 and 2001 to comply with the Department of Labor (DOL) claims and appeals procedures. These procedures apply equally to both self-funded and fully insured health plans. During the 2001 legislative session, this very Chapter 26.1-26.4 was amended to meet and be consistent with the DOL claims and appeal regulations.

The proposed bill will alter these currently uniform procedures and create numerous inconsistencies within the claims and appeals processes used by insurers.

One example of such an inconsistency may be found in the definitions used in the proposed bill. Several of these definitions are inconsistent with current federal guidelines, such as the term(s) "adverse decision" in the bill and "adverse benefit determination" in the DOL claims and appeals regulations. Similarly, there are terms used in the proposed bill that are not defined but that are defined under federal law or in the health benefit plans currently in place between BCBSND and its members. One example of this is the term "medical necessity".

Another inconsistency created in the proposed bill relates to the timeframes that are to be applied to the appeals process. Several of the timeframes set forth in the bill are inconsistent and violate current federal law. An example of this is the appeals period in place for reviewing claims involving emergency medical conditions. The proposed bill sets this timeframe at seven (7) days where the DOL requirement is set at seventy-two (72) hours. Such differences will create inconsistencies between the varying processes that will need to be addressed.

One final inconsistency involves the fact that the proposed bill, even if it should be adopted, cannot be applied to self-funded health plans. As previously highlighted, currently, there is one appeals process in place that applies to both self-funded and fully insured plans. Enactment of the proposed bill in its current form will result in separate claims and appeals processes being implemented for insured business than used for self-funded business. This will result in inconsistencies and confusion for members/consumers through the fact that each will have differing appeal rights depending on the type of health benefit plan they have in place. It also will result in inconsistencies and confusion for

providers, who will have to make an up-front determination of what type of health plan their patients have so they will know what claims and appeals process is available.

Confusion/Uncertainty.

Senate Bill Number 2282 in its current format will also lead to confusion and uncertainty in the administration of health care services at many levels.

One such unanswered issue and confusing aspect of the bill involves the fact that it cedes implementation to the North Dakota Department of Insurance, without addressing a multitude of important and significant issues:

- How will the external review entity be established?
- Who will monitor the review entity to ensure consistency and that decisions are based on medical evidence?
- Where will the external review entity come from?
- Are there going to be dollar thresholds for any appeals?
- Are there going to be filing fees and, if so, who pays?
- Are there filing deadlines? Will these comply with federal laws and benefit plan terms?
- Will there be differences from contract terms and definitions/processes used by entity – what are the "governing criteria" for the external appeals entity?
- Who pays the costs of the review and administration?
- What disputes are subject to review?
- Are an external entity's decisions final and binding on the health plan?
- Who can request an external review?
- Will the confidentiality of the reviewer be assured and, if so, how will this confidentiality be reconciled with the DOL claims regulations?
- How accessible is the external review process to those affected by it?

These are all unanswered questions that lead to the discomfort of insurers such as BCBSND with this proposal.

The failure to address these kinds of issues in Senate Bill Number 2282 also leads to potential legal uncertainty related to the validity of the statute in light of the health plan protections contained in the Employee Retirement Income Security Act (ERISA). Clearly, Senate Bill Number 2282 as proposed is a statute that relates to health benefit plans. As such, it is preempted by under ERISA. Although the validity of some external review statutes was upheld by the United States Supreme Court through Rush Prudential HMO, Inc. v. Moran, 536 U.S. 355 (2002) (upholding the validity of the external review laws in Illinois because these required what was tantamount to a second medical review of a claim), there is some authority to the contrary. See, e.g., Hawaii Management Alliance Association v. Insurance Commissioner, 100 P.3d 952 (Haw. 2004) (finding that the external claim review law in Hawaii was preempted under ERISA §502(a) because the law was merely another adjudication).

Adoption of the proposed amendments in Senate Bill Number 2282 will also cause confusion because of the administrative uncertainty it will create. This confusion is created through the fact that there will be different claims and appeals strictures between self-funded health plans than fully insured plans. There will also be confusion over whether or not the affected members are entitled to external review or not.

Costs.

The proposed bill creates a costly and unfunded statutory mandate that will require compliance by insurers.

Increased Premium and Health Plan Costs.

The creation of an expansive mandated external review process will act to increased premiums and costs to employers and consumer. A couple of estimates:

- An increased cost of $1.20 per person annually, or a premium increase of two (2) to sixteen (16) cents per member per month. See, Annotated Bibliography on Health Plan External Grievance Review, page 1, citing "Estimated Costs of Selected Consumer Protection Proposals," prepared by Coopers & Lybrand for the Kaiser Family Foundation, April 1998 (attached hereto as Attachment 1).
- An estimation in California that there would be an increase of three (3) cents per enrollee per month, or a premium increase of .03 percent. See, Issue Brief: Independent Review of Health Plan Decisions, page 1, referencing a Price Waterhouse analysis for the Kaiser Family Foundation, August 1998 (attached hereto as Attachment 2).
- The Congressional Budget Office (CBO) estimates the external review feature in the Patients' Bill of Rights Act of 1998 predicted a premium increase of .03%. See, Issue Brief, *supra*, page 2.

The increases anticipated by this external review mandate proposed in Senate Bill Number 2282 are in addition to the already escalating costs of health insurance and health care.

"Hard" Costs of the External Review Process.

In addition to the anticipated premium rate increases caused by the external review feature of Senate Bill Number 2282, there are hard costs associated with the actual review proceedings and administration of external review appeals. These "hard" costs are estimated as follows:

- "We understand that a few Fortune 500 companies have recently sought estimates for the cost of external reviews in general . . . They estimate that external reviews cost between $1500 to $2000 per review." Testimony of Mark Waskow, National Federation of Independent Business, before the Senate Labor and Human Resources Committee, March 24, 1998.
- "Costs of Reviews. Blue Cross and Blue Shield Plans in seven states were able to provide estimates of their average direct cost (i.e., external reviewer fee) for complying with the requirements of the external review process. Five Plans reported similar direct costs, ranging from $300 to $410 per case. The Plans with the largest average costs were New York at $600 and Texas at $650. These costs reflect the cost of single physician reviewer." Legislative Report 18-00, "Impact of State External Review Laws", page 4, Blue Cross Blue Shield Association, June 23, 2000, (attached hereto as Attachment 3).
- "Direct costs appear reasonable, in the realm of $400-500 per case." Mark R. Anderlik, "State-Mandated External Review: Panacea, Empty Promise, or Modest Policy Success?", page 2, Health Law & Policy Institute, August 21, 2000 (attached hereto as Attachment 4).

There are also "indirect" costs involving administrative costs to prepare for and participate in the external review process.

- "Only four Plans were able to estimate their average indirect costs. They include Arizona ($150), Maryland ($500), New Jersey ($500-$1,000) and Rhode Island ($200). In addition, the Texas Plan provided detailed times estimates by task associated with the external review process which indicated that, on average, a Plan employee devotes between 5 and 5½ hours per case." See, Legislative Report, *supra*, at page 4.

Here I am able to reference the actual costs to BCBSND in implementing the external review and other requirements set forth in Senate Bill Number 2282. The actual costs of the administrative burden of on-going implementation of the DOL Claims and Appeals regulations continues. The implementation costs affected nearly all systems and departments of the company including: Legal, Planning, Medical Management, Member Services, Provider Contracting, Contract Administration, Claims and Information Services with costs estimated currently at $360,000 (cost estimates compiled from internal BCBSND data). The costs of implementing the changes contained in Senate Bill Number 2282 will have a similar financial impact, equating to a cost of $1.90 to $2.00 per contract per annum.

Increased Claims Experience.

All surveys of claims and appeals procedures with an external appeal aspect assume that this will exude a "trickle down" result by leading to health plan payment of more claims that would not have been paid absent the prospective external review. See, *generally*, "Independent Medical Review of Health Plan Coverage Decisions: Empowering Consumers with Solutions", Policy & Implications, American Association of Health Plans, April 2001 (attached hereto as Attachment 5).

Infrequent Use of External Claims Programs.

It appears clear that even where available, use of the external review process is infrequent. The use of external appeals mechanisms is not the most cost-effective approach to settle disputed health care claims because of the insignificant impact external review appeals have on the overall claims and appeal process and there must be a better, less expensive alternative. External review requirements are very expensive to implement, maintain and administer but have a relatively low impact on the number of cases and result in a negligible overall benefit to members. As a whole, the numbers are enlightening. The number of claims sent for external appeals are significantly less that one percent (1%) of all claims administered by an average health plan *in toto*. Of this less than one percent (1%), approximately fifty percent (50%) of cases appealed externally are reversed. See, *generally*, "Independent Medical Review", *supra*. Here is some actual data from Blue Cross Blue Shield of Connecticut from 1998 to 2000: 59 total appeals submitted to the external review organization; of these 59 cases, fifty-three percent (53%) were decided in favor of the enrollees, forty-six percent (46%) affirmed the determination of the plan, and one percent (1%) between the plan and enrollee.

Alternatives.

It seems clear that in its current form, Senate Bill Number 2282 applies to all claims disputed by enrollees or providers doing business with any utilization review organization, including health

insurance companies such as BCBSND. The position of the North Dakota Healthcare Association in supporting this legislation is that its purpose is to establish a mechanism to address claim payment disputes between insurance companies such as BCBSND and the providers of medical services. This proposed bill extends significantly beyond this objective by requiring changes to the manner in which all claims are reviewed, most significantly by establishing the external review mechanism. As to the issue of concern with the North Dakota Healthcare Association, BCBSND views this matter as a private contracting issue between two arms-length business entities, who are sophisticated and able to resolve disputes without legislative intervention. There are already mechanisms in place to address such payment disputes contained in the BCBSND participating provider agreements. Similarly, there are dispute resolution procedures already contained within BCBSND programs that are implemented to review provider payment and reimbursement trends and practices. Finally, BCBSND has already undertaken a project to review alternate dispute mechanism programs, including external review, during the current fiscal year.

For all of these reasons, BCBSND respectfully requests a DO NOT PASS on Senate Bill Number 2282.

Testimony provided on Tuesday, January 25, 2005, before the Senate Committee on Industry, Business and Labor, Roosevelt Park Room.

Legislative Report 18 – 00 **June 23, 2000**

IMPACT OF STATE EXTERNAL REVIEW LAWS

A primary focus of state lawmakers in recent years has been the creation of independent external review programs to resolve disputes between health plans and enrollees over coverage and payment matters. Prior to 1997, just five states had enacted some type of external review process. There has been an explosion of legislation since then and today there are mandatory review programs in 38 states and the District of Columbia (see Exhibit 1).

To learn what impact this priority legislation has had, Blue Cross and Blue Shield Plans in the 20 states with external review laws in effect for at least one year were recently surveyed. Regulators in 13 of these states have collected and made available industry-wide data on the actual number and outcomes of the external reviews performed to date. In the remaining seven states, either no external reviews have been completed, or industry-wide data on compliance with external review laws could not be obtained from state officials.

This *Issue Review* presents preliminary findings from the 13 states in which regulators have collected industry-wide data on the prevalence, types and outcomes of external reviews. This data was either published by state officials or orally transmitted to Blue Cross and Blue Shield Plans. (It should be noted that the North Carolina data is limited because it only pertains to external reviews performed for enrollees of the Blue Cross and Blue Shield Plan.) In addition, Blue Cross and Blue Shield Plans in several of these 13 states have been able to provide Plan-specific data on the costs of participating in external review and on satisfaction with the process itself. The *Issue Review* also presents observations as to whether external review appears to be meeting the objectives set forth in the enabling legislation.

(Note: This survey dealt only with enrollee complaints or appeals of denials allowed under states' formal external review programs, and not with generalcomplaints filed with insurance regulators by consumers and health care providers.)

Prevalence of Reviews

The total number of external reviews performed by all health plans licensed in the 13 states in question was not large. As set forth in Exhibit 2, some 4,922 external reviews have been performed cumulatively on eligible appeals cases since the institution of the programs. These reviews were performed over different timeframes that varied by state, as explained in Exhibit 2. The greatest numbers of reviews were amassed in Michigan (1,714) and Florida (1,000). The external review process has also generated considerable interest in several states where the intensity of public debate over managed care has been high: Texas (901), New York (345) and Arizona (326).

Any assessment of the success of state external review efforts, should focus on the number and resolution of "eligible" appeals only. In order to become eligible, all 13 of the state laws require that enrollees first go through a health plan's internal review system (exceptions are generally made for reviews involving medical emergencies). Blue Cross and Blue Shield Plans in these 13 states have reported that the great majority of their enrollees' appeals are resolved during the two-tiered internal review process. Complaints not resolved internally may be submitted to either the state regulator or the independent review organization for consideration. These entities routinely perform a legitimate screening function to see if the disputes meet the law's eligibility requirements for external review. Maryland's experience is illustrative:

- "The agency received 1,063 complaints in which consumers or health care providers claimed that medically necessary care was denied. Of these cases, 753 were outside the Maryland Insurance Administration's jurisdiction due to federal laws such as ERISA, or because the health plan did not actually issue a denial, or the consumer had not filed an internal appeal with the health plan. Of the remaining 310 cases, the health plan reversed its initial denial during the MIA's investigation in 109 cases and 110 (other) cases were withdrawn. Ultimately, the MIA investigated 91 cases to completion, which included full review by outside medical experts." ("Maryland Appeals & Grievances, MIA, April 17, 2000)

Some observers have blamed the infrequent use of external review programs on "barriers to access" contained in the laws, such as claims thresholds, filing fees and filing deadlines ("External Review of Health Plan Decisions: An Update," Kaiser Family Foundation, May 2000). However, these so-called barriers do not appear to be a significant factor in 12 of the 13 state external review programs analyzed. Only one of the states in question requires a claims threshold to be met (i.e., a minimum dollar value of a requested service). Vermont law stipulates that the adverse determination to be reviewed must involve a request for a health plan to expend at least $100. Turning to filing fees, only five of the states surveyed require individuals to pay a nominal administrative fee that reflects the cost of processing a request for external review. Connecticut, New Jersey and Vermont regulators will waive the $25 fee in financial

hardship cases. Enrollees may also be required to pay filing fees in Pennsylvania ($25) and New York ($50).

A number of the external review programs do require enrollees to observe filing deadlines. These deadlines range from one to two years after receiving notice of an adverse determination (FL, MI), to a period of from 30 to 60 days (AZ, CT, MD, NJ, NY, RI), down to 15 days (PA). It can be argued that timely filing deadlines are necessary to ensure that external reviews are initiated and completed as expeditiously as practicable. Consumers benefit from speedy resolution of treatment denials because it facilitates the prompt delivery of medically necessary care. In addition, the relevant medical evidence needed to conduct an external review is often best preserved when the review is prompt.

Rhode Island is the only case study state that imposed a potentially significant cost-sharing requirement on enrollees. The 1994 law required both parties to an external review to split the cost of conducting the review. The law was recently amended, however, so that if a denial is overturned in the future, the health plan will have to reimburse the appellant.

Types and Outcomes of Reviews

Regulators in nine states indicated that for the industry as a whole, treatment denials based on medical necessity grounds generated the most external reviews (see Exhibit 2). Appeals of denials of requests for investigational procedures were also frequently recorded. In addition, the data indicates that a lesser, but still significant, number of external reviews involved requests for cosmetic surgery (MD, NJ, NC), for specialized drugs (NC, TX), and for durable medical equipment (MD, TX).

The outcomes of the external reviews were remarkably similar, regardless of the size, geography or degree of urbanization of the states surveyed. In 11 of the 13 states, reviewers issued decisions in favor of enrollees roughly half of the time and they upheld health plan denials about half of the time. The exceptions are Michigan and North Carolina, where reviewers found in favor of health plans a clear majority of the time.

Another interesting finding is that reviewers in five states issued industry-wide decisions that were partially in favor of the enrollee and partially in favor of the health plan in a small number of cases. For instance, seven percent of the reviews performed in Texas fell into this category (e.g., an enrollee's request for transplant surgery was approved, while the drugs were denied; or an enrollee's request for several DME items was honored in part).

Costs of Reviews

Blue Cross and Blue Shield Plans in seven states were able to provide estimates of their average direct cost (i.e., external medical reviewer fee) for complying with the requirements of the external review process. Five Plans reported similar direct costs, ranging from $300 to $410 per case. The Plans with the largest average direct costs were New York at $600 and Texas at $650. These figures reflect the cost of a single physician reviewer.

Only four Plans were able to estimate their average indirect costs (i.e., administrative costs to prepare for and participate in the review process). They include Arizona ($150), Maryland ($500), New Jersey ($500 - $1,000) and Rhode Island ($200). In addition, the Texas Plan provided detailed time estimates by task associated with the external review process which indicate that, on average, a Plan employee devotes between 5 and 5 ½ hours per case.

Health Plan Compliance with Review Decisions

Survey respondents were asked whether their Plan accepted or appealed the decisions of the external reviewer. BCBS Plans in six states where the decisions are binding on health plans replied that they did not appeal decisions (CA, CT, NY, NC, RI, TX). On the other hand, BCBS Plans in Maryland, Michigan and Vermont, where review decisions are also binding on health plans, indicated that they occasionally appealed a decision. In all cases, however, Plans have ultimately complied with the decisions of the external review entities.

In Arizona and New Jersey, external review decisions have been advisory to health plans. Blue Cross and Blue Shield Plans in these states said they have appealed some decisions in the interest of promoting quality care and upholding medical necessity standards. (Both the Arizona and New Jersey external review laws were amended this year to make external review decisions binding on health plans in the future.)

Blue Cross and Blue Shield Plans were also queried as to whether the existence of their state's external review process served as an adequate alternative to litigation. In other words, did the existence of external review deter enrollees from filing suit against the plan? Blue Cross and Blue Shield Plans in five states said they thought it did. For example, according to Blue Cross and Blue Shield Plans in New York, "A determined enrollee is not barred by the external appeal process from pursuing a claim in court, however, the fact that an independent party has sided with the health plan is an obvious deterrent." Four other Plan respondents thought it was too early to assess whether external review served such a deterrent function, while one Plan thought it did not.

Satisfaction with External Review Process

- **"In your opinion, is the external review process fair, objective and speedy?"**

Survey findings revealed that Blue Cross and Blue Shield Plans in six states (AZ, CA, CT, MI, NY, RI) believe their external review process is fair, objective and speedy. The Texas and Vermont Plans said that it is too early to form a conclusion.

Three other Plans offered critical assessments of their programs to date. Blue Cross and Blue Shield of Maryland said that while the program is satisfactory overall, sometimes its denials of enrollee requests for investigational treatments were reversed by the external review entity without adequate justification based on the scientific evidence and peer-reviewed medical criteria. In New Jersey, the Plan replied that sometimes its enrollees' cases involving cosmetic surgery were decided by external reviewers without properly taking the terms of coverage and the medical evidence into account.

Finally, Blue Cross and Blue Shield of North Carolina responded that the state's external review process is too cumbersome to be speedy. North Carolina law generally requires external review decisions to be made by a panel of three reviewers.

The external review laws in the states surveyed strive to achieve a speedy decision by generally requiring that standard reviews be completed within 30 working days after the request or after receipt of necessary documentation. In addition, most states have established an expedited process for emergency cases wherein reviews must be performed within 72 hours of the request (see Exhibit 3).

- **"Are you satisfied with the quality and consistency of the external review entities?"**

Blue Cross and Blue Shield Plans in the following five states answered positively: Arizona, Michigan, New York, Rhode Island and Texas. However, Plans in Connecticut, Maryland and New Jersey are not generally satisfied with the performance of all of their external reviewers.

The Connecticut Plan commented that one of the three review entities used by the state insurance department sometimes appeared to favor the enrollee's perspective, instead of maintaining strict objectivity in decision making. The Maryland Plan indicated that it is concerned because occasionally there are inconsistencies on the part of external reviewers that have resulted in different outcomes in similar cases. The dissatisfaction of the New Jersey Plan with its external reviewers is described above.

- **"Do your enrollees appear to be aware of and satisfied with external review?"**

Plan answers to this question were divided into two parts: degree of enrollee awareness and degree of enrollee satisfaction. Blue Cross and Blue Shield Plans generally said they believed their enrollees were aware of their right to request an external review. This is not surprising given the fact that state external review laws require health plans to routinely inform members of their rights of appeal whenever a denial of coverage is issued, as well as in other ways. The experience of the Rhode Island Plan is typical: "We notify our enrollees of the right to external appeal whenever a service is denied for medical necessity. There is also information regarding external appeals in our Subscriber Agreements, Member Handbooks and on our web page."

The availability of external reviews is also publicized by state officials. For instance, regulators in Connecticut, New Jersey and Pennsylvania either prepare and distribute consumer brochures on the topic or include information on the external review process in an annual HMO report card. The Texas Department of Insurance maintains a toll free hot-line to contact independent review organizations and posts information on its web page. In Florida, state officials periodically notify enrollees directly of their right to an external review of an adverse determination.

Regarding enrollee satisfaction, the Plans in New York and Texas reported that their members appeared to be satisfied with the external review process. On the other hand, most Blue Cross and Blue Shield Plans answered that they simply did not know or it was premature to assess whether their enrollees were satisfied with how the external review program was working. It should be pointed out that neither the Plans surveyed, nor their regulators, have conducted a scientific consumer satisfaction survey to formally evaluate their external review programs.

Observations on State Experience with External Review

While most state external review programs have not established sufficient track records to make definitive conclusions, several important inferences can be drawn from the Blue Cross and Blue Shield survey with respect to these 13 states. In these states:

- Health plan enrollees seek external reviews infrequently. Because most disputes are satisfactorily resolved during internal review, there is less need to invoke external review, which represents the final step of a comprehensive process.

- State laws do not appear to have placed unreasonable barriers on the use of external review by consumers.

- The key measure of success is not how many reviews are performed, but whether those enrollees who legitimately need external review have access to it.

- Comprehensive efforts are made by health plans and state officials to ensure that enrollees who most need to avail themselves of external review are informed of their rights.

- External review entities uphold health plan denials roughly half of the time, while finding in favor of the enrollee approximately half of the time.

- Most Blue Cross and Blue Shield Plans responding to the survey believe their state external review process is fair and objective. However, several Plans pointed to the need for better oversight of external review entities to ensure that their decisions are consistent and based on the medical evidence.

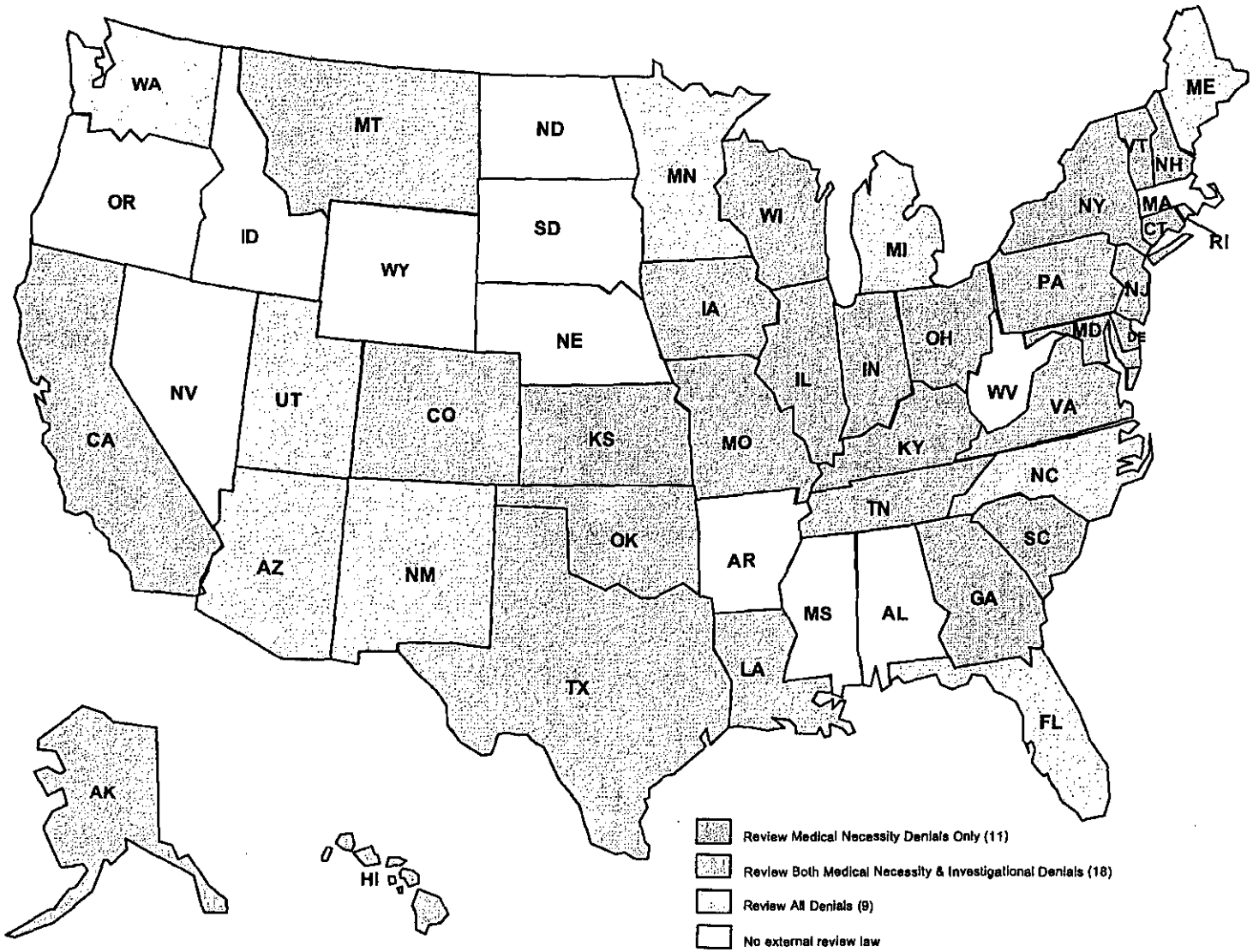
- The cost to health plans of performing external reviews would be substantially higher in the absence of appropriate safeguards to ensure that only meritorious cases receive external review.

- External review programs that involve a three-member panel of reviewers result in a relatively cumbersome and slower process.

For more information on state external review laws and programs, Plans can call Susan Laudicina at 202.626.4803.

Exhibit 1

SCOPE OF STATE EXTERNAL GRIEVANCE REVIEW LAWS



Source: Blue Cross and Blue Shield Association, June 2000

Exhibit 2

IMPACT OF STATE EXTERNAL REVIEW LAWS

State (effective date)	# of Reviews	Timeframe of Reviews	Most Frequent Types of Reviews	Outcomes of Reviews	Average Plan Cost Per Review
Arizona (July 1998)	326	July 1998 – December 1999	Treatment denials Payment denials Requests for non-par MDs Investigational procedures	39% decided for enrollees 61% decided for plans	$300 direct costs $150 indirect costs
California (July 1998)	123	January 1999-April 2000	Investigational procedures	41% decided for enrollees 59% decided for plans	Not available
Connecticut (January 1998)	59	April 1998 – January 2000	Treatment denials Investigational procedures	53% decided for enrollees 46% decided for plans 1% decided for both	Costs borne by DOI budget
Florida (January 1985/ amended 1994)	1,000	July 1997 – April 2000	Not available	49% decided for enrollees 51% decided for plans	Not available
Maryland (January 1999)	91	January 1999 – December 1999	Treatment denials Cosmetic surgery Requests for DME	43% decided for enrollees 49% decided for plans 8% decided for both	$410 direct costs $300 indirect costs
Michigan (January 1978)	1,714	December 1986 – April 2000	Payment denials	19% decided for enrollees 77% decided for plans 4% decided for both	Not available

Source: Table compiled by Blue Cross Blue and Shield Association, June 2000, based on data collected by state insurance regulators. Cost data was estimated by individual Blue Cross and Blue Shield Plans.

IMPACT OF STATE EXTERNAL REVIEW LAWS

State (effective date)	# of Reviews	Timeframe of Reviews	Most Frequent Types of Reviews	Outcomes of Reviews	Average Plan Cost Per Review
New Jersey (March 1997)	69	March 1997 – July 1998	Treatment denials Payment denials Cosmetic surgery	42% decided for enrollees 58% decided for plans	$375 direct costs $500 - $1,000 indirect costs
New York (July 1999)	345	July 1999 – February 2000	Treatment denials Investigational procedures Clinical trials	47% decided for enrollees 53% decided for plans	$600 direct costs indirect costs unknown
North Carolina (July 1998)	65 (BCBS only)	January1999 – April 2000	Payment denials Investigational procedures Specialized drugs Cosmetic surgery	17% decided for enrollees 75% decided for plans 8% decided for both	Not available
Pennsylvania (January 1999)	45	January 1999 – April 2000	Treatment denials	49% decided for enrollees 51% decided for plans	Not available
Rhode Island (January 1994)	169	January 1994 – April 2000	Treatment denials	53% decided for enrollees 47% decided for plans	$370 direct costs $200 indirect costs
Texas (November 1997)	901	November 1997 – April 2000	Treatment denials Investigational procedures Specialized drugs Requests for DME	49% decided for enrollees 44% decided for plans 7% decided for both	$650 direct costs indirect costs unknown
Vermont (July 1999)	15	July 1999- May 2000	Treatment denials	40% decided for enrollees 60% decided for plans	$375 direct costs indirect costs unknown

Source: Table compiled by Blue Cross Blue and Shield Association, June 2000, based on data collected by state insurance regulators. Cost data was estimated by individual Blue Cross and Blue Shield Plans.

Exhibit 3

TIMEFRAMES FOR EXTERNAL REVIEW DECISIONS

Laws by State	Standard	Expedited
Arizona	--	--
California	30 days of request	72 hours
Colorado	50 days of request	72 hours
Connecticut	30 working days	--
Delaware	50 days of request	--
Florida	15 working days after hearing	24 hours
Georgia	15 working days	72 hours
Hawaii	30 days after hearing	--
Illinois	5 days	24 hours
Indiana	15 working days	72 hours
Iowa	30 days of request	72 hours
Kansas	30 working days	7 days
Kentucky	21 days of request + 14 extension	24 – 48 hours
Louisiana	30 days	72 hours
Maryland	30 working days of request	24 hours
Michigan	--	--
Minnesota	40 days of request	72 hours
Missouri	20 days	--
Montana	--	--
New Hampshire	20 days	72 hours
New Jersey	30 working days	--
New Mexico	30 days	--
New York	30 days of request	72 hours
North Carolina	52 days of request	4 days
Ohio	30 days of request	7 days
Oklahoma	30 days	72 hours
Pennsylvania	60 days of request	--
Rhode Island	10 working days	48 hours
Tennessee	30 days	7 days
Texas	20 days of request	8 days of request
Utah	--	--
Vermont	--	--
Virginia	30 working days of request	--
Washington	20 days of request	8 days of request

*Unless otherwise indicated, specified timeframes are "within ___ days after receipt of necessary documentation." The only exceptions are laws in KS, NM andRI which do not refer to necessary documentation.

Source: Blue Cross and Blue Shield Association, April 2000

Dan Ulmer/Testimony

SB2282 relates to a statute that passed during my tenure as Deputy Insurance Commissioner under Earl Pomeroy in the 1991 legislative session. Those of you who were on the committee at the time will probably recall that I could hardly spell insurance much less explain the intricacies of Utilization Review.

Here we are some seven legislative sessions later still trying to get it right. When I first heard of UR the providers wanted access to payment criteria. On the other hand, insurers were fearful that such a move would jeopardize the keys to the vault. We ended up comprising by allowing specialists to review cases and the criteria in their specific field. I can't accurately recall the chronology, but over the years we adjusted the timelines for review, made sure that a prudent person received appropriate emergency care, on and on. Last session we instituted the DOL rules so that Utilization Reviews would be standardized no matter if the insurance product was fully insured or self funded. All plans, providers, and, most importantly our members came under one set of rules for Utilization Review.

And now we're back with SB2282 and we're left in a quandary as to why. BCBSND has always been on the forefront of utilization review...we understand that our members need whatever treatment the doctor has ordered and the last thing anyone needs when they're sick is a hassle from their insurance company.

Health care is a vulnerable purchase, when we're sick we really don't care what it costs we'll spend everything we have to save a loved one or our self. Our role at Blue Cross puts us between providers, members, and patients. Our task is to help our members receive the finest care they can get and to do that we, like our providers and patients, often find our selves out on the frontiers of the art of medicine.

We at Blue Cross are constantly asked to approve new treatments, to reimburse new life saving techniques, new technology, approve new drugs, on and on and on. The art of medicine is in a constant state of evolution...miracles today will become ho-hum stuff of tomorrow...and so far we Americans have been willing to fund these miracles.

But for how long? Last Friday I was talking with a couple of our Bismarck based sales guys and they were bemoaning the fact that they were about to hand a couple of businesses premiums that exceeded $1200/month.

I remember back in 1987 when then Blue Cross President Hale Layborn took a large group of us legislators to lunch and informed us that if we weren't careful premiums will hit $300/month. Here we are 18 years later and premiums are four times that fear.

We do what we do at Blue Cross for around $.08 on the dollar so $.92 of every dollar goes to pay health care claims, thus we mirror the costs of health care in North Dakota. One is left to wonder how much longer can this health care conundrum go on.

Can't we insurers stop the price spiral? One of the few ways we can control costs is to review the utilization of our members. We think we do a good job until another bill like 2282 comes along and we once again get the opportunity to review our utilization review process for you.

We oppose 2282 for a variety of reasons, as Bob Stroup will explain shortly, we already do a good job of reviewing utilization and establishing prices for any given medical procedure given to us. We have expended a lot of resources complying with the existing law and we believe our system is not only more than adequate but open to whatever inspections the insurance commissioner, legislators, providers, or members might want to conduct.

We have a solid internal and external review process based on the best medical knowledge available to us. It's not uncommon for our stances to be overturned or adjusted upon appeal nor is it uncommon for our position to be upheld...each case is taken on its merits and we think the system is fair.

I'd like to introduce you to Bob Stroup our legal counsel on this issue to give you a better understanding of the details involved 2282...and further shore up our opposition to this bill.

Dan Ulmer
AVP Government Relations BCBSND

Rod St. Aubyn

From: Rod St. Aubyn [rod.st.aubyn@noridian.com]
Sent: Tuesday, February 08, 2005 6:26 AM
To: Joel Heitkamp; April Fairfield; Duane Mutch; Jerry Klein; Duaine Espegard
Subject: SB 2282

Please look at 26.1-26.4 (and page 2, lines 30-31 and on page 3, lines 1-7 of SB 2282) for the definitions of "Retrospective" and "Utilization Review". Retrospective is one type of utilization review. In Retrospective Review it says that it "means utilization review of medical necessity which is conducted after services have been provided to a patient, **but does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding, or adjudication for payment.**" (emphasis added by me.) The bolded statement is exactly what Chip Thomas is using for his examples in his testimony. Those were the result of DRG validation, a form of audit. It is not that we denied coverage for a member, but that we disagreed how it was coded and to be reimbursed. As a result, his bill will do **nothing** to correct what he points out as a problem. The language that I bolded are still in the bill. Utilization Review has **nothing** to do with how much a service is reimbursed. This entire chapter, which this bill sets out to amend, is being totally changed with their intent to review how services are being reimbursed.

I hope to have time with your committee today to point out a few issues. The issue discussed has been reduction of payments throught the DRG Validation Process. This type of audit was requested to be done by our consumer majority Board. The Board members can be found at this link: http://bcbsnd.com/about/corp_board.html
We have a fidicuary responsibility to our members.

The first point I want to make, **this should not be a legislative issue**. No one forces any provider to sign a contract with BCBSND. The providers have ever right and some contractual responsibilities to deal with us first. If that doesn't work, they have every right to deal with our Board, which I might add is comprised of 13 members - 5 of which represent the providers. In addition, the Hospital Association and the Medical Association appear at the request of the Board annually. During their most recent appearance, NDHA on August 27, 2004 and NDMA on October 22, 2004, just brief mention was made of issues such as this. In fact, only one issue dealt with Utilization Review, but did not deal with the DRG validation. I have included their comments from their power point presentations below:

NDHA (8/27/04) - One bullet point out of 37 slides with multiple points in each slide.

The Plan's utilization review program should be evaluated and steps taken as required to insure payment for medically necessary services.

NDMA (10/22/04) - One bullet point out of 36 slides with multiple points in each slide.

Develop a forum to address ongoing concern over BCBSND utilization review practices (e.g., retrospective reviews, level of care determinations) to ensure payment for medically-necessary care.

Not even 2 Board meetings have passed since that last recommendation, and we now have a bill draft on an issue which is not even "Utilization Review".

The providers have other recourses as well. They can take their disputes to court. We do have that occasionally and are currently dealing with an issue as we speak. It is not a common problem, but that recourse is definitely available to them. In addition, the provider can elect to go non-participating and not sign a contract. That option is not something that is in the best interest of our members and we would try to avoid that option, however, it is still an option available by the provider. Then they are not bound by any of our decisions of payment amounts. They then have the legal right to collect their charges from our member.

The second point I wanted to make is you are considering a bill in which we don't know what the finished product will look like. That is left up to the Insurance Commissioner through rule making process. This is a significant

policy issue and should be clearly spelled out in bill form.

Our staff is trying to find information concerning the 100+ DRG validation appeals in regards to facilities. The dollar amounts for each appeal will take longer to research. They hope to have the list of facilites included in these appeals this afternoon. I urge you to consider this issue carefully and hopefully realize that this is a contractual issue between two parties and not a legislative issue. I look forward to visiting with you all later. Rod

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CHAPTER 26.1-26.4
HEALTH CARE SERVICE UTILIZATION REVIEW

26.1-26.4-01. Purpose. The purpose of this chapter is to:

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

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

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

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

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

26.1-26.4-02. Definitions. For purposes of this chapter, unless the context requires otherwise:

1. "Commissioner" means the insurance commissioner.

2. "Emergency medical condition" means a medical condition of recent onset and severity, including severe pain, that would lead a prudent layperson acting reasonably and possessing an average knowledge of health and medicine to believe that the absence of immediate medical attention could reasonably be expected to result in serious impairment to bodily function, serious dysfunction of any bodily organ or part, or would place the person's health, or with respect to a pregnant woman the health of the woman or her unborn child, in serious jeopardy.

3. "Emergency services" means health care services, supplies, or treatments furnished or required to screen, evaluate, and treat an emergency medical condition.

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

5. "Health care insurer" includes an insurance company as defined in section 26.1-02-01, a health service corporation as defined in section 26.1-17-01, a health maintenance organization as defined in section 26.1-18.1-01, and a fraternal benefit society as defined in section 26.1-15.1-02.

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

7. "Retrospective" means utilization review of medical necessity which is conducted after services have been provided to a patient, but does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding, or adjudication for payment.

8. "Utilization review" means a system for prospective, retrospective, and concurrent review of the necessity and appropriateness in the allocation of health care

resources and services that are subject to state insurance regulation and which are given or proposed to be given to an individual within this state. Utilization review does not include elective requests for clarification of coverage.

9. "Utilization review agent" means any person or entity performing utilization review, except:

   a. An agency of the federal government; or

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

26.1-26.4-03. Certification. A utilization review agent may not conduct utilization review in this state unless the utilization review agent has certified to the commissioner in writing that the agent is in compliance with section 26.1-26.4-04. Certification must be made annually on or before March first of each calendar year. In addition, a utilization review agent must file the following information:

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

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

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

4. A list of the third-party payers for whom the private review agent is performing utilization review in the state.

A provider may request that a utilization review agent furnish the provider with the medical review criteria to be used in evaluating proposed or delivered health care services. Any material changes in the information filed in accordance with this section must be filed with the commissioner within thirty days of the change.

26.1-26.4-04. Minimum standards of utilization review agents. All utilization review agents must meet the following minimum standards:

1. Notification of a determination by the utilization review agent must be provided to the enrollee or other appropriate individual in accordance with 29 U.S.C. 1133 and the timeframes set forth in 29 CFR 2560.503-1.

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

3. Any notification of a determination not to certify an admission or service or procedure must include the information required by 29 U.S.C. 1133 and 29 CFR 2560.503-1.

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

   a. On appeal, all determinations not to certify an admission, service, or procedure as being necessary or appropriate must be made by a physician or, if appropriate, a licensed psychologist.

b. Utilization review agents shall complete the adjudication of appeals of determinations not to certify admissions, services, and procedures in accordance with 29 U.S.C. 1133 and the timeframes for appeals set forth in 29 CFR 2560.503-1.

c. Utilization review agents shall provide for an expedited appeals process complying with 29 U.S.C. 1133 and 29 CFR 2560.503-1.

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

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

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

8. Psychologists making utilization review determinations shall have current licenses from the state board of psychologist examiners. Physicians making utilization review determinations shall have current licenses from the state board of medical examiners.

9. When conducting utilization review or making a benefit determination for emergency services:

   a. A utilization review agent may not deny coverage for emergency services and may not require prior authorization of these services.

   b. Coverage of emergency services is subject to applicable copayments, coinsurance, and deductibles.

10. When an initial appeal to reverse a determination is unsuccessful, a subsequent determination regarding hospital, medical, or other health care services provided or to be provided to a patient which may result in a denial of third-party reimbursement or a denial of precertification for that service must include the evaluation, findings, and concurrence of a physician trained in the relevant specialty to make a final determination that care provided or to be provided was, is, or may be medically inappropriate.

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

26.1-26.4-04.1. Utilization review in this state - Conditions of employment. A utilization review agent is deemed to be conducting utilization review in this state if the agent conducts utilization review involving services rendered or to be rendered in the state regardless of where the agent actually performs the utilization review. No person may be employed or compensated as a private review agent under any agreement or contract when compensation of the review agent is contingent upon a denial or reduction in the payment for hospital, medical, or other health care services.

26.1-26.4-04.2. Utilization review - Duty of health care insurers. A health care insurer that contracts with another entity to perform utilization review on its behalf remains responsible to ensure that all the requirements of this chapter are met to the same extent the health care insurer would be if it performed the utilization review itself.

26.1-26.4-05. Utilization review agent violations - Penalty. Whenever the commissioner has reason to believe that a utilization review agent subject to this chapter has

been or is engaged in conduct that violates section 26.1-26.4-03 or 26.1-26.4-04, the commissioner shall notify the utilization review agent of the alleged violation. The utilization review agent has thirty days from the date the notice is received to respond to the alleged violation.

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

If, after the hearing, the commissioner determines that the utilization review agent has engaged in violations of this chapter, the commissioner shall reduce the findings to writing and shall issue and cause to be served upon the utilization review agent a copy of the findings and an order requiring the utilization review agent to cease and desist from engaging in the violations. The commissioner may also, at the commissioner's discretion, order:

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

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

Board of Directors

BCBSND is directed by a board of 13 men and women who represent business, government, health care a education.. All are committed to improving the quality of life and health in North Dakota.

The Board meets six times a year. Committees meet three to five times a year. Each Director serves on t committees, namely: Audit & Compliance, Governance & Nominating, Human Resources & Compensation, Finance & Investment, and the Quality Committee.

Officers of the Board
The present composition of the Board of Directors is eight Consumer Directors and Five Provider Directors **Frank Keogh**, President of American State Bank and Trust Co., Williston, is Chairman of the Board. **Dr. Robert Grossman**, United Clinics P.C., Hettinger, is Vice Chairman; and **Dennis Elbert, Ph.D.** is Secretary/Treasurer.

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Grand Forks, N.D.

Gary Miller
St. Alexius Medical Center
Bismarck, N.D.

2005 Senate Bill No. 2282
Testimony before the House Industry, Business, and Labor Committee
Presented by: Timothy J. Wahlin
Staff Counsel
Workforce Safety & Insurance
January 25, 2005

Mr. Chairman, Members of the Committee:

My name is Tim Wahlin and I am Staff Counsel with Workforce Safety & Insurance. I am here to testify in support of 2005 Senate Bill No. 2282 as amended. This bill proposes changes to the North Dakota Insurance Commissioner's Office requiring him to set up an External Review Organization in order to conduct reviews of adverse treatment decisions arising between providers and insurers.

Currently, WSI is not overseen by the North Dakota Insurance Commissioner's office. WSI operates as the sole provider of workers compensation insurance in North Dakota which arises from a Constitutional mandate.

WSI would offer an amendment removing **section 4** from the bill.

Senate Bill No. 2282, as it exists, would at section 4, alter WSI's dispute resolution decision process which currently exists. As it is, should a dispute arise over an Injured Workers' course of treatment, the provider may elect to enter WSI's binding dispute resolution service. This process is set forth at N.D.Admin. Rule section 92-01-02-46. This generally includes another medical review, by an appropriate outside professional regarding the advisability of the requested treatment. It includes an exchange of opinions between the provider and reviewer. This system has been in place since 1994 and has operated without any significant problems.

Under this bill, without our amendment, the legislation will add another layer of review.

The Board of Director's for WSI is not intrinsically opposed to this possibility. While on its face the process appears duplicative, if in practice this process adds value for our providers, we believe WSI has the ability to participate in the External Review established within this legislation, should there be no objection from the Insurance Department.

Consistent with this, WSI would offer this amendment removing Section 4 from the bill entirely.

OPPOSED

TESTIMONY BEFORE THE SENATE INDUSTRY BUSINESS & LABOR COMMITTEE

REGARDING SENATE BILL 2282

JANUARY 25, 2005

Chairman Mutch, members of the committee, I am David Zentner, Director of Medical Services for the Department of Human Services. I appear before you to provide information and to express concerns about how this bill will affect the Medicaid program.

The bill requires the Department of Human Services through the Medicaid program to participate in the external review process proposed in this bill. Section 2, paragraph 11, on lines 8 through 10, on page 5 requires our participation.

The Department has numerous concerns regarding this proposed legislation. First, it appears that any decision made by the external review organization would be binding on the Department. Section 4, paragraph 3 indicates that a written decision is provided. It does not indicate what recourse our office would have if the decision were adverse to the Department. Attached is a letter dated May 26, 2004 from the Centers for Medicare and Medicaid Services that indicates the Medicaid agency may not delegate or permit others to substitute their judgment for the agency's. This proposed law would appear to be in conflict with this federal regulation. The Department would still need to be able to make the final determination even if the external review organization overturned our original decision.

Lines 3 through 8 on page 5, permits either a provider, or in the case of Medicaid, a recipient to use this process to appeal a decision. The Department has an appeal process that permits a recipient to appeal any adverse decision through the administrative appeal process outlined in federal regulations. A second

appeal process for Medicaid recipients would be redundant and confusing for recipients.

Much of the language of the bill relates to medical insurance. The Medicaid program is a joint federal and state program that uses taxpayer funds to pay for medical services for low-income households. Language such as insured, insure, and insured's contract, are not terms associated with the Medicaid program. Eligibility for Medicaid is a means tested process. There is no contract. Recipients receive a package of services from providers who agree to enroll in the Medicaid program. If the Medicaid program is to be included in this bill, it may be necessary to include language that better defines the relationship between the state, the recipients, and participating providers.

The Department is cognizant of concerns that providers do not currently have an appeal mechanism when Medicaid denies payment for services provided. House Bill 1206 also deals with permitting providers to appeal adverse decisions of the Department. We are working with the bill sponsor to create an internal appeal process that would provide an inexpensive process. If providers are not satisfied with the independent decision within the Department, they could appeal directly to the courts. The Department requests that House Bill 1206 be considered before making a decision to include the Medicaid program in this bill.

The Department was not contacted regarding a fiscal note on this bill. We are concerned because Section 3 paragraph 1, item f, requires the Department to reimburse the cost of the review if the appeal by the provider or recipient is successful. We have no funds in our proposed budget to pay for these appeals. In addition, there is no mention of who pays if a recipient appeals. This section does indicate that an insured may not be assessed a fee for an appeal. Who pays the cost of the appeal in this situation to the external review organization? Most Medicaid recipients will not have the wherewithal to pay for such reviews. We are

uncertain if the intent is to have the Department pay for those reviews as well. If so, that would increase the cost to the Department's budget as well.

The Department requests that you consider removing the Medicaid program from this bill. We do understand that providers are frustrated by not having a direct appeal process, and we are trying to remedy that through HB 1206. If that mechanism proves to be unsatisfactory to providers, the Medicaid program could be added to this legislation in 2007.

I would be happy to respond to any questions you may have.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services

Andrew A. Fredrickson
Associate Regional Administrator, Division of Medicaid & Children's Health

1301 Young Street, Room 833
Dallas, Texas 75202
Phone (214) 767-6496
Fax (214) 767-0270

May 26, 2004

Mr. Ben Bearden, State Medicaid Director
Department of Health and Hospitals
Post Office Box 91030
Baton Rouge, LA 70821-9030

Dear Mr. Bearden:

We have reviewed your May 25, 2004 letter concerning the proposed removal of the fair hearings process from the Department of Health and Hospitals (DHH) per House Bill No. 1451. This bill proposes to move the Medicaid appeals process to the Division of Administrative Law. Decisions made by this organization would be final and binding on DHH, the single state Medicaid agency.

Under 42 CFR § 431.10(e), the State Medicaid agency may not delegate functions which involve authority to change or disapprove agency policies, or permit others to substitute their judgment for the agency's. If other State or local agencies or offices perform services for the Medicaid agency, they must not have the authority to change or disapprove any administrative decision of that agency, or otherwise substitute their judgment for that of the Medicaid agency with respect to the application of policies, rules, and regulations issued by the Medicaid agency.

Federal regulations do not permit the outsourcing of the Medicaid appeals process as reflected in House Bill No. 1451. If you have any questions, please contact me at (214) 767-4425.

Sincerely,

Jack Allen

Jack Allen
Health Insurance Specialist

CMS

PROPOSED AMENDMENTS TO SENATE BILL NO. 2282

Page 1, line 3, remove ", and 65-02-20"

Page 1, line 3, after "26.1-26.4-02," insert "and"

Page 1, line 4, remove "and workforce"

Page 1, line 5, remove "safety and insurance procedures for dispute resolution;"

Page 5, lines 7 and 8, remove ", including review of decisions affecting medical providers under section 65-02-20"

Page 7, Remove lines 12 through 31

Page 8, Remove lines 1 through 8

Submitted by WSI Staff attorney

Testimony in Support of Senate Bill No. 2282
Senate ~~Human Services~~ Committee /Bill
January 25, 2005

Chairman Mutch and Committee Members, I'm Bruce Levi representing the North Dakota Medical Association. NDMA is the professional membership organization for North Dakota's physicians, residents and medical students. NDMA supports the North Dakota Healthcare Association on this bill, SB 2282, which would establish an independent external appeal mechanism for the review of insurance claims denied for medical necessity. NDMA shares the concerns expressed by hospitals of the need for the availability of this kind of review mechanism in North Dakota.

Most States Provide for Independent Review

Legislators across the country are increasingly recognizing the need to ensure that consumers and health facilities and professionals have access to fair and impartial procedures that address complaints and provide for appeals of decisions to deny covered benefits. As a result, at least 42 states now require health plans to establish an independent external review process to provide enrollees who have exhausted the internal appeals process with an additional level of appeal – Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Hawaii, Georgia, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Montana, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin and the District of Columbia either have legislation or regulations in place concerning an independent review process for health plan enrollees.

The United States Supreme Court – The Moran Decision Recently Upheld State Independent Review Laws

State statutes that provide for independent external review of denied claims have been upheld by the United State Supreme Court. On June 20, 2002, the Supreme Court in Rush Prudential HMO, Inc. v. Moran upheld the Seventh Circuit Court of Appeals decision that, where a patient's claim has been denied for medical necessity, the patient has a right to review by an independent medical review. The Moran case, which upheld an Illinois statute, illustrates one

example of how these types of review mechanisms can assist consumers of health care receive what they are entitled to in their insurance contracts.

Moran, a patient, sought reimbursement for the expense she incurred for microneurolysis surgery. Rush, her insurer, denied the claim because in its opinion the surgery was not medically necessary. The Illinois law requires that, in such disputes, the matter be submitted to an independent reviewer for a binding determination. Rush refused to provide the independent reviewer, so Moran obtained a court order compelling the independent review. The independent reviewer found that the microneurolysis surgery was medically necessary, but Rush still refused to pay. It relied on its own reviewers, who contended that the surgery was medically unnecessary. Moran then sought a court order requiring Rush to pay in accordance with the decision of the independent reviewer and proceeded through a series of court proceedings resulting in the decision of the Supreme Court.

The Moran decision allows doctors to act as stronger advocates for their patients. If a doctor truly believes that a certain covered treatment is the best course of action for a patient, he or she can now act with the knowledge that the insurer does not have final decision-making power. In at least 42 states, patients and physicians can be secure in the knowledge that disagreements between physician treatment recommendations and insurer decisions can be taken to an objective, third-party review board. When Moran was decided, many called it a victory for consumers. A victory, at least, for those states with external review laws in place.

SB 2282 Provisions

SB 2282 would require the North Dakota Insurance Commissioner to adopt rules establishing external review procedures to address "disputes between a provider of record or enrollee and the utilization review agent over adverse utilization review determinations regarding coverage of services or the medical necessity of a covered admission, service, or procedure." The bill places these provisions in chapter 26.1-26.4 and uses current definitions. An adverse decision is defined as "a determination by an insurer that a proposed or delivered health care service which would be otherwise covered under an insured's contract is not or was not medically necessary or the health care treatment has been determined to be experimental or investigational."

In adopting rules setting up the independent external review, the Insurance Commissioner would be required to negotiate contracts with external review organizations which would be eligible to conduct independent reviews of adverse decisions. An "external review organization" is defined in the bill to include the federally designated state peer review organization, which in North Dakota is North Dakota Health Care Review, Inc. located in Minot, or the organization could be another entity that has experience serving as an external quality review organization in health programs administered by the state or be a nationally accredited external review organization which utilizes health care providers actively engaged in the practice of their profession in the state who are qualified and credentialed with respect to the health care service review.

SB 2282 also provides several parameters for the Commissioner in establishing the rules, including timeframes for the review, the need for an expedited process if the case involves an emergency medical condition, standards of review, and discretion to determine appropriate fees for the review if the reviews are sought by a hospital, physician or other medical service provider. The standard of review must be whether the health care service denied by the health care insurer was medically necessary and a covered service under the terms of the insured's contract. In reviews regarding experimental or investigational treatment, the standard of review must be whether the health care service denied by the health care insurer was covered or excluded from coverage under the terms of the insured's contract. The bill states clearly that the right to external review may not be construed to change the terms of coverage under a health insurance plan or insurance policy. In other words, if an admission, service or procedure is not covered under an enrollee's policy, the independent external review would not make something covered that is not covered. The purpose of the review is to examine whether a covered admission, service or procedure was medically necessary or not.

The state's Insurance Commissioner is in the best position to develop external review procedures. The North Dakota Medical Association believes SB 2282 is an idea whose time as come for North Dakota, to ensure that medical decisions made by patients in consultation with their physician are not hampered or thwarted by insurance companies.

On behalf of North Dakota's physicians, I urge you to support SB 2282 with a "do pass" recommendation.

NORTH DAKOTA
MEDICAL
ASSOCIATION

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Testimony in Support of Senate Bill No. 2282
House Industry Business and Labor Committee
March 9, 2005

Chairman Keiser and Committee Members, I'm Bruce Levi representing the North Dakota Medical Association. NDMA is the professional membership organization for North Dakota's physicians, residents and medical students. NDMA supports the North Dakota Healthcare Association on this bill, SB 2282, which would establish an independent external review mechanism for the review of insurance claims. NDMA shares the concerns expressed by hospitals of the need for the availability of this kind of review mechanism in North Dakota.

Most States Provide for Independent Review

Legislators across the country are increasingly recognizing the need to ensure that consumers and health facilities and professionals have access to fair and impartial procedures that address complaints and provide for appeals of decisions to deny or reduce covered benefits. As a result, at least 42 states now require health plans to establish an independent external review process to provide enrollees or providers who have exhausted the plan's internal appeals process with an additional level of appeal – Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Hawaii, Georgia, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Montana, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin and the District of Columbia either have legislation or regulations in place concerning an independent review process for health plans.

The United States Supreme Court Recently Upheld State Independent Review Laws

State statutes that provide for independent external review of denied claims have been upheld by the United State Supreme Court. On June 20, 2002, the Supreme Court in Rush Prudential HMO, Inc. v. Moran upheld the Seventh Circuit Court of Appeals decision that, where a patient's claim has been denied for medical necessity, the patient has a right to review by an independent medical review. The Moran case, which upheld an Illinois statute, illustrates one example of how these types of review mechanisms can assist consumers of health care receive what they are entitled to in their insurance contracts.

Moran, a patient, sought reimbursement for the expense she incurred for microneurolysis surgery. Rush, her insurer, denied the claim because in its opinion the surgery was not medically necessary. The Illinois law requires that, in such disputes, the matter be submitted to an independent reviewer for a binding determination. Rush refused to provide the independent reviewer, so Moran obtained a court order compelling the independent review. The independent reviewer found that the microneurolysis surgery was medically necessary, but Rush still refused to pay. It relied on its own reviewers, who contended that the surgery was medically unnecessary. Moran then sought a court order requiring Rush to pay in accordance with the decision of the independent reviewer and proceeded through a series of court proceedings resulting in the decision of the Supreme Court.

The Moran decision allows doctors to act as stronger advocates for their patients. In at least 42 states, patients and physicians can be secure in the knowledge that disagreements between physician treatment recommendations and insurer decisions can be taken to an objective, third-party review board.

SB 2282 Provisions

Engrossed SB 2282 would require a nonprofit mutual insurance company that offers an accident and health line of insurance to establish and implement an independent external review mechanism to review and determine whether medical care rendered was medically necessary and appropriate to the claim as submitted by the provider. In our view, a major weakness in the engrossed bill is the lack of a definition of what would constitute an "independent external

review mechanism." NDMA would support any amendments to Engrossed SB 2282 that would provide such a definition.

On behalf of North Dakota's physicians, I urge you to further amend SB 2282 as suggested and support the amended bill with a "do pass" recommendation.

NDHA
North Dakota Healthcare Association

Vision
The North Dakota Healthcare Association will take an active leadership role in major healthcare issues.

Mission
The North Dakota Healthcare Association exists to advance the health status of persons served by the membership.

Testimony for SB 2282
March 9, 2005

My name is Arnold Thomas. I am the President of the North Dakota Healthcare Association and I am appearing in support of SB 2282.

Let me share with you why this bill is needed. Here's a hypothetical:

Suzie is 14 years old. She is experiencing severe abdominal pain. She is admitted to a hospital. It looks like appendicitis. Tests are run and what we find is not appendicitis – but rather an ovarian cyst. We keep her for a couple of days in the hospital. We undertake a treatment program -- Her condition improves and we discharge her with several days worth of antibiotics.

Suzie was kept in the hospital for two days. Her bill is $3,400 and we submitted that to her insurance carrier. Her insurance carrier reviewed the case and concluded that she should have been treated as an outpatient. Her insurance carrier sends the hospital a check for $900. The hospital appeals the claim to the insurance carrier. The insurance carrier looks at the claim again and says – "Sorry, we think she should have been treated as an outpatient -- Our check to you for $900 is payment in full."

Here's the problem. When Suzie was checked in, her attending physician made certain medical judgments.

Her insurance carrier reviews the case and decides that it does not agree with the medical judgments that Suzie's physician had made.

If the two judgments conflict, and payment is denied in whole or in part, we -- the hospitals – have no one to whom we can turn for a review of the decision.

That's why we need to have you create for us an external review mechanism -- one that is independent and impartial. We don't expect to be paid for providing more services than are medically necessary but, by the same token, we can't be the entity on which the insurance company balances its budget. If we provide legitimate services -- we expect and need to be paid for those services.

Let me take this opportunity to clarify for you some concepts that seem to be getting in the way of this bill.

Insurance carriers may refer to their use of an external review mechanism. This sounds a lot like the external review mechanism that we are seeking with this bill. It is not.

PO Box 7340 Bismarck, ND 58507-7340 Phone 701-224-9732 Fax 701-224-9529

Depending upon the contested claim, a carrier may not employ the necessary medical staff for reviewing the contested claim. In these instances, the carrier hires consultants to review the disputed claim and its decision of denial. These retained consultants are frequently referred to as external reviewers. While external to the company, they are in fact on the payroll of only one of the parties.

What we want to have is access to an external review process -- to one that is truly impartial. If we submit a bill to a commercial insurance carrier and if the carrier denies the payment after completing its own review, we want to have the option of the disputed claim being reviewed by someone who owes no allegiance to either the hospital or the insurance carrier.

If the claim is reviewed and the hospital prevails, the insurance carrier pays for the review. If the claim is reviewed and the insurance carrier prevails, the hospital pays for the review.

This is not a novel concept. In fact, all but 9 states already have an independent external review. In this state, Medicaid claims are still settled by courts. However, Medicare uses a neutral third party and Work Force Safety has committed to instituting an external review mechanism using a neutral third party for disputed claims.

As introduced, SB 2282 established an independent external - outside review of disputed claims. As passed by the Senate, the bill remained true to its purpose, but less clear in defining expectations and responsibility for costs. I therefore have an amendment that I would like to share with you. The first provision clarifies what is meant by an external review process. It is not to be confused with any internal review that a payer already has for its own purposes. The second provision clarifies that the cost of this external review is borne by the party that does not prevail.

With that Mr. Chairman, I will be happy to answer any questions the committee might have.

We respectfully request a Do Pass on SB 2282 with our offered amendments.

Fifty-ninth
Legislative Assembly
of North Dakota

AMENDMENTS TO
ENGROSSED SENATE BILL NO. 2282

Introduced by:

Senators Brown, Heitkamp, Lyson

Representatives Nelson, Price

A BILL for an Act to create and enact a new section to chapter 26.1-12 of the North Dakota Century Code, relating to nonprofit mutual insurance company independent external review requirements.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. A new section to chapter 26.1-12 of the North Dakota Century Code is created and enacted as follows:

Independent external review. A nonprofit mutual insurance company that offers an accident and health line of insurance shall establish and implement an independent external review mechanism to review and determine whether medical care rendered was medically necessary and appropriate to the claim as submitted by the provider. An independent external review shall mean a review conducted by North Dakota Health Care Review, Inc., another PRO-like organization meeting the requirements of section 1152 of the Social Security Act, or any organization, group or individual designated by the North Dakota Commissioner of Insurance to conduct such an independent external review. A determination made by the independent external reviewer is binding on the parties. Costs associated with the independent external review shall be the responsibility of the non-prevailing party.