1999 SENATE HUMAN SERVICES

SB 2400

1999 SENATE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. SB2400

Senate Human Services Committee

❑ Conference Committee

Hearing Date FEBRUARY 10, 1999

Tape Number		Side A	Side B	Meter #
	1	X	X	
	2	X		
2/15/99	1	X		2,590
2/15/99	1		X	5,030
2/15/99	2	X		
Committee Clerk Signature		Carol Kolodejchuk		

Minutes:

The committee was called to order.

The hearing was opened on SB2400.

SENATOR KILZER, sponsor, introduced the bill. (written testimony).

REPRESENTATIVE SVEDJAN opposes the bill. (written testimony).

SENATOR DEMERS asked if the ALTRU plan is opposed to the bill. REP. SVEDJAN replied that it was.

SENATOR DEMERS, sponsor, explained the Medical concepts came from the Federal Bill of Rights. This is important in preventing problems. It tries to re-balance and come down to physician/patient or provider/patient relationship.

DR. LAYMAN, ND Medical Assoc., supports bill with written testimony.

BRUCE LEVI, ND Medical Association, supports bill, and explained the bill summary in written testimony. Offered amendments. SENATOR LEE asked if we didn't pass this bill in the last session? MR. LEVI stated the last session bill put in gag clause; what we are dealing with now is not interfering with the physician/patient communications. This one is financial incentives that reduce, denying a medical procedure. SENATOR LEE stated that we spent a lot of time on utilization last session, why bring it up again? MR. LEVI: Last session was restricted to peer review. This is different. SENATOR LEE: Do financial incentives control cost? MR. LEVI: Financial incentives are orders for additional tests. That is why we have utilization review. SENATOR LEE: What are we talking about in withholding care? Is it fair to ask if a test is important? MR. LEVI: Yes, because DR's get part payment for each test. SENATOR LEE: Is telemedicine licensed in ND or is there any telemedicine? MR. LEVI: There is a bill in the House 1158 to license telemedicine. SENATOR LEE: Would this permit selling names and information? MR. LEVI: No, we have a confidentiality law. SENATOR LEE: In the physician's profile can the patients inquire about the records? Would this admit a physician's personal letters to be included. MR. LEVI: The bill itself would require any practice profile would be disclosed by a third party that that would have to go along with it. SENATOR DEMERS: Rep. Svedjen was concerned with section 10. Does the bill go too far in protecting? MR. LEVI: The section starts with the old law and we made changes. If a physician were to be involved is excessive pattern of practice, he would be given six months to clean up his act. If not, they could be sanctioned, terminated or be termed non payable and would get a review by a committee of the carrier. The physician could not be designated non pay unless the committee

recommended that. Our process includes any sanction, termination or pay status. This bill is more strict than old one.

CAL ROLFSON, Attorney representing Pharmaceutical Research and Mfg. of America, supports bill in written testimony. Amendments were offered. Page 16, line 18. Page 17 line 2. New section 4. SENATOR DEMERS: Are you eliminating outcomes? MR. ROLFSON stated that is was okay with PHARMA.

CRAIG BOECKEL, attorney for ND Chiropractic Assoc., supports bill in written testimony. Amendments were presented.

CHRIS RUNGE, Exec Director of ND Public Employees Assoc., supports bill in written testimony.

KAREN HAGEL, Prime Care Health Group, supports bill. We feel it is important for patients to have choices and to be informed of these options and it is important to have the patient/physician relationship protected as well as the confidentiality.

CHRIS EDISON, ND Insurance Dept., supports bill. Sections 3 & 5, section 11, are very appealing to the department. Section 2 is put in another bill and may need to be squared. The bill is a House bill 1178.

DON MORRISON, Progressive Coalition, supports bill. Consumers need to be protected. There is an insurance bureaucracy between patient and provider. We need to look at the opposition. There is a concern of costs.

PENNY WESTON, ND Nurses Assoc., supports bill and healthier provider amendments.

AL WOLF, ND Trial Lawyers, supports bill and presented amendments. Page 12, line 26 need to have all insurer's of limited policies included; not left out.

Opposition on SB2400

JON RICE, MD with BC/BS, opposes bill with written testimony. SENATOR THANE: Don't you feel SB2400 is way to address the customers? DR. RICE: Some ideas are in place; some are left out and some go to far. We need to get back to the center balance. SENATOR KILZER asked about the tier plan. DR. RICE: This is an efficiency rating of physician. It has been talked about in theory, but the mechanics don't exist. It is not concrete. SENATOR DEMERS: Do you supply same standards to Medicare as personal plans. DR. RICE: Medicare is done in a separate office. Does not interact. These are requirements from HCLA.

TOM SMITH, Health Insurance of America, opposes bill. One of the concerns is the continuing enactment of statutory provisions which create serious barriers as far as insurance companies who operate out of state. BC/BS only operate in ND; 70% of the market. Narrowing down the requirements as far as time frames. This will eliminate competition. The consumer will have no choice. AFLAC is the largest specified disease underwriter. We buy these policies to protect us so when we go into the hospital, like accident, dental, vision, Medicare supplement, long term care insurance. We need this protection. Do not include limited benefit policies. Mr. Wolf's amendments demand this.

SENATOR DEMERS: Do you ever turn down someone with a claim? Mr. SMITH: We do not write flood insurance. There may be instances where disputes arise, but they are clear cut decisions.

DAN ULMER, BC/BS, I work on Federal legislation. You must look at this bill and see that it is payment protection; it is also provider protection. It is minimal as far as patient protection. Page 13 of the bill under B. If they are non par with us they will pay 80% and they determine by what

the market is. Page 14, description of any method used by the insurer providing financial payments, but we cannot publicly disclose the individual contract. Are we hiding? Is there something wrong with how we pay people. What about the Dr.'s track record; what about the Hospital's track record; what about the patient's risk; doesn't that come into the game.

SENATOR DEMERS: Where do you see a middle ground? MR. ULMER: We need to take time; there is too much in this bill. Study resolution would work some of these things out. All have to come together. SENATOR THANE: Would a study resolution get both sides together? MR. ULMER: Some days the magic works; sometimes it doesn't. SENATOR DEMERS: I have been witnessing a moving apart. No longer have advisory board members from the Med. world. MR. ULMER: We are moving away from provider domination to consumer domination. SENATOR DEMERS: Maybe insured domination.

No more testimony was given. The hearing was closed on SB2400.

BRUCE LEVI offered amendments from the ND Med Assoc in conjunction with other entities and explained them. (written). It incorporates lay person for emergency service. It deletes all review language. It removes the definition of medical necessity and how it might apply to other aspects of the code. Take out reference to retaliation to physician. Grievance anything except nonpayment. Remove Section B completely. It cuts the bill in half.

DAN ULMER: We are still opposed to the bill with these amendments. You now have patient protection at Federal level. Grievance procedure must go through Insurance Commissioner. Where are the problems now? Are these problems to come? Things are functioning very well. We would like to see a study resolution instead of a bill. Offered amendments.

SENATOR DEMERS: How can we depend on Federal legislation? It has been known to not be there in the past. MR. ULMER: They have switched the process back to committees and the presumption is that the committees will move forward with it.

TOM SMITH: Limited policies should not be part of this bill.

The discussion was closed until this afternoon.

BC/BS offered amendments. Select choice of programs. Amend out confidentiality on page 15. Without these amendments we cannot support the bill. SENATOR DEMERS asked why they objected to medical confidentiality rules? MR. ULMER stated that we get mandated and want only one law in all states rather than a law in each state.

SENATOR KILZER stated that these amendments are not acceptable. Protective patient is only a maneuver. This is an insurance company mandating which person should see which physician. Discussion continued.

SENATOR DEMERS moved the ND Med Assoc. amendments. SENATOR KILZER seconded the motion. Roll call vote carried 6-0-0. SENATOR LEE moved the BC/BS amendments. SENATOR FISCHER seconded. Roll call vote failed 2-4-0. SENATOR KILZER moved a DO PASS AS AMENDED. SENATOR DEMERS seconded it. Roll call vote carried 4-2-0. SENATOR KILZER will carry the bill.

FISCAL NOTE

(Return original and 10 copies)

Bill/Resolution No.: _____ Amendment to: SB 2400

Requested by Legislative Council Date of Request: 2-18-99

1. Please estimate the fiscal impact (in dollar amounts) of the above measure for state general or special funds, counties, cities, and school districts.

   Narrative:

   House Bill No. 2400 will require the Insurance Department to review additional filings from health insurers in this state. There will be a minor increase in fees collected for such filings. However, the amount of the increase should be insignificant. Also, we anticipate being able to review those filings without any additional staff. As such, we do not anticipate that House Bill No. 2400 will have a fiscal impact.

2. **State** fiscal effect in dollar amounts:

	1997-99 Biennium		1999-2001 Biennium		2001-03 Biennium	
	General Fund	Special Funds	General Fund	Special Funds	General Fund	Special Funds
Revenues:	0	0	0	0	0	0
Expenditures:	0	0	0	0	0	0

3. What, if any, is the effect of this measure on the appropriation for your agency or department:
   a. For rest of 1997-99 biennium: None
   b. For the 1999-2001 biennium: None
   c. For the 2001-03 biennium: None

4. **County, City, and School District** fiscal effect in dollar amounts:

1997-99 Biennium			1999-2001 Biennium			2001-03 Biennium		
Counties	Cities	School Districts	Counties	Cities	School Districts	Counties	Cities	School Districts
0	0	0	0	0	0	0	0	0

If additional space is needed, attach a supplemental sheet.

Signed _____

Typed Name Chris Edison

Date Prepared: 2/23/99

Department Insurance Department

Phone Number 328-2440

FISCAL NOTE

(Return original and 10 copies)

Bill/Resolution No.: SB 2400 Amendment to: _____

Requested by Legislative Council Date of Request: 1-27-99

1. Please estimate the fiscal impact (in dollar amounts) of the above measure for state general or special funds, counties, cities, and school districts.

   Narrative:

   House Bill No. 2400 will require the Insurance Department to review additional filings from health insurers in this state. However, the Insurance Department anticipates being able to review these filings without any additional staff. As such, we do not anticipate that House Bill No. 2400 will have a fiscal impact.

2. **State** fiscal effect in dollar amounts:

	1997-99 Biennium		1999-2001 Biennium		2001-03 Biennium	
	General Fund	Special Funds	General Fund	Special Funds	General Fund	Special Funds
Revenues:	0	0	0	0	0	0
Expenditures:	0	0	0	0	0	0

3. What, if any, is the effect of this measure on the appropriation for your agency or department:
   a. For rest of 1997-99 biennium: None
   b. For the 1999-2001 biennium: None
   c. For the 2001-03 biennium: None

4. **County, City, and School District** fiscal effect in dollar amounts:

1997-99 Biennium			1999-2001 Biennium			2001-03 Biennium		
Counties	Cities	School Districts	Counties	Cities	School Districts	Counties	Cities	School Districts
0	0	0	0	0	0	0	0	0

If additional space is needed, attach a supplemental sheet.

Signed _____

Typed Name Chris Edison

Date Prepared: 2/1/99

Department Insurance Department

Phone Number 328-2440

February 10, 1999
North Dakota Medical Association

PROPOSED AMENDMENTS TO SENATE BILL NO. 2400

Page 12, line 5, after the underscored period, insert "The review panel shall issue a written decision to the enrollee or the provider of record within five business days of completing the review meeting or, in the case of a review from an expedited appeal, as expeditiously as the enrollee's medical condition requires."

Page 16, line 27, after "26.1-26.4" insert an underscored comma and after "claim" insert an underscored comma

Renumber accordingly

February 15, 1999
North Dakota Medical Association

PROPOSED AMENDMENTS TO SENATE BILL NO. 2400

Page 1, line 1, replace the second "four" with "two"
Page 1, line 6, replace "subsections 4 and 5 of section 26.1-26.4-02, sections 26.1-26.4-03," with "subsection 9 of section"
Page 1, line 7, replace "26.1-26.4-04.1," with "and section" and remove ", and subsection 2 of section 26.1-47-03"

Page 2, remove lines 16 through 22
Page 2, line 23, replace "f." with "e."

Page 3, line 9, remove ", or protests a decision, policy, or"
Page 3, remove line 10
Page 3, line 11, remove "the provider's ability to provide medically necessary care"
Page 3, line 29, replace "Four" with "Two"

Page 4, remove lines 11 through 29

Page 5, remove lines 1 through 27
Page 5, line 28, replace "Section" with "Subsection 9 of section"
Page 5, remove lines 30 and 31

Page 6, remove lines 1 through 31

Page 7, remove lines 1 through 31

Page 8, remove lines 1 through 31

Page 9, remove lines 1 through 31

Page 10, remove lines 1 through 11
Page 10, line 12, remove the overstrike over "9"
Page 10, line 16, remove "14. Emergency services."
Page 10, remove lines 20 through 28
Page 10, line 29, replace "c." with "b."

Page 11, remove lines 1 through 31

Page 12, remove lines 1 through 31

Page 13, remove lines 1 through 3

Page 14, line 21, remove ". This subdivision may not be construed as requiring"
Page 14, remove line 22
Page 14, line 23, remove "arrangements between a health care provider and an insurer"

Page 16, line 18, replace "only" with "or epidemiological or outcomes research"

Page 16, line 27, after "26.1-26.4" insert an underscored comma and after "claim" insert an underscored comma

Page 16, line 28, after the underscored period insert "This section does not apply to data or information disclosed by an insurer as part of a biomedical research project approved by an institutional review board established under federal law."

Page 17, line 11, replace the second "a" with "an excessive or inappropriate"
Page 17, line 12, remove "that indicates provision of care that is not medically necessary"
Page 17, line 14, replace "not medically necessary" with "excessive or inappropriate"
Page 17, line 16, replace the second "physician's" with "excessive or inappropriate"
Page 17, line 18, after "contract" insert an underscored comma and replace ", if the physician's" with "designate"
Page 17, remove line 19
Page 17, line 20, remove "medically necessary," and remove "may be designated"
Page 17, line 23, replace "a majority representation" with "at least one representative"
Page 17, line 29, replace "except in a legal" with an underscored period
Page 17, remove line 30

Page 18, line 1, remove "in its contract review"
Page 18, line 2, replace "disclose in its contract with the" with "provide,"
Page 18, line 3, remove "physician, and" and remove "provide"

Page 19, line 11, remove "The grievance procedure is in addition to"
Page 19, remove line 12
Page 19, line 13, remove the underscored colon
Page 19, line 14, replace "a. A" with "a" and remove ", over a period of at least three previous"
Page 19, line 15, remove "years," and replace "and appeals;" with "since the date of its last examination of the grievances."
Page 19, remove lines 16 through 19

Page 20, line 20, remove ", reduce, limit, or delay"
Page 20, line 21, remove "or interfere"
Page 20, remove lines 22 and 23
Page 20, line 24, remove "necessary for treatment or diagnosis"
Page 20, remove lines 28 through 31

Page 21, remove lines 1 through 3

Renumber accordingly

adopted

February 15, 1999
North Dakota Medical Association

PROPOSED AMENDMENTS TO SENATE BILL NO. 2400

Page 1, line 1, replace the second "four" with "two"
Page 1, line 6, replace "subsections 4 and 5 of section 26.1-26.4-02, sections 26.1-26.4-03," with "subsection 9 of section"
Page 1, line 7, replace "26.1-26.4-04.1," with "and section" and remove ", and subsection 2 of section 26.1-47-03"

Page 2, remove lines 16 through 22
Page 2, line 23, replace "f." with "e."

Page 3, line 9, remove ", or protests a decision, policy, or"
Page 3, remove line 10
Page 3, line 11, remove "the provider's ability to provide medically necessary care"
Page 3, line 29, replace "Four" with "Two"

Page 4, remove lines 11 through 29

Page 5, remove lines 1 through 27
Page 5, line 28, replace "Section" with "Subsection 9 of section"
Page 5, remove lines 30 and 31

Page 6, remove lines 1 through 31

Page 7, remove lines 1 through 31

Page 8, remove lines 1 through 31

Page 9, remove lines 1 through 31

Page 10, remove lines 1 through 11
Page 10, line 12, remove the overstrike over "9"
Page 10, line 16, remove "14. Emergency services."
Page 10, remove lines 20 through 28
Page 10, line 29, replace "c." with "b."

Page 11, remove lines 1 through 31

Page 12, remove lines 1 through 31

Page 13, remove lines 1 through 3

Page 14, line 21, remove ". This subdivision may not be construed as requiring"
Page 14, remove line 22
Page 14, line 23, remove "arrangements between a health care provider and an insurer"

Page 16, line 18, replace "only" with "or research"

Page 16, line 27, after "26.1-26.4" insert an underscored comma and after "claim" insert an underscored comma

Page 16, line 28, after the underscored period insert "This section does not apply to data or information disclosed by an insurer as part of a biomedical research project approved by an institutional review board established under federal law."

Page 17, replace lines 6 through 30 with:

"1. An insurance company, as defined by section 26.1-02-01, issuing a health and accident policy, a health maintenance organization, or any other entity providing a plan of health insurance or health benefits subject to state insurance regulation may not terminate a practitioner's participating contract, designate a practitioner as nonpayable, or otherwise impose sanctions on any practitioner for an excessive or inappropriate practice pattern unless the requirements of this section are met. If a practitioner engages in an excessive or inappropriate practice pattern as compared to the practice pattern for the practitioner's specialty, the entity shall inform the practitioner, in writing, as to the manner in which the practitioner's practice pattern is excessive or inappropriate. The entity shall consult with the practitioner and provide a reasonable time period of not less than six months within which to modify the practitioner's practice pattern. If the excessive or inappropriate practice pattern continues, the entity may impose reasonable sanctions on the practitioner, terminate the practitioner's participating contract, or designate the practitioner as nonpayable. If considered for sanction, termination, or nonpayable status, the affected practitioner must first be given the opportunity to be present and to be heard by a committee appointed by the entity which must include at least one representative of the practitioner's specialty. The entity may not impose sanctions on a practitioner, terminate a practitioner, or designate a practitioner as nonpayable in the absence of the committee's recommendation to do so. All reports, practice profiles, data, and proceedings of the entity relative to a practitioner who is sanctioned, terminated, or considered for designation as nonpayable are confidential, and may not be disclosed or be subject to subpoena or other legal process. Nonpayable status under this section may not commence until after appropriate notification to the entity's subscribers and the affected practitioner. As used in this section, "practitioner" includes an optometrist, a physician, a chiropractor, or an advanced registered nurse practitioner duly licensed to practice in this state."

Page 18, line 1, remove "in its contract review"
Page 18, line 2, replace "physician's" with "practitioner" and replace "disclose in its contract with the" with "provide,"
Page 18, line 3, remove "physician, and" and replace "physician provide" with "practitioner"
Page 18, line 5, replace "physician" with "practitioner"
Page 18, line 6, replace the first "physician" with "practitioner" and the second "physician" with "practitioner"
Page 18, line 7, replace "physician's" with "practitioner's" and replace "physician" with "practitioner"
Page 18, line 8, replace "physician" with "practitioner"
Page 18, line 11, replace "physician" with "practitioner"
Page 18, line 12, replace "physicians" with "practitioners"
Page 18, line 13, replace "physician" with "practitioner"
Page 18, line 17, replace "physicians" with "practitioners"
Page 18, line 22, replace "physician" with "practitioner"
Page 18, line 24, replace "physician" with "practitioner"
Page 18, line 25, replace "physician" with "practitioner"
Page 18, line 27, replace "physician" with "practitioner"
Page 18, line 28, replace "physician" with "practitioner"
Page 18, line 30, replace "9" with "6"

Page 19, line 11, remove "The grievance procedure is in addition to"
Page 19, remove line 12
Page 19, line 13, remove the underscored colon
Page 19, line 14, replace "a. A" with "a" and remove ", over a period of at least three previous"
Page 19, line 15, remove "years," and replace "and appeals;" with "since the date of its last examination of the grievances."
Page 19, remove lines 16 through 19

Page 20, line 20, remove ", reduce, limit, or delay"
Page 20, line 21, remove "or interfere"
Page 20, remove lines 22 and 23
Page 20, line 24, remove "necessary for treatment or diagnosis"
Page 20, remove lines 28 through 31

Page 21, remove lines 1 through 3

Renumber accordingly

Date: 2/15/99
Roll Call Vote #: 1

1999 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2400

Senate HUMAN SERVICES COMMITTEE Committee

☐ Subcommittee on _____
or
☐ Conference Committee

Legislative Council Amendment Number _____

Action Taken ND Med Assoc. Amendments

Motion Made By Sen DeMers Seconded By Sen Kilzer

Senators	Yes	No	Senators	Yes	No
Senator Thane	✓				
Senator Kilzer	✓				
Senator Fischer	✓				
Senator Lee	✓				
Senator DeMers	✓				
Senator Mutzenberger	✓				

Total 6 (yes) 0 (no)

Absent 0

Floor Assignment _____

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

Date: 2/10
Roll Call Vote #: 2400 2

1999 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2400

Senate HUMAN SERVICES COMMITTEE Committee

☐ Subcommittee on _____
or
☐ Conference Committee

Legislative Council Amendment Number _____

Action Taken Blue Cross/Blue Shield defeated

Motion Made By Sen Lee Seconded By Sen Fischer

Senators	Yes	No	Senators	Yes	No
Senator Thane		✓			
Senator Kilzer		✓			
Senator Fischer	✓				
Senator Lee	✓				
Senator DeMers		✓			
Senator Mutzenberger		✓			

Total 2 (yes) 4 (no)

Absent 0

Floor Assignment _____

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

Date: 2/5/99
Roll Call Vote #: 3

1999 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2400

Senate HUMAN SERVICES COMMITTEE Committee

☐ Subcommittee on _____
or
☐ Conference Committee

Legislative Council Amendment Number _____

Action Taken Do Pass As Amended

Motion Made By Sen Kilzer Seconded By Sen DeMers

Senators	Yes	No	Senators	Yes	No
Senator Thane	✓				
Senator Kilzer	✓				
Senator Fischer		✓			
Senator Lee		✓			
Senator DeMers	✓				
Senator Mutzenberger	✓				

Total 4 (yes) 2 (no)

Absent 0

Floor Assignment Sen Kilzer

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

REPORT OF STANDING COMMITTEE

SB 2400: Human Services Committee (Sen. Thane, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (4 YEAS, 2 NAYS, 0 ABSENT AND NOT VOTING). SB 2400 was placed on the Sixth order on the calendar.

Page 1, line 1, replace the second "four" with "two"

Page 1, line 6, replace "subsections 4 and 5 of section 26.1.26.4-02, sections 26.1-26.4-03," with "subsection 9 of section"

Page 1, line 7, replace "26.1-26.4-04.1," with "and section" and remove ", and subsection 2 of section 26.1-47-03"

Page 2, line 16, remove ""Medically necessary care" means health care services, supplies, or"

Page 2, remove lines 17 through 22

Page 2, line 23, remove "f."

Page 3, line 9, remove ", or protests a decision, policy, or"

Page 3, remove line 10

Page 3, line 11, remove "the provider's ability to provide medically necessary care"

Page 3, line 29, replace "Four" with "Two"

Page 4, remove lines 11 through 29

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Page 14, line 23, remove "arrangements between a health care provider and an insurer"

Page 16, line 18, replace "only" with "or research"

Page 16, line 27, after "26.1-26.4" insert an underscored comma and after "claim" insert an underscored comma

Page 16, line 28, after the underscored period insert "This section does not apply to data or information disclosed by an insurer as part of a biomedical research project approved by an institutional review board established under federal law."

Page 17, line 9, replace "physician's" with "practitioner's" and replace "physician" with "practitioner"

Page 17, line 10, replace "physician" with "practitioner for an excessive or inappropriate practice pattern"

Page 17, line 11, replace "physician" with "practitioner" and replace the second "a" with "an excessive or inappropriate"

Page 17, line 12, replace "that indicates provision of care that is not medically necessary" with "for the practitioner's specialty"

Page 17, line 13, replace "physician" with "practitioner" and replace "physician's" with "practitioner's"

Page 17, line 14, replace "pattern indicates provision of care that is not medically necessary" with "is excessive or inappropriate"

Page 17, line 15, replace "physician" with "practitioner"

Page 17, line 16, replace the first "physician's" with "practitioner's" and replace the second "physician's" with "excessive or inappropriate"

Page 17, line 18, replace "physician" with "practitioner", replace the first "physician's" with "practitioner's", after "contract" insert an underscored comma, remove the second underscored comma, and replace "if the physician's" with "designate the practitioner"

Page 17, remove line 19

Page 17, line 20, remove "medically necessary, the physician may be designated"

Page 17, line 21, replace "physician" with "practitioner"

Page 17, line 23, replace "a majority representation" with "at least one representative"

Page 17, line 24, replace "physician's" with "practitioner's" and replace "physician" with "practitioner"

Page 17, line 25, replace the first "physician" with "practitioner" and replace the second "physician" with "practitioner"

Page 17, line 27, replace "physician" with "practitioner"

Page 17, line 29, replace "except in a legal" with ". Nonpayable status under this section may not commence until after appropriate notification to the entity's subscribers and the affected practitioner. As used in this section "practitioner" includes an optometrist, a physician, a chiropractor, or an advanced registered nurse practitioner duly licensed to practice in this state."

Page 17, remove line 30

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Page 18, line 2, replace "physician's" with "practitioner's" and replace "disclose in its contract with the" with "provide"

Page 18, line 3, remove "physician, and" and replace "physician provide" with "practitioner"

Page 18, line 5, replace "physician" with "practitioner"

Page 18, line 6, replace the first "physician" with "practitioner" and replace the second "physician" with "practitioner"

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Page 18, line 8, replace "physician" with "practitioner"

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Page 18, line 13, replace "physician" with "practitioner"

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Page 18, line 28, replace "physician" with "practitioner"

Page 18, line 30, replace "9" with "6"

Page 19, line 11, remove "The grievance procedure is in addition to"

Page 19, remove line 12

Page 19, line 13, remove the underscored colon

Page 19, line 14, replace "a. A" with "a" and remove ", over a period of at least three previous"

Page 19, line 15, remove "years," and replace "and appeals;" with "since the date of its last examination of the grievances."

Page 19, remove lines 16 through 19

Page 20, line 20, remove ", reduce, limit, or delay"

Page 20, line 21, remove "or interfere"

Page 20, remove lines 22 and 23

Page 20, line 24, remove "necessary for treatment or diagnosis"

Page 20, remove lines 28 through 31

Page 21, remove lines 1 through 3

Renumber accordingly

1999 HOUSE HUMAN SERVICES

SB 2400

1999 HOUSE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. SB 2400

House Human Services Committee

❑ Conference Committee

Hearing Date March 3, 1999

Tape Number	Side A	Side B	Meter #
1	x		30.0-end
2	x		0.0-end
2		x	0.0-end
3	x		0.0-6.5
Committee Clerk Signature			

Minutes:

Senator RALPH KILZER, District 47 testified. (Testimony attached)

Rep. CLARA SUE PRICE asked if anything was being done to inform the consumer about the cost of medical care by clinic. Senator RALPH KILZER responded that fee schedules established by clinics don't mean much because third party providers follow their own.

Senator JUDY DEMERS, District 18 testified: (Testimony attached)

Dr. MATT LAYMAN, President of the North Dakota Medical Association testified. (Testimony attached.)

BRUCE LEVI, North Dakota Medical Association testified. (Testimony attached)

Rep. TODD PORTER asked about the physicians ability to "cherry pick" between plans and forcing the patient to take on a higher cost plan. He was concerned about consumer protection in this area. BRUCE LEVI responded that the best protection for the consumer will come from

creating a situation that will force the carrier to include the providers in the development of plans.

Rep. ROXANNE JENSEN asked if the current carrier ban emergency room service without a referral. BRUCE LEVI responded that he didn't think so.

Rep. CLARA SUE PRICE asked who was responsible to insure that the information pamphlet was provided to every employee before the contract was signed. Response: Carrier.

Dr. STEPHEN PODRYGULA, Ph.D, Minot, ND testified. (Testimony attached)

Rep. ROXANNE JENSEN asked who the third party companies where. Dr. STEPHEN PODRYGULA responded they were a 3rd party contracted through federal government, Marriage Behavior Care.

CHRIS EDISON, General Counsel for the North Dakota Insurance Department testified that he was present representing Insurance Commissioner Glenn Pomeroy. He wants to point out some sections that the commissioner feels are strong consumer protection measures. Section 2 contains provisions forbidding retaliation for patient advocacy and prohibiting contract clauses containing financial incentives for physicians to withhold medically necessary care are strongly supported. The prudent lay person standard for reimbursement of emergency medical services in sections 3 and 4 is a strong consumer protection measure being discussed on the national level that is supported by the ND insurance commissioner. In section 8 subjects health insurance to the same grievance standards as health maintenance organizations.

ARLETTE PRESTON representing MeritCare Health System testified. (Testimony attached.)

KAREN HAGEL, representative for the NDMGMA testified the she works with managed care on a daily basis and would answer any questions.

PENNI WESTON, North Dakota Nurses Associations testified that the association was on record as supporting the bill.

OPPOSITION

JON RICE, Medical Director at Blue Cross Blue Shield of North Dakota testified. (Testimony Attached.)

Rep. CLARA SUE PRICE asked if there was anything in the confidentiality part of the bill that would prevent the legislature obtaining information. JON RICE responded that aggregate information would not be affected, only individual information.

Rep. WANDA ROSE asked if individuals identified by their claims as being asthmatic or diabetic were notified that they should seek other care. JON RICE responded that the project was about to start that would include contact to the individual to let them know about the benefits of the program. Rep. WANDA ROSE asked if products would provide different levels of coverage that would require a decision by the consumer. JON RICE responded that there are some differences. Rep. WANDA ROSE asked how is information about doctor practices gathered. JON RICE responded that the information was gathered through the billing process by comparing frequency of procedures with the frequency in other parts of the state. Rep. WANDA ROSE asked if the provider can find out the basis for the evaluation of the practice. JON RICE responded yes, usually based on the practice and national companies.

Rep. TODD PORTER asked the witness to comment on unfair practices where a provider may be forced to accept a lessor policy in order to retain the option of a higher coverage policy that the provider likes. JON RICE replied that he was only aware of the tie between BlueChoice and SelectChoice plans which were usually set up at the request of business. Rep. TODD PORTER

asked about the differences in reimbursement of the two plans. JON RICE responded that SelectChoice is reimbursed as a fee for service while BlueChoice is a contracted amount agreed to with the providers and they share in the gain or loss. Rep. TODD PORTER is capitation rate state wide or by area. JON RICE responded that capitation rate was statewide with adjustments for age and gender. Rep. TODD PORTER asked if the tying of BlueChoice and SelectChoice provided a benefit for urban consumers. The response was that the provider must participate in SelectChoice in order to be able to provide BlueChoice also. Rep. TODD PORTER wanted to know what the driving force to require physicians join the fee-for-service arena and not let them decide to remain only in the capitated market. JON RICE replied that some employers were not ready to participate in BlueChoice even though they were conformable with the SelectChoice option.

Rep. WANDA ROSE asked who decides on the product list when BlueChoice negotiations take place between providers and insurers. JON RICE noted that the product was new in 1997 and is still evolving. Input from parties is used in the contract negotiations. Rep. WANDA ROSE asked if consumers were represented at the negotiations as well as doctors. JON RICE replied that there was no formal consumer input although the company does have an active consumer service area which tracks consumer calls and attitudes. A local example is a Bismarck coalition of employers who provide input from their employees.

Rep. CLARA SUE PRICE asked about the representation on the Blue Cross Blue Shield Board of Directors. JON RICE responded that the current make-up was eleven consumers and ten providers.

Rep. TODD PORTER asked what actions Blue Cross Blue Shield was taking to change the perception that they have control over the situation and a "take it or leave it" attitude in dealing with providers. JON RICE responded that the organization is trying to involve more provider input and are trying to evolve into a more compatible model. There are many areas that have to be considered in trying to accomplish this. Rep. TODD PORTER stated that it looks like this section of the bill was created to insure fair treatment as a last resort. JON RICE disagreed. He doesn't think BCBS has been heavy handed.

Rep. ROXANNE JENSEN asked the reason that the bill was introduced. JON RICE thinks there are two causes: 1) Changes in the national scene have brought about inappropriate decisions relative the policies and 2) BCBS is feeling pressure from employers to help keep premiums down.

Rep. RALPH METCALF asked about the board composition. JON RICE responded the board composition is five hospitals and 5 doctors.

SPARB COLLINS representing the North Dakota Public Employees Retirement System testified. (Testimony attached.)

Rep. CLARA SUE PRICE asked why PERS should be excepted from the provisions that would apply to all other North Dakotans. SPARB COLLINS replied that he only wanted to point out the impact of the proposed bill to the PERS system.

Rep. WANDA ROSE asked if the EPO participants in the PERS program are limited to referral group. JON RICE replied that the EPO program is a managed care program with an annual enrollment period when a member selects the program and the providers that the will use for the next year. They need a referral to use a provider outside the selected network.

Rep. WILLIAM DEVLIN sakes about the increase in PERS premium for the next biennium. The premium is up sixteen percent and the administrative costs will rise from 4.1% to 6%.

Hearing recessed and reconvened.

DAN ULMER representing Blue Cross Blue Shield testified. He wants to discuss some proposed amendment to the bill. The original senate bill was very difficult to accept. Even with the senate amendments there are still some problems. We don't think there have been any significant number of coverage problems in the state. We don't ask questions about emergency room or ambulance services. This is a national problem. There are currently six patient protection acts in Congress. There will be a lot of changes coming as a result of managed care. All of these problems are the result of the population's fear of not being able to afford health care. Health care is a vulnerable purchase. The people who care about health care costs are the healthy people who are paying the premiums. The premiums have leveled off from the 28% increases in the early 1990s. Last year, because of loss experience, BCBS had to raise premiums 9% and cut staff. There is a genuine concern for patient protection. But there is a fine line between patient protection and payment protection. This bill, as originally written, was a payment protection bill. There are some amendments that are still needed.

Section 2 is already in HB1178. We don't try to induce providers to give less than medically service. We can't sanction anyone for blowing the whistle. Unfair participation (favored nation) clauses in contracts have never been allowed by the insurance commission. We don't preauthorize emergency medical procedures. There seems to be some confusion concerning the information disclosure section. Usually what happens is an employer calls and wants to know about a product. BCBS representative provides material on the product.

Sometime the employer asks the representative to talk to employees to help make the decision about which product to take. The representative meets with employees and discusses the options. Once the choice of product level is made then the local providers provide the employees with information about the competing networks that can be chosen. It isn't being done perfectly because the program is only two year old and is still evolving. But the majority of the information disclosure required by the bill is already being done.

We disagree with the confidentiality section. We don't have problems with the contract limitations section. We feel that we have a good grievance procedure in place as do most plans. We don't think the bill will make a major difference in the marketplace or in the way we do business.

Rep. WANDA ROSE : It is my understanding that your primary problem with the confidentiality issue in the bill is that future federal legislation, but how will the consumer be protected if the federal government doesn't come through. DAN ULMER: Congress has to decide on this by August. I makes more sense to have every state operating on the same confidentiality basis as apposed to every insurance company having to coordinate fifty different confidentiality laws. Rep. WANDA ROSE :How does a provider correct incorrect information that may have been given. DAN ULMER: We currently check back to the source of the information and correct it. At this point that information is only given to clinics and providers, not to the general public. Rep. WANDA ROSE : What safeguards does a provider have to correct incorrect information in the data bank? DAN ULMER: A simple phone call works at this point.

Rep. RALPH METCALF : Is there anything in this bill needed to correct problems that we may be having with other insurance companies? DAN ULMER: The insurance department has a significant amount of latitude because this is a prior approval state. Approval is required before any policy can be offered.

Rep. WANDA ROSE : Back to the confidentiality issue; I would like to be able to insure that my husband can't find out that I met with a particular. DAN ULMER: Agree that should happen.

TOM SMITH, Health Insurance of American testified. The insurance industry is very heavily regulated and the provisions of SB2400 could bring about more self-insurance. We went through the selection program with our employees; met with them. BCBS provided excellent information about the programs. The employees made selections. The bill will prohibit the employer's choice to select coverage. The insurance book has a specific provision for the insurance commissioner to issue a cease and desist order for any violation of the insurance code. The confidentiality provision means that I could not receive an explanation of a checkup that my 22 year old daughter in college received under my policy. Concerned about page 9 which says that an employer or patient can't get information about a doctor who has done something wrong.

Rep. CLARA SUE PRICE asked about page 9 information in a malpractice law suit. TOM SMITH couldn't say.

Rep. WANDA ROSE : What options does the provider have to find out the parameters being used in evaluation. TOM SMITH: Providers can make contact and find out what the parameters are.

Rep. CLARA SUE PRICE : It we pass section 7 and the federal government passes rules different is North Dakota in danger of losing insurance companies. TOM SMITH: The Insurance institute of American thinks it is foolish to pass legislation because the federal government wil and it will supersede anything the states have in place.

Rep. SALLY SANDVIG : If this legislation is so bad why has it been passed in so may other states? TOM SMITH: Thinks that the provisions of each of these state bills are significantly different.

Rep. WANDA ROSE : What is the time frame for practitioner to correct improper behavior? TOM SMITH: Six months. Rep. WANDA ROSE : Once letter is sent because of a question about proper procedure how much time does the practitioner have to respond? TOM SMITH: Unlimited because they won't get paid until the question is cleared up.

Rep. CLARA SUE PRICE :In initial claim denials what percent are based on wrong codes? TOM SMITH: Most of them.

Rep. TODD PORTER requested information on BlueChoice and SelectChoice customer complaints.

Rep. CLARA SUE PRICE asked if information about doctors can be provided to hospitals and she was told that the information was only provided in the aggregate as compared to other aggregates. Individual information can be provided with the release of the individual physician.

Rep. SALLY SANDVIG asked why states were waiting for federal law on the confidentiality issue. The response was that it is going to happen at the federal level and when it does anything that the states have put in place will be superseded.

Hearing closed on SB2400.

1999 HOUSE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. SB2400

House Human Services Committee

❑ Conference Committee

Hearing Date March 16, 1999

Tape Number	Side A	Side B	Meter #
1		x	0.0-23.2
2		x	23.2-26.8
Committee Clerk Signature			

Minutes:

COMMITTEE DISCUSSION

BRUCE LEVI, North Dakota Medical Association, presented proposed amendments that were developed through joint discussions between Blue Cross Blue Shield North Dakota and the North Dakota Medical Association (attached) and discussed the points of the proposal. DAN ULMER, Blue Cross Blue Shield North Dakota, told the committee that BCBSND can live with the amendments proposed. In discussion with committee Mr. ULMER also said that he expects the confidentiality issue to appear at the next session because federal action will require the state to revisit the subject. The unfair participation feature of the program is not a coersive practice but, rather a contractural issue.

COMMITTEE DISCUSSION was closed and reopened.

Rep. TODD PORTER moved the amendments proposed by Mr. LEVI, seconded by Rep.

ROXANNE JENSEN. The motion PASSED on a roll call vote: 11 YES, 1 NO, 3 ABSENT.

Rep. PAT GALVIN move DO PASS AS AMENDED, seconded by Rep. WANDA ROSE.

The motion PASSED on a roll call vote: 9 YES, 3 NO, 3 ABSENT.

CARRIER: Rep. WANDA ROSE.

Adopted by the Human Services Committee
March 16, 1999

VR
3/17/99
1 of 2

HOUSE AMENDMENTS TO ENGROSSED SENATE BILL NO. 2400 **HUMSER 3/17/99**

Page 1, line 1, replace "four" with "three"

Page 1, line 16, after the underscored comma insert "a health maintenance organization,"

Page 1, line 17, remove "or health benefits"

HOUSE AMENDMENTS TO ENGROSSED SENATE BILL NO.2400 HUMSER 3/17/99

Page 2, line 16, replace "Four" with "Three"

Page 2, line 26, after the underscored period insert "As used in this subsection, "medically necessary care" means health care services, supplies, or treatments that a reasonably prudent physician or other health care provider would provide to a patient for the prevention, diagnosis, or treatment of illness, injury, disease, or its symptoms which are in accordance with generally accepted standards of medical practice, clinically appropriate in terms of type, frequency, extent, site, and duration, and not primarily for the convenience of the patient, physician, or other health care provider. This definition does not preclude an entity from establishing a definition of "medically necessary care" for determining which services are covered by the health plan."

Page 2, line 30, after the underscored comma insert "or"

HOUSE AMENDMENTS TO ENGROSSED SENATE BILL NO. 2400 HUMSER 3/17/99

Page 3, remove lines 13 through 17

HOUSE AMENDMENTS TO ENGROSSED SENATE BILL NO. 2400 HUMSER 3/17/99

Page 4, line 15, remove the second "or"

Page 4, line 16, remove "health benefits"

Page 4, line 17, replace "provides the insured with" with "makes available to persons covered under the policy or contract"

Page 4, line 20, replace "insured" with "person covered under the contract, in any manner reasonably assuring availability,"

HOUSE AMENDMENTS TO ENGROSSED SENATE BILL NO.2400 HUMSER 3/17/99

Page 6, line 30, remove "or health"

Page 6, line 31, remove "benefits"

HOUSE AMENDMENTS TO ENGROSSED SENATE BILL NO. 2400 HUMSER 3/17/99

Page 8, line 4, after "review" insert "or management"

Page 8, line 5, after the second underscored comma insert "to analyze health plan claims or health care records data, to conduct disease management programs with health care providers,"

Page 8, line 20, remove "or health benefits"

HOUSE AMENDMENTS TO ENGROSSED SENATE BILL NO.2400 HUMSER 3/17/99

Page 8, line 22, after "practitioner" insert "solely"

HOUSE AMENDMENTS TO ENGROSSED SENATE BILL NO.2400 HUMSER 3/17/99

Page 10, line 20, remove "or health benefits"

HOUSE AMENDMENTS TO ENGROSSED SENATE BILL NO.2400 HUMSER 3/17/99

Page 11, line 21, after the second underscored comma insert "and" and remove ", and any"

Page 11, line 22, remove "applicable federal or state programs"

Renumber accordingly

Date: 3/16/99
Roll Call Vote #: 6

1999 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. SB2400

House Human Services Committee

☐ Subcommittee on _____
or
☐ Conference Committee

Legislative Council Amendment Number _____

Action Taken Move Amendment.

Motion Made By Porter Seconded By Thoreson

Representatives	Yes	No	Representatives	Yes	No
Clara Sue Price - Chairwoman	✓		Bruce A. Eckre		
Robin Weisz - Vice Chairman			Ralph Metcalf	✓	
William R. Devlin	✓		Carol A. Niemeier		✓
Pat Galvin	✓		Wanda Rose	✓	
Dale L. Henegar	✓		Sally M. Sandvig	✓	
Roxanne Jensen	✓				
Amy N. Kliniske					
Chet Pollert	✓				
Todd Porter	✓				
Blair Thoreson	✓				

Total Yes 11 No 1
Absent 3

Floor Assignment _____

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

Date: 3/16/99
Roll Call Vote #: 7

1999 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. SB 2400

House Human Services Committee

☐ Subcommittee on

or

☐ Conference Committee

Legislative Council Amendment Number

Action Taken Do Pass as Amended.

Motion Made By Rep Galvin Seconded By Rep Rose.

Representatives	Yes	No	Representatives	Yes	No
Clara Sue Price - Chairwoman	✓		Bruce A. Eckre		
Robin Weisz - Vice Chairman			Ralph Metcalf	✓	
William R. Devlin		✓	Carol A. Niemeier	✓	
Pat Galvin	✓		Wanda Rose	✓	
Dale L. Henegar	✓		Sally M. Sandvig	✓	
Roxanne Jensen		✓			
Amy N. Kliniske					
Chet Pollert	✓				
Todd Porter	✓				
Blair Thoreson		✓			

Total **Yes** 9 **No** 3
Absent 3

Floor Assignment Rep Rose

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

REPORT OF STANDING COMMITTEE

SB 2400, as engrossed: Human Services Committee (Rep. Price, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (9 YEAS, 3 NAYS, 3 ABSENT AND NOT VOTING). Engrossed SB 2400 was placed on the Sixth order on the calendar.

Page 1, line 1, replace "four" with "three"

Page 1, line 16, after the underscored comma insert "a health maintenance organization,"

Page 1, line 17, remove "or health benefits"

Page 2, line 16, replace "Four" with "Three"

Page 2, line 26, after the underscored period insert "As used in this subsection, "medically necessary care" means health care services, supplies, or treatments that a reasonably prudent physician or other health care provider would provide to a patient for the prevention, diagnosis, or treatment of illness, injury, disease, or its symptoms which are in accordance with generally accepted standards of medical practice, clinically appropriate in terms of type, frequency, extent, site, and duration, and not primarily for the convenience of the patient, physician, or other health care provider. This definition does not preclude an entity from establishing a definition of "medically necessary care" for determining which services are covered by the health plan."

Page 2, line 30, after the underscored comma insert "or"

Page 3, remove lines 13 through 17

Page 4, line 15, remove the second "or"

Page 4, line 16, remove "health benefits"

Page 4, line 17, replace "provides the insured with" with "makes available to persons covered under the policy or contract"

Page 4, line 20, replace "insured" with "person covered under the contract, in any manner reasonably assuring availability,"

Page 6, line 30, remove "or health"

Page 6, line 31, remove "benefits"

Page 8, line 4, after "review" insert "or management"

Page 8, line 5, after the second underscored comma insert "to analyze health plan claims or health care records data, to conduct disease management programs with health care providers,"

Page 8, line 20, remove "or health benefits"

Page 8, line 22, after "practitioner" insert "solely"

Page 10, line 20, remove "or health benefits"

Page 11, line 21, after the second underscored comma insert "and" and remove ", and any"

Page 11, line 22, remove "applicable federal or state programs"

Renumber accordingly

1999 TESTIMONY

SB 2400

Summary of Proposed Amendments to Senate Bill No. 2400
North Dakota Medical Association

The amendments to Senate Bill No. 2400 proposed by the North Dakota Medical Association would:

1. Remove the definition of "medical necessity" in section 1, notwithstanding that the definition technically applies only to the descriptions of prohibited insurance practices in section 2 and not more broadly as suggested by BCBSND and the Altru Health Plan.

2. Remove language that prohibits insurance carrier retaliation for patient advocacy by a health care provider in carrier policy matters, notwithstanding that the provision is clear that the advocacy must be the "sole" reason for the retaliation. While House Bill No. 1178 contains similar language, the provision in Senate Bill No. 2400 is placed in the prohibited practices chapter of the insurance title, which provides for specific penalties. The provision in House Bill No. 1178 would only apply to preferred provider arrangements.

3. Retain the "all-products" and "most-favored nation" prohibitions. The North Dakota Medical Association strongly supports these provisions as measures to protect both patients and health care providers from inappropriate plans and participation in plans against the will of the provider. While BCBSND argues that these provisions should be left to contract negotiation, it is clear that it is difficult to negotiate such matters with a carrier with substantial market share as BCBSND. The Altru Health Plan's argument against the "all-products" prohibition is actually consistent with having such a prohibition. Altru suggests that it would like to reward providers who participate in less desirable plans by giving them "the first opportunity to participate" in other plans. Giving providers the opportunity to participate in plans is far different than mandating providers to participate in plans against their will or terminating a provider who does not wish to participate in some other product. Nevertheless, if Senate Bill No. 2400 passes the Senate, the Medical Association has agreed to work with the Altru Health Plan to determine whether there should be specific exceptions to the "all-products" provision.

4. With the exception of the provisions relating to emergency services and the prudent layperson standard, remove all the provisions relating to utilization review in sections 3, 4, 5, 6, and 7, including the licensure issue, review timeframes, and requirements for review by a physician in the same or similar specialty.

5. With regard to patient disclosures in section 8 relating to financial incentives that may be included in a health plan, remove the clarifying language about not disclosing specific details or individual contracts as suggested by BCBSND. This provision was originally included in the bill at the request of a BCBSND representative. This provision is not problematic, as suggested by BCBSND. It only requires that the insurer's financial incentives be disclosed in general terms for the benefit of patients, so that patients can understand how their health plan works. The proposed amendments otherwise retain the information disclosure provision in section 8.

The Altru Plan argued that a clarification is necessary as to whether the information is disclosed in the subscription certificate or is a supplemental document. The bill requires disclosure "prior to" the issuance of the policy or contract.

6. Include the proposed amendments regarding confidentiality offered on behalf of the Pharmaceutical Research and Manufacturers of America for research. BCBSND questioned whether certain activities that monitor certain high-risk patients with those patients' physicians would be precluded under the confidentiality provision in section 9. Inasmuch as BCBSND and the patient's physician would both have access to the patient's medical information, no "disclosure" of information to a third party would appear to occur if discussions occur between the carrier and the physician.

7. Revise the language in section 10 (due process for termination, sanctions, or nonpayable status) to follow more closely the language of the law that BCBSND was subject to prior to mutualization in section 26.1-17-12. The revised language would still require that there be a hearing in cases involving sanctions or termination, and require that at least one person sitting on the review committee be in the same specialty as the physician being reviewed.

8. Remove the requirement in section 10 that practice profiling be disclosed in physician contracts, as objected to by the Altru Health Plan.

9. Remove language regarding grievance procedures in section 11 so that the language tracks what is already required for HMOs under section 26.1-18.1-10. BCBSND argued that there is no definition of grievance; however, the provision defines a grievance as "complaints by covered persons and providers and addressing questions and concerns regarding any aspect of the plan, including access to and availability of services, quality of care, choice and accessibility of providers, and network adequacy." BCBSND already has a grievance procedure that allows subscribers to bring complaints to BCBSND Customer Service with respect to "facility and provider related concerns: waiting times, rudeness, failure to adequately explain referral or treatment processes, parking problems, etc." With regard to BCBSND's other arguments, it is not so much a question as to what BCBSND will do with the information as it is a mechanism for patients and providers to "resolve complaints." This provision simply provides a mechanism to resolve complaints, which is already provided by law with respect to HMOs.

10. Remove the proposed language in section 12 prohibiting carrier interference in a preferred provider's medical decisionmaking.

11. Remove section 13 of the bill. BCBSND argued that the "unfairly" language of existing law is problematic. While BCBSND does not propose an alternative standard, we propose to remove the section from the bill, thereby retaining the existing law on this issue.

With these proposed amendments, the North Dakota Medical Association believes strong and reasonable protections would be in place that do not result in excessive regulation. We request the Committee to accept these proposed amendments and recommend a "do pass" on Senate Bill No. 2400 as amended.

TESTIMONY ON SB 2400

PRESENTED BY SENATOR RALPH KILZER

FEBRUARY 10, 1999

Good morning Mr. Chairman and fellow members of the Human Service Committee. Senate Bill 2400 is called the Fairness in Health Care Bill. It is submitted at the request of the North Dakota Medical Association.

Generations ago, the patient-physician relationship was a strong one-on-one bond. As technology came along and these new expensive treatments were unaffordable, insurance was developed in the 1940's to spread the risk and make these new expensive treatments available to the premium payers who needed them. This system of a "third party" payer was originally paid for by the individual or family. As the decades went along and with tax incentives, the payments shifted from the individual to the employer. In the early 1970's, we saw incentives to control the rapidly rising premiums. These included such things as deductibles, co-pays, indemnity plans, and the most recent approaches using DRGs, RBRBS, HMOs and managed care.

All of the above listed factors affect the original, but still very necessary, patient-physician relationship. The above factors are designed to control costs, by controlling utilization and eliminating unnecessary and inappropriate care. However, there must be safeguards because the incentives to "cut corners" are too strong. This is the reason for the bill.

You will note that this is a rather unusual group of sponsors. However, all the sponsors or spouses of the sponsors, are involved with health care. There are people here to go through the bill section by section. I would hope that you could support the bill. I would be glad to attempt to answer any questions. Thank you for your consideration.

TESTIMONY BY

CALVIN N. ROLFSON

ON BEHALF OF

PHARMACEUTICAL RESEARCH AND MANUFACTURERS OF AMERICA

REGARDING

SENATE BILL NO. 2400

MY NAME IS CAL ROLFSON. I AM AN ATTORNEY HERE IN BISMARCK AND I REPRESENT THE PHARMACEUTICAL RESEARCH AND MANUFACTURERS OF AMERICA (PhRMA). PhRMA DOES NOT OPPOSE SENATE BILL 2400, BUT WE RECOMMEND AN AMENDMENT.

THE PHARMACEUTICAL RESEARCH AND MANUFACTURERS OF AMERICA IS A CONSORTIUM OF ALL MAJOR PHARMACEUTICAL AND HEALTH RESEARCH COMPANIES IN THE UNITED STATES. PHRMA SUPPORTS CONFIDENTIALITY OF MEDICAL INFORMATION THAT IDENTIFIES PATIENTS, AS LONG AS THESE EFFORTS PRESERVE LEGITIMATE ACCESS TO AND USE OF SUCH DATA FOR RESEARCH IN THE CONTINUING DISCOVERY AND DEVELOPMENT OF MEDICINES.

INNOVATIONS IN MEDICINE AND BIOMEDICAL RESEARCH ARE REVOLUTIONIZING THE FUTURE OF HEALTH CARE. THIS RESEARCH REQUIRES INFORMATION FROM CLINICAL RESEARCH AND INFORMATION REGARDING THE SAFETY AND EFFICACY OF TREATMENTS IN THE REAL-LIFE CONDITIONS UNDER WHICH PEOPLE RECEIVE HEALTH CARE. ACCURATE AND COMPLETE RECORDS OF A PATIENT'S HEALTH AND HEALTH CARE HISTORY ARE ALSO ESSENTIAL TO

ENSURE THE PROMPT AVAILABILITY AND OPTIMAL PROVISION OF HEALTH CARE FOR THE INDIVIDUAL PATIENT. OVERLY RESTRICTIVE LIMITATIONS ON ACCESS TO AND USE OF MEDICAL INFORMATION BY HEALTH CARE RESEARCHERS, PROVIDERS AND PAYERS COULD IMPEDE THE QUALITY OF HEALTH CARE AVAILABLE TO PATIENTS AND THE EFFECTIVENESS, INCLUDING COST EFFECTIVENESS, OF THE HEALTH CARE SYSTEM.

BIOMEDICAL RESEARCHERS SHOULD HAVE ACCESS TO MEDICAL INFORMATION THAT DOES NOT IDENTIFY PATIENTS. RESEARCHERS SHOULD BE ALLOWED THE USE OF MEDICAL INFORMATION THAT HAS BEEN ANONYMIZED BY CODING OR ENCRYPTING SO THAT IT NO LONGER DIRECTLY IDENTIFIES THE PATIENT. ARCHIVES OF MEDICAL RECORDS AND BIOLOGICAL MATERIALS ARE AN INVALUABLE RESOURCE AND RESEARCHERS' ACCESS TO THIS DATA SHOULD NOT BE CONSTRAINED.

PHRMA FIRMLY BELIEVES THAT MEDICAL INFORMATION THAT IDENTIFIES PATIENTS SHOULD BE KEPT CONFIDENTIAL.

SENATE BILL 2400 APPEARS APPROPRIATE. HOWEVER, PHRMA HAS A CONCERN IN TWO AREAS AND TO PROTECT THE VALUABLE SCIENTIFIC RESEARCH THAT HELPS PATIENTS, PhRMA RECOMMENDS THE FOLLOWING AMENDMENTS.

THE FIRST ONE IS FOUND AT PAGE 16 OF THE BILL. SECTION 9 OF THE BILL BEGINNING ON PAGE 15 SETS OUT STANDARDS FOR CONFIDENTIALITY OF MEDICAL INFORMATION. CERTAINLY ALL OF THAT SECTION IS APPROPRIATE.

HOWEVER, LEGISLATION PROTECTING THE CONFIDENTIALITY OF MEDICAL INFORMATION MUST BE CONSISTENT WITH PROTECTING AND PROMOTING RESEARCH AND DEVELOPMENT BY HEALTH CARE SCIENTISTS. BY REQUIRING THE CONSENT OF EVERY PHYSICIAN WHOSE NAME MAY APPEAR IN THE PATIENT RECORD, THE PROPOSED BILL COULD CURTAIL ACCESS TO PATIENT-ANONYMIZED MEDICAL ARCHIVES. THIS WOULD BE PHYSICALLY DIFFICULT AND FINANCIALLY PROHIBITIVE FOR EPIDEMIOLOGICAL AND OUTCOMES RESEARCH.

THIS CAN BE CORRECTED BY INSERTING ON PAGE 16, LINE 18, AFTER THE WORD "PURPOSES" THE WORDS: "EPIDEMIOLOGICAL OR OUTCOMES RESEARCH." IN OTHER WORDS, IT IS NOT ONLY IMPORTANT TO INSURE ANONYMIZED INFORMATION FOR STATISTICAL PURPOSES, BUT ALSO FOR HEALTH SCIENCE RESEARCH.

REGARDING OUR SECOND PROPOSED AMENDMENT, FEDERAL LAWS AND REGULATIONS PROVIDE EXTENSIVE PROTECTIONS FOR PATIENT INFORMATION. THE PROVIDER AND PATIENT CONSENT REQUIREMENTS OF THIS BILL COULD THWART RESEARCH PROJECTS WHERE AN INSTITUTIONAL REVIEW BOARD HAS DETERMINED, IN ACCORDANCE WITH FEDERAL REGULATIONS, THAT CONSENT IS NOT FEASIBLE OR REQUIRED. ACCORDINGLY, IN ORDER NOT TO REQUIRE A REVOLVING DOOR OF MULTIPLE CONSENT FORMS FROM PATIENTS, INSURERS, HEALTH CARE PROVIDERS AND THE LIKE, PhRMA SUGGESTS ADDING THE FOLLOWING ADDITIONAL SUBSECTION TO SECTION 9, TO BE INSERTED AFTER LINE 2 ON PAGE 17 OF THE BILL:

"4. This section does not apply to data or information disclosed by an insurer as part of a biomedical research project approved by an institutional review board established under federal law."

WITH THESE ADDITIONS, PhRMA HAS NO OBJECTION TO THIS BILL.

I HAVE PREVIOUSLY SHARED WITH THIS COMMITTEE IN TESTIMONY ON ANOTHER BILL ("SB 2166") EXAMPLES OF THE SIGNIFICANT RESEARCH AND BREAKTHROUGHS THAT ARE OCCURRING SO FREQUENTLY NOW IN THE DEVELOPMENT OF NEW AND LIFESAVING THERAPEUTIC DRUGS FOR OUR NATION. I WON'T REPEAT THAT INFORMATION AGAIN HERE EXCEPT TO REFER YOU TO MY TESTIMONY IN SB 2166.

THANK YOU. I WOULD BE PLEASED TO RESPOND TO QUESTIONS.

Prepared Testimony

TO: Senate Human Services Committee

FROM: Craig Boeckel, Attorney at Law
Lobbyist for the North Dakota Chiropractic Association

DATE: February 10, 1999

RE: SB 2400

The North Dakota Chiropractic Association (NDCA) is offering amendments to SB 2400 which will make the bill uniformly consistent. Presently, SB 2400 speaks of "health care providers" in some parts of the bill, and "physicians" in other parts. We can think of no valid reason for the discrepancies. Our proposed amendments replace the term "physician" with the term "health care provider" throughout the entire bill. Also, on page 10 of the bill we are proposing language which will ensure that any "health care provider" performing utilization review must have a current license from the state board regulating that health care provider.

In short, our proposed amendments will ensure that the scope of the bill extends not only to physicians, but also to doctors of chiropractic as well as to all other health care providers treating patients in North Dakota.

Thank you for your considerations.

BEFORE THE
SENATE HUMAN SERVICES COMMITTEE
FEBRUARY 10, 1999

NORTH DAKOTA CHIROPRACTIC ASSOCIATION

PROPOSED AMENDMENTS TO SENATE BILL 2400

Page 5, line 19, after "physicians" insert "or other health care providers"

Page 5, line 20, after "physicians" insert "or other health care providers"

Page 7, line 11, after "psychologist" insert "or other health care provider"

Page 7, line 12, after "psychologist" insert "or other health care provider"

Page 8, line 13, after "psychologist" insert "or other health care provider"

Page 8, line 23, after "psychologist" insert "or other health care provider"

Page 9, line 13, after "physician" insert "or other health care provider"

Page 10, line 11, after the underscored period insert "Any other health care provider making utilization review determinations must have a current license from the state board regulating such health care provider."

Page 11, line 13, replace "physician" with "health care provider" and remove "to practice medicine"

Page 11, line 17, replace "physician" with "health care provider"

Page 17, line 9, replace "physician's" with "health care provider's" and replace "physician" with "health care provider"

Page 17, line 10, replace "physician" with "health care provider"

Page 17, line 11, replace "physician" with "health care provider"

Page 17, line 13, replace "physician" with "health care provider" and replace "physician's" with "health care provider's"

Page 17, line 15, replace "physician" with "health care provider"

Page 17, line 16, replace the first "physician's" with "health care provider's" and replace the second "physician's" with "health care provider's"

Page 17, line 18, replace "physician" with "health care provider" and replace the first "physician's" with "health care provider's" and replace the second "physician's" with "health care provider's"

Page 17, line 20, replace "physician" with "health care provider"

Page 17, line 21, replace "physician" with "health care provider"

Page 17, line 24, replace "physician's" with "health care provider's" and replace "physician" with "health care provider"

Page 17, line 25, replace the first "physician" with "health care provider" and replace the second "physician" with "health care provider"

Page 17, line 27, replace "physician" with "health care provider"

Page 17, line 30, replace "physician" with "health care provider"

Page 18, line 2, replace "physician's" with "health care provider's"

Page 18, line 3, replace the first "physician" with "health care provider" and replace the second "physician" with "health care provider"

Page 18, line 5, replace "physician" with "health care provider"

Page 18, line 6, replace the first "physician" with "health care provider" and replace the second "physician" with "health care provider"

Page 18, line 7, replace "physician's" with "health care provider's" and replace "physician" with "health care provider"

Page 18, line 8, replace "physician" with "health care provider"

Page 18, line 11, replace "physician" with "health care provider"

Page 18, line 8, replace "physicians" with "health care providers"

Page 18, line 13, replace "physician" with "health care provider"

Page 18, line 17, replace "physicians" with "health care providers"

Page 18, line 22, replace "physician" with "health care provider"

Page 18, line 24, replace "physician" with "health care provider"

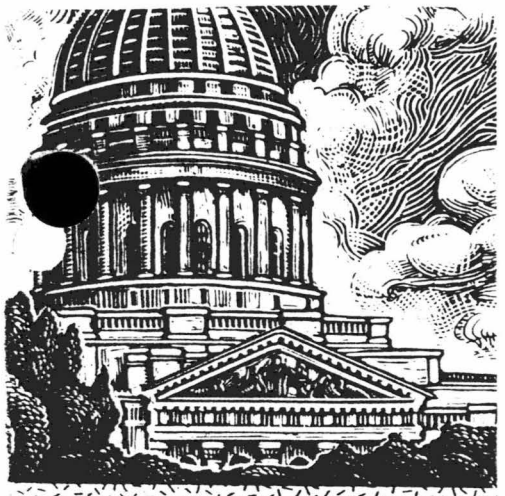
Page 18, line 25, replace "physician" with "health care provider"

Page 18, line 27, replace "physician" with "health care provider"

Page 18, line 28, replace "physician" with "health care provider"

Page 20, line 22, replace "physician" with "health care provider"

Renumber accordingly.



American Medical Association

Physicians dedicated to the health of America

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State Legislation

Government and Political Affairs

Special Report

Comprehensive Patient Protection Laws in the States

October 1998

AMERICAN MEDICAL ASSOCIATION
DIVISION OF STATE LEGISLATION

Ross N. Rubin, JD
Director

Rebecca Cerny, JD
Senior Legislative Counsel

Lou Anne Wolfson, JD
Senior Legislative Counsel

Sari H. Ratican, JD
Legislative Counsel

Senate Bill 2400 Protects the Patient

Patient receives insurance plan

Plan description must be written in easily understandable language

No incentives that deny, limit, reduce, or delay medically necessary care

Patient requires medical care

Assures confidentiality of patient medical information maintained by carrier

Requires carriers to provide grievance procedures

Patient requires emergency care

Prudent layperson standard used to determine covered emergency services

Prohibits any preauthorization requirement

Expedited coverage determinations and appeals

SB 2400 Protects Medical Service Providers

Carrier offers participation in health plan → **Physician considers participation in health plan**

No incentives that limit medically necessary care

No carrier policies that automatically reduce provider payments

No carrier policies that require participation in the carrier's other insurance products

Confidentiality of identifiable provider information unless consent for disclosure or authorized in contract

Due process for physician terminated or sanctioned by carrier

Practice profile safeguards

Safeguards for preferred provider arrangements

SB 2400 Protects the Patient-Physician Relationship

Patient requires medical care

Patient denied coverage for medical care

Patient receives medical care

Assures confidentiality of identifiable patient information

Requires carriers to provide grievance procedures

No incentives that deny, limit, reduce, or delay medically necessary care

Allows physician to be a patient advocate without fear of retaliation

Requires a record of grievances and appeals

Written utilization review program

Physician input in development of medical review criteria

Certain time frames required for utilization review

Standards for utilization review appeals, including review by physician in same or similar specialty

Utilization reviewers are licensed in North Dakota

NDPEA NORTH DAKOTA PUBLIC EMPLOYEES ASSOCIATION

AMERICAN FEDERATION OF TEACHERS LOCAL 4660 AFL-CIO

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NDPEA TESTIMONY IN SUPPORT OF SB 2400

Before the Senate Human Services Committee
North Dakota Public Employees Association, AFT Local 4660 AFL-CIO

February 10, 1999

Chairman Thane, members of the Senate Human Services Committee, my name is Chris Runge and I am Executive Director of the North Dakota Public Employees Association and Secretary-Treasurer of the North Dakota AFL-CIO. I am here to testify on behalf of SB 2400.

While I do not profess to understand all the intricacies of this bill, the members of NDPEA and the North Dakota AFL-CIO are extremely concerned with the escalating costs of health care and are just as concerned with how is health care is currently being provided. Who would have thought that doctors would have to seek protection from the government in order to provide needed health care to their patients? Who would have thought those doctors would have to seek passage of a law that would prevent an insurance company from retaliating against a medical provider's ability to provide medically necessary care? And finally, who would have thought that providers would have to seek protection from the government in order to be reimbursed for reasonable emergency medical services when someone like me seeks emergency medical treatment?

I stand before you today professing to be a totally confused representative of 20,000 working men and women in North Dakota most of whom with good health benefits. On one hand we clearly

Testimony

GCIU 260-C

understand that health care costs are spiraling out of control and there is the need to control health care costs. On the other hand, we want to know that when we seek medical care from our physician that there won't be a third party in the examining room with us second-guessing whether the doctor should or should not provide a particular treatment. Most of all, we should not have to worry that a doctor might be receiving some sort of incentive to deny, reduce, limit, or delay medically necessary care already provided by my health care plan. The task before you is daunting and the bottom line is this: I want to know and I want assurances that when my doctor prescribes a medical procedure that I won't have that nagging thought in the back of my mind: Is this really the best treatment for me or is my doctor prescribing a medical procedure because my health care plan has provided some kind of inducement or limit on what can be provided to me?

Another important part of this bill pertains to confidentiality of medical records. There has been an explosion of companies around the country that brag about their ability to obtain medical information on prospective or new employees, including whether they have been injured on the job and what type of medical treatment an employee has received. This type of information is being used to keep workers from getting employment all without their knowledge and definitely without their consent. There is quite frankly, nothing more important than the confidentiality of patient medical records and anything that this legislature can do to protect our medical records would be appreciated.

As a policyholder of one of the best health insurance plans in the state, and having received health care from the best medical providers in this state, the answer, in the end, must be that health care decisions must be left to a doctor and his or her patient.

We support SB 2400 and I am available to answer any questions that you may have.

Thank you.

"Fairness in Health Care"
Summary of Senate Bill No. 2400
North Dakota Medical Association

- *Senate Bill No. 2400, in sections 1 and 2, expands the list of prohibited insurance carrier practices:*

  Prohibits incentive plans that may induce a health care provider to deny, reduce, limit, or delay medically necessary care. The bill includes a definition of "medically necessary care" developed by the AMA.

  Prohibits retaliation for patient advocacy by a health care provider, including grievances and utilization review appeals and for advocacy that involves the protest of any carrier decision, policy, or practice on behalf of a patient.

  Prohibits "most-favored nation" clauses in contracts or policies that require health care providers to charge a carrier the lowest payment for care that the provider charges or receives from any other carrier, and prohibits "all-products" contract clauses or policies that require a health care provider that participates in a carrier's health plan or product to participate in the carrier's other health plans or products.

- *The bill, in sections 3 and 6, requires insurance carriers to use the prudent layperson standard in determining coverage for emergency services, and prohibit carriers from requiring prior authorization for emergency services.*

- *The bill, in sections 3 through 7, expands and strengthens the standards that apply to insurance carriers when they perform utilization review:*

  Requires that input in the development of a carrier's medical review criteria be provided by physicians in the relevant specialty area.

  Requires carriers to maintain and implement written utilization review programs that describe all review activities.

  Requires that utilization review programs be administered by a physician or other health care professional.

  Requires that physicians who perform utilization review activities to be licensed to practice medicine in North Dakota.

  Requires that determinations relating to the coverage for health services be made within certain time frames.

  Requires that the insurance carrier's appeals process in utilization review include at least a two-tier appeals process, with the final-level appeal requiring the appointment of a review panel comprised of physicians or other health care professionals. The panel's decision requires the concurrence of a physician licensed in ND who is trained in the same or similar specialty that manages the care under review.

Requires that expedited appeals in emergency or life-threatening situations be evaluated by a physician who is trained in the same or similar specialty that manages the care under review.

Clarifies that insurance carriers are responsible for meeting all the statutory utilization review standards, even if utilization review is delegated to a third party.

- *The bill, in section 8, requires insurance carriers to disclose information about their health plan in plain language to their members and requires that other information be available upon request.*

- *The bill, in section 9, requires confidentiality of identifiable patient or provider information maintained by insurance carriers, unless appropriate written consent is provided to disclose the information. With regard to identifiable information relating to a health care provider, the bill allows for disclosure that is mutually agreed upon in the physician's contract with the insurance carrier.*

- *The bill, in section 10, provides due process for physicians who are sanctioned, terminated, or designated as nonpayable by a health plan, including the opportunity for a hearing by a committee comprised primarily of physicians in the same specialty. The bill also places standards on the use of practice profiles for evaluating physicians. These standards include:*

  Any physician can, at any time, request a description of the criteria used to evaluate the physician, and that information must be included in physician contracts.

  A physician can review the information and specific data underlying any findings by the carrier.

  Any evaluation or practice profile must consider additional factors, including allowances for the severity of illness or condition of the patient mix and for patients with multiple illnesses or conditions.

  A physician can prepare a written response to any practice profile and the carrier is required to negotiate in good faith to correct any inaccuracies or to make the profile complete. If the profile is not corrected, the carrier is required to include the physician's response in any disclosure of the profile to a third party.

- *The bill, in section 11, requires insurance carriers to adopt grievance procedures for complaints by patients or providers regarding issues not related to utilization review, including access to and availability of services, quality of care, the choice and accessibility of providers, and the adequacy of the plan's network of providers.*

- *The bill, in sections 12 and 13, requires insurance carriers in preferred provider arrangements to specifically identify any administrative responsibilities that are shifted to the health care provider.*

February 10, 1999

"Fairness in Health Care"
Testimony of Bruce Levi, North Dakota Medical Association, in Support of Senate Bill No. 2400
Before the Senate Human Services Committee

On behalf of the physician members of the North Dakota Medical Association, I'm pleased to have this opportunity to present comments and an explanation of the provisions of Senate Bill 2400, relating to fairness in health care between North Dakota patients, health care providers, and insurance carriers.

What I would like to do is take you through this bill by topic. I've distributed a brief summary of the bill. I want to point out that as you review the bill, you'll notice that the revisions to many existing statutes cross different chapters of the code and there is some shifting of terminology throughout the bill because of existing definitions. For example, the bill describes a patient in a variety of ways, as a covered person, a patient, an enrollee, or an insured. There's different language that describes the insurance carrier, including an entity, a utilization review agent, a health insurance carrier, an insurance company, or a health care insurer. And there is different language that describes the physician, the health care provider, the provider of record, and a preferred provider. It tends to be confusing unless you review the bill by topic. There are basically seven topics within the bill – prohibited insurance practices in sections 1 and 2, utilization review in sections 3 through 7, information disclosure in section 8, confidentiality of medical information in section 9, contract limitations in section 10, grievance procedures in section 11, and preferred provider arrangements in sections 12 and 13.

In addition to the brief summary, the graphic handout distributed by Dr. Layman puts the various provisions of the bill in perspective in terms of identifying where each provision fits in the various health care relationships. Senator Kilzer and Dr. Layman have focused on the reasons for this bill – the impact of our changing healthcare environment on patient care and the need to be proactive in continuing to recognize and protect the supremacy of individual patient interests in medical decisions.

In recent years, we have witnessed a rapid growth throughout the United States in the number of people who receive health care through some form of managed care or other similar health care arrangement. While these arrangements are designed to control health care utilization and curb "unnecessary or inappropriate" care, the changes have been quite unsettling for many patients and physicians. They have also raised fears that economic and other incentives may result in the denial of necessary care, infringe

unfairly on the patient-physician relationship, or trap physicians in ethical dilemmas (See the appendix). Nationally, state lawmakers are aggressively enacting legislation that protects patients from health care abuses and threats to quality care. No one can predict with any certainty what our health care system in North Dakota will look like ten years from now – five years from now – or even two years from now. As managed care continues to grow in North Dakota, it is important to put tools in place to address these concerns as, and when, they occur in our state.

Last session, we worked with you to pass legislation that prohibits contract clauses and insurance carrier policies that interfere with medical communications between a patient and the patient's health care provider (gag clauses), and clauses or policies that attempt to inappropriately shift the liability for a health carrier's negligence, misconduct, or breach of contract to the health care provider (hold-harmless clauses). Senator Judy DeMers was very instrumental in working for the passage of the 1997 legislation, as were other legislators concerned about what the future might bring to health care in our state.

We watched the inability of the Congress to pass meaningful patient protection legislation last year. But the real story in this country is how individual states – state lawmakers and state medical societies and other patient advocates – have been very successful in passing patient protection legislation and legislation banning unfair insurance practices. (Handout). This handout is a summary of patient protection legislation passed in other states prepared by the American Medical Association.

It is important to point out what this bill does not include. It does not include a provision like Texas, that allows a patient to sue an insurance company for inappropriate medical decisionmaking. This is the hot topic in the public debate about patient protections that will likely be settled at the federal level and, if not, in the courts. And the bill does not include provisions, like one out of every three states has now, that provide an external, independent review of decisions by insurance carriers to deny coverage for medical care. SB 2400 strengthens our utilization review statutes but does not incorporate an external review process.

You will likely hear from insurance carriers today that there is uncertainty in how some of the language in this bill will be applied to any given insurance practice in the future, and that that uncertainty causes some trepidation on their part. Or that the bill will result in more costs. In this case, the "fear of the unknown" works both ways. This bill weighs in on the side of protecting patients and ensuring fairness,

and considers the individual costs that might occur because of an inappropriate insurance practice or a coverage decision that is wrong.

SB 2400 is actually a fourth draft of a legislative proposal we began circulating in early January to a number of interested parties, including the Insurance Department, BlueCross BlueShield of North Dakota, a representative of other independent insurance carriers, and a number of healthcare organizations. There have already been substantial revisions made in our proposal, particularly with regard to utilization review.

The Challenge to Medical Decisionmaking

Much of what we will talk about today centers around a challenge to a core principle underlying the legal structure in this country for health care delivery and finance – that principle is the supremacy of individual patient interests in medical decisions. The challenging value is a societal interest in conserving resources expended on health care. In the past our legal system has historically treated medical decisions for patients and coverage decisions by health plans as independent activities. Coverage decisions are considered as a transaction between the patient and the health plan and medical decisions are viewed as transactions between the physician and the patient. These two transactions are considered independent because the coverage decision is not supposed to affect the physician's judgment in medical decisions about what is best for the patient, and a refusal to cover treatment recommended by a physician does not bar the patient from obtaining the services with the patient's own funds. What has occurred, however, as a practical matter, is that the medical decision made as part of the coverage decision is not independent from the medical decisions made by the physician and patient. Because medical care can be very expensive, many patients cannot afford to purchase care that a physician recommends but the health plan will not cover and therefore, they have to accept the medical decision of the health plan. The coverage decision becomes the treatment decision. And today, insurance carriers use a variety of techniques to influence or control medical decisions made by physicians.

That is the reality. What is occurring nationally today is a recognition of the true role that insurance carriers are playing in medical decisionmaking, as states develop mechanisms to appropriately balance the societal interest in conserving resources with the individual patient interest.

Changes need to be made to the legal structure to recognize the realities of insurance carrier control over medical decisions and to maintain a patient-centered system of health care. The current structure does not recognize the economic leverage that insurance carriers have over physicians, and the difficulty that physicians will have in resisting pressures to withhold care. Changes should focus on restoring a better balance between insurance carriers, physicians, and patients in medical decisions. SB 2400 is designed to begin that process.

Prohibited Insurance Practices

Last session, the prohibition on gag clauses and hold harmless clauses was placed in that part of the Century Code that identifies prohibited insurance practices. Chapter 26.1-04 sets monetary penalties and gives the Insurance Commissioner the ability to issue a cease and desist order to require that a certain practice be stopped. This bill would create four new prohibited practices.

Incentives to withhold medically necessary care (Sections 1 and 2)
This provision does not give health care providers the discretion to decide what services are covered by a health plan. The provision prohibits a financial incentive that would induce a provider to deny, reduce, limit, or delay medically necessary care that is otherwise covered by the plan.

Recently, the Texas Attorney General filed a lawsuit against six HMOs in that state contending they used financial incentives to encourage doctors to limit medical treatment, penalizing doctors who exceed budgets for medical treatments, and giving patients untruthful or misleading information about emergency coverage, prescription drug coverage and referrals to specialists.

The definition of medically necessary care is important (Page 2, line 16). The definition used in the bill includes three distinct components – services provided in accordance with generally accepted standards of medical practice, clinically appropriate services, and those not provided primarily for the convenience of the patien or the provider. This is a definition advocated by the American Medical Association and incorporated in several patient protection statutes from other states. What it excludes is specific criteria that incorporates a "lowest cost" standard.

Again, this provision does not set a definition of "medical necessity" for all insurance carriers to adhere to in setting benefits and coverage under a plan. But it does prohibit financial incentives that would deny medically necessary care that is covered by the insurance carrier.

We have one specific concern in this area. In North Dakota, BCBSND has been suggesting for two years that it will implement a "tiered" reimbursement system that would tie financial incentives or disincentives for physicians to the health care utilization of the physicians' patients. The concept has not been described to our Association in any detail. Physicians are very concerned about what form those financial incentives and disincentives will take. The North Dakota Medical Association has not been asked to provide physician input into the design of those incentives or disincentives, nor is it clear what impact the incentive plan will have on patient care.

Many other states have enacted provisions to prohibit financial incentives that impact patient care, including Alaska, Arizona, California, Georgia, Idaho, Kansas, Minnesota, Missouri, Montana, Louisiana, Maryland, Nebraska, Nevada, New Jersey, New Mexico, Ohio, Pennsylvania, Rhode Island, Texas, Utah, Vermont, and West Virginia.

Retaliation for patient advocacy

The bill would prohibit retaliation for patient advocacy by a health care provider, including grievances and utilization review appeals and for advocacy that involves the protest of any carrier decision, policy, or practice on behalf of a patient (Page 3, line 5).

Most insurance carriers do not have vehicles to involve their participating physicians in providing input into their medical policies or other policies that affect how the physicians practice. Carriers generally have a medical director or even a panel of physicians with whom they consult, but they do not obtain broad-based input. This bill in another section provides for some additional physician input in developing medical review criteria in utilization review. However, vehicles for input into health plans by participating physicians will not be of any benefit to patients unless the physicians feel free to advocate their beliefs about what constitutes good patient care. They should not have to fear being terminated from a health plan if they advocate policies that the management of a insurance carrier does not want. Therefore, there should be procedures for physicians to use if they believe they have been terminated or sanctioned by a carrier because of their advocacy efforts.

This provision uses language similar to the 1997 law in describing the kind of retaliation that would be prohibited, if that retaliation were the result of a good faith report to state or federal authorities about an

act or practice by the carrier that jeopardizes patient care, an effort by the physician to advocate on behalf of a patient in a utilization review program or grievance procedure, or, in more general terms, an effort by the physician to protest a decision or policy of the carrier that the physician believes would interfere in the physician's ability to provide medically necessary care.

A number states have enacted similar protections, including Colorado, Connecticut, Kansas, Maryland, Missouri, Montana, Nebraska, Nevada, New Jersey, Ohio, Oregon, Pennsylvania, Tennessee, Texas, and Virginia.

"Most-favored nation" policies

The bill would prohibit "most-favored nation" clauses in contracts or policies that require health care providers to charge a carrier the lowest payment for care that the provider charges or receives from any other carrier (Page 3, line 18). This kind of practice is prevalent in other states. It's an especially effective tool for health carriers that dominate a health care market.

This kind of practice puts the provider at significant financial risk. For example, consider the case of physician who participates in an insurance carrier's plan with a most-favored nation clause in its contract and whose enrollees constitute 25% of the physician's patient population, or 1,000 patients. Under the agreement, the physician would be paid $90 for an office visit unless the physician agrees to accept a lower price from another plan, at which point the physician would be required to offer the original plan the same lower price. If the physician contracts with another managed care organization for a $65 office visit, he or she will have to reduce fees for an office visit by $25 for all 1,000 patients of the first plan.

This kind of a practice would discourage competition because it would be difficult for physicians to participating in competitor plans. It's difficult to imagine any other business in which the price paid to a "supplier" can be reduced just because the supplier agreed with someone else to be paid at a lower rate. Insurance carriers should be held to their contracts.

"All-products" policies

The bill prohibits "all-products" contract clauses or policies that require a health care provider to participate in all of a health carriers products in order to participate in any one of the products (Page 3,

line 24). If a health care provider decides to terminate participation in one of the carrier's plans, and the carrier invokes an "all products" policy by shutting the provider out of the carrier's other plans or products, the continuity of care of patients would be interfered with and the result would diminish the provider's choice in selecting appropriate plans that are beneficial to patients.

As an example, one of the articles attached to Dr. Layman's testimony describes what is occurring in another state with the Aetna insurance company and how Aetna used an all-products policy to shut physicians out of all of Aetna's plans after physicians left an Aetna HMO that was experiencing all kinds of problems.

Emergency Services

The bill, in sections 3 and 6, requires insurance carriers to use the prudent layperson standard in determining coverage for emergency services, and prohibits carriers from requiring prior authorization for emergency services.

In an effort to curb the inappropriate use of hospital emergency rooms for routine health care, many health plans across the country have instituted policies regulating emergency room care. These policies, while effective in discouraging inappropriate use of emergency rooms, can also discourage appropriate use. And, they can delay medically necessary care.

In addition, some insurance carriers require members to obtain approval from the plan before they receive emergency care. These prior authorizations are at best a burden on someone who is ill and, at worst, the cause of potentially dangerous delay for someone who needs immediate medical attention. A person having a heart attack should get to a hospital as quickly as possible, without stopping first to find a telephone to call his or her insurance carrier for authorization of treatment.

Carriers also may refuse to pay for an emergency room visit unless the condition turns out to be a genuine emergency. But only a trained professional can determine what is, and what is not, an emergency. Are chest pains caused by a heart attack or by indigestion? Does abdominal pain with a fever and vomiting signal appendicitis or a virus? Patients who fear that they will have to pay a large emergency room bill themselves if they guess wrong may decide to forgo care—possibly complicating their condition or even threatening their lives.

The standard is met when a prudent or reasonable layperson, with an average knowledge of medical care, is experiencing the sudden onset of symptoms (including pain) so severe that he or she could reasonably believe his or her health would be in serious jeopardy without medical treatment (Page 10, line 16). This standard is advocated by the American Academy of Emergency Room Physicians. The definitions and prudent layperson standard used in the bill are consistent with the definitions in HB 1039, which deals with ambulance services, and HB 1038, the Department of Human Services appropriations bill which was amended to provide a comparable provision with respect to the state's Medicaid program.

The bill sets up a presumption that a participating provider in the carrier's health plan or other authorized agent of the carrier who authorizes emergency services cannot later retract that authorization. That presumption does not apply if provider materially misrepresented the patient's health condition (Page 10, line 20). This provision is taken from a model bill on utilization review developed by the National Association of Insurance Commissioners.

The emergency care would still be subject to a plan's applicable copayments, coinsurance, and deductibles (Page 10, line 29).

More than three-fifths of the states have passed laws requiring carriers to pay for emergency care based on a prudent layperson standard. Those states include Arkansas, California, Colorado, Connecticut, the District of Columbia, Georgia, Hawaii, Idaho, Indiana, Iowa, Kentucky, Louisiana, Maine, Maryland, Michigan, Minnesota, Missouri, Nebraska, Nevada, New Mexico, New York, North Carolina, Ohio, Oregon, Pennsylvania, South Carolina, Texas, Vermont, Virginia, Washington, West Virginia, and Wisconsin.

Utilization Review

Another part of the bill strengthens existing law that sets standards for carriers and other organizations that perform utilization review. The purpose of utilization review is to determine, based on the best information or clinical criteria available, what is and what is not appropriate care and, ultimately, what services will be covered. Many of the revisions proposed in this bill are from the model bill developed by the National Association of Insurance Commissioners.

The bill sets basic parameters for utilization review, but does not attempt to prescribe a rigid procedure. Some of our basic concerns were to ensure that final and expedited appeals are heard by physicians in the same or similar specialty that manages the care under review and that reasonable time frames are adhered to. Otherwise, an insurance company is free to develop an appeals process that the carrier feels is appropriate.

The bill, in sections 3 through 7, expands and strengthens the standards that already apply to insurance carriers when they perform utilization review in chapter 26.1-26.4:

- Requires that input in the development of a carrier's medical review criteria be provided by North Dakota physicians in the relevant specialty area (Page 5, line 17).

- Requires carriers to maintain and implement written utilization review programs that describe all review activities (Page 6, line 1).

- Requires that utilization review programs be administered by a physician or other health care professional (Page 6, line 19).

- Requires that physicians and psychologists who perform utilization review activities to be licensed to practice in North Dakota (Page 8, line 11). There is a House bill, HB 1136, that requires North Dakota licensure (Passed the House 71-24). With this change, physicians who decide whether medical services are necessary would be subject to the same disciplinary rules that all other physicians licensed in North Dakota are subject to, including competency, physical or mental disability, the habitual use of alcohol or drugs, unethical conduct, gross negligence in the practice of medicine, or any of the 28 grounds for disciplinary action in section 43-17-31.

- Requires that determinations and appeals relating to the coverage for health services be made within certain time frames, as follows:

Prior authorization or approval	3 business days (Page 6, line 28)
Initial determination	2 business days (current law, page 7, line 4)
Concurrent review	1 business day (Page 7, line 20)
Retrospective review	30 calendar days (Page 7, line 29)
First appeal	20 days (currently 30 days, page 8, line 18)
Expedited appeal	2 business days (current law) or as expeditiously as the patient's condition requires (Page 9, line19)

Final appeal	As expeditiously as the patient's condition requires. Otherwise 45 days to convene review panel (Page 11, line 19) after which 5 days to make decision (Proposed amendment)

•A physician might have difficulty obtaining the medical review criteria upon which an adverse utilization decision is made. The bill requires an insurance carrier to furnish the provider with the utilization review criteria used in evaluating health care services if the provider requests it (Page 5, line 22).

•Requires that the insurance carrier's appeals process in utilization review include at least a two-tier appeals process, with the final-level appeal requiring the appointment of a review panel comprised of physicians or other health care professionals. The panel's decision requires the concurrence of a physician licensed in ND who is trained in the same or similar specialty that manages the care under review (Page 11, line 13).

•Requires that expedited appeals in emergency or life-threatening situations be evaluated by a physician who is trained in the same or similar specialty that manages the care under review (Page 9, line 13), and that a second appeal in an expedited situation also be evaluated by a physician who is trained in the same or similar specialty that manages the care under review (Page 11, line 13).

An insurance carrier can require its participating physicians to be licensed in North Dakota, have hospital privileges at a network hospital, and in some instances be of a certain specialty or have training and clinical experience in a given type of care. Why shouldn't a carrier be required to have reviews performed, especially when decisions affect services provided and the availability of those services, by a physician with the same qualifications? Medical decisions affecting care can currently be made by individuals who are not licensed by the state, not trained or experienced in the care under review, and not accountable for any adverse decisions.

The qualifications required in the bill are necessary to assure that the reviews are being conducted by true "peers" who are themselves capable under their license and scope of practice to understand the service or procedure under review and capable of providing such care. These requirements will provide an important safeguard to the patient and should lessen the need for further appeals by the health care provider, thus addressing the cost argument of the plans.

- Clarifies that insurance carriers are responsible for meeting all the statutory utilization review standards, even if utilization review is delegated to a third party (Page 12, line 25).

Information Disclosures

Consumers need accurate, reliable, and understandable information that will allow them to assess differences in the quality and cost of health plans, the health care providers who will treat them, and the facilities that the plan uses. Consumers need this information to choose the health plan that is best for their families and, once they are in the plan, they need information to allow them to use the plan effectively.

The bill sets up a two tier process for sharing information. The first tier is information that must be disclosed in plain and ordinary language to prospective or current subscribers, including a summary of all covered benefits and exclusions, the carrier's definition of "medical necessity," the subscriber's financial responsibilities under the plan, how a subscriber might obtain services from a provider who doesn't participate in the plan, a description of prescription drug coverage, information on the plan's internal procedures and policies, the procedures for emergency services, a description of any methods the carrier uses in giving providers financial payment incentives, important mailing addresses and telephone numbers, and other basic plan information (Page 13, line 14, through page 14).

A second tier (Page 15, line 1) requires a plan to disclose certain kinds of information upon request, including information abut the plan's credentialing process, information about confidentiality policies and procedures, information on how the plan deals with experimental treatments or drugs, whether a particular drug is covered under the plan, and a list of providers.

It just makes good sense do what we can do to assist patients in understanding their health plan and controlling their own utilization.

Confidentiality

People are concerned about the confidentiality of their medical records and whether the most intimate details of their health and health care will be passed on to their employer or others, threatening their jobs and privacy.

Although there is agreement on the need for confidentiality of patient records and the Congress is under a self-imposed deadline to pass health privacy legislation by August 1999, there is disagreement on how it should be done. Nevertheless, in the last few years a number of states have enacted legislation addressing confidentiality issues. Most prohibit plans from selling names or identifying information about people who enroll in the plan.

The bill provides some basic protections. It imposes a duty on insurance carriers to ensure that all identifiable information maintained by the carrier regarding the health, diagnosis, and treatment of a patient is kept confidential (Page 15, line 25), subject to some clearly delineated exceptions (Page 15, line 30).

With regard to identifiable information relating to a patient, the bill allows for disclosure if the person consents in writing or consent is received in writing from a person authorized to consent for an incapacitated person or a minor (Page 16, line 5).

With regard to identifiable information relating to a health care provider, the bill allows for disclosure if the provider consents to disclosure in writing or if there is provision for disclosure in any contract between the physician and the insurance carrier (Page 16, line 9). There is also a specific exception relating to an insurer's duty under chapter 23-01.1 to provide data to the health care data committee (Page 16, line 12).

The confidentiality provision would provide a number of clarifications of activity that would not be considered prohibited or subject to a requirement for obtaining written consent, including disclosures necessary to conduct utilization review, to facilitate payment of a claim, or to reconcile or verify claims under a shared risk or capitation arrangement (See proposed amendment). These are clarifications we worked out with BlueCross BlueShield of North Dakota (Page 16, line 25). There is also a provision that clarifies that the Insurance Commissioner would still have access to an insurance carrier's records for purposes of enforcing the insurance laws and that any medical records acquired by the Commissioner as part of an examination would remain confidential (Page 16, line 28). This clarification was suggested by the Insurance Commissioner.

Due Process

Physicians in North Dakota need to be protected from inappropriate second-guessing, and deserve some level of due process on decisions that impact their livelihood. The bill provides a fair process of review for physicians who are sanctioned, terminated, or designated as nonpayable by an insurance carrier. Its modeled with some significant variations after section 26.1-17-12(2) (the nonprofit health service corporation law that applied to BCBSND prior to mutualization). The process includes reasonable notice of an inappropriate practice pattern (6 months), and the opportunity for a hearing by a committee comprised of a majority of physicians who practice in the same specialty as the affected physician (Page 17, line 5).

Practice Profiles

A rising concern among physicians in North Dakota is the inability to correct inaccurate data portrayed in individual practice profiles, or flawed methodologies in the analysis of data used to evaluate a physician. The bill requires that any practice profiling meet certain safeguards and standards (Page 18, line 1):

Any physician would, at any time, be able to request a description of the criteria used to evaluate the physician, and that information must be included in physician contracts (Page 18, line 1).

A physician would be able to review the information and specific data underlying any findings by the carrier to terminate, sanction, or designate the physician as nonpayable (Page 18, line 6).

Any evaluation or practice profile would be required to consider additional factors, including allowances for the severity of illness or condition of the patient mix and for patients with multiple illnesses or conditions (Page 18, line 14).

An insurance carrier would be required to periodically evaluate the quality and accuracy of practice profiles, data sources, and methodologies, and have safeguards in place to protect against the unauthorized use or disclosure of practice profiles (Page 18, lines 17-21).

A physician would be allowed to examine a practice profile at any time and prepare a written response to any inaccuracies. The carrier would be required to negotiate in good faith to correct any

inaccuracies or to make the profile complete. If the profile is not corrected, the carrier would be required to include the physician's response in any disclosure of the profile to a third party that is disclosed consistent with the confidentiality provision in the bill or in a proceeding to terminate or sanction the physician (Page 18, line 22).

Grievance Procedures

The bill, in section 11, requires insurance carriers to adopt grievance procedures for complaints by patients or providers regarding issues not related to utilization review, including access to and availability of services, quality of care, the choice and accessibility of providers, and the adequacy of the plan's network of providers (Page 19, line 3). This provision is similar to another statute that requires grievance procedures for HMOs – section 26.1-18.1-10.

Preferred Provider Arrangements

Many health care arrangements today employ a shared risk concept in which the provider is placed at risk for the cost or utilization of health care services. These risk sharing arrangements are more prevalent today in North Dakota. For example, BCBSND's BlueChoice product is that company's managed care, provider risk sharing product. BCBSND has noted that over 50% of their fully insured employer group business in September, 1998 was enrolled in either a shared-risk product or a limited provider network product such as SelectChoice.

Administrative cost shifting

Physicians in North Dakota have expressed concern about the cost shifting that has occurred in some shared risk arrangements. With shared risk products such as BlueChoice, more and more administrative costs are being absorbed or expected to be incurred by the provider, including referral authorization, pre-certification, and case management. In order to be a successful participant in BlueChoice, the provider must take on more workload and more discounts. Often, the physician must contract, credential, and negotiate with all providers within their network.

The bill, in section 12, requires insurance carriers in preferred provider arrangements to specifically identify in the preferred provider contract any administrative responsibilities that are shifted to the health care provider. Any responsibilities not identified are deemed to be the responsibility of the carrier (Page 20, line 10).

Interference with medical care

The bill would provide a specific prohibition, within the context of preferred provider arrangements, of any interference with a treating physician regarding the manner or setting in which particular services are covered and medically necessary for treatment or diagnosis (Page 20, line 20). Like many other provisions in the bill, this provision sets a basic standard that prohibits interference in the patient-physician relationship.

Exclusive arrangements

The bill would prohibit any preferred provider arrangement that requires an exclusive arrangement, i.e., any restriction on a health care provider from entering into an arrangement with other health care insurers (Page 20, line 25). This kind of arrangement restricts competition and disrupts continuity of care for patients.

Differences in payments to out-of-network providers

The bill clarifies that the differences in payment to preferred providers and non-preferred providers cannot also unfairly "reduce, limit, or delay" (as opposed to denying) payment for covered services (Page 20, line 30). This is consistent with other provisions in the bill that restrict certain insurance practices and is particularly important in a state like North Dakota with a large carrier that dominates the health care market.

Health care in North Dakota is at a crossroads. The challenges to medical decisionmaking and the patient-physician relationship are real and they are here in North Dakota. Senate Bill 2400 provides basic protections for patients and ensures fairness in health care. We have been fortunate in North Dakota to watch the dark side of managed care, for the most part, from the sidelines. It behooves us to be prepared. Senate Bill 2400 brings us a substantial step forward in that preparation. The North Dakota Medical Association and the physicians of North Dakota ask you, on behalf of their patients, to actively support this bill and give it a "do pass" recommendation.

Appendix

American Medical Association Code of Medical Ethics

E-8.13 Managed Care.

The expansion of managed care has brought a variety of changes to medicine including new and different reimbursement systems for physicians with complex referral restrictions and benefits packages for patients. Some of these changes have raised concerns that a physician's ability to practice ethical medicine will be adversely affected by the modifications in the system. In response to these concerns, the following points were developed to provide physicians with general guidelines that will assist them in fulfilling their ethical responsibilities to patients given the changes heralded by managed care.

(1) The duty of patient advocacy is a fundamental element of the physician-patient relationship that should not be altered by the system of health care delivery in which physicians practice. Physicians must continue to place the interests of their patients first.

(2) When managed care plans place restrictions on the care that physicians in the plan may provide to their patients, the following principles should be followed:

A. Any broad allocation guidelines that restrict care and choices - which go beyond the cost/benefit judgments made by physicians as a part of their normal professional responsibilities - should be established at a policy making level so that individual physicians are not asked to engage in bedside rationing.

B. Regardless of any allocation guidelines or gatekeeper directives, physicians must advocate for any care they believe will materially benefit their patients.

C. Physicians should be given an active role in contributing their expertise to any allocation process and should advocate for guidelines that are sensitive to differences among patients. Managed care plans should create structures similar to hospital medical staffs that allow physicians to have meaningful input into the plan's development of allocation guidelines. Guidelines for allocating health care should be reviewed on a regular basis and updated to reflect advances in medical knowledge and changes in relative costs.

D. Adequate appellate mechanisms for both patients and physicians should be in place to address disputes regarding medically necessary care. In some circumstances, physicians have an obligation to initiate appeals on behalf of their patients. Cases may arise in which a health plan has an allocation guideline that is generally fair but in particular circumstances results in unfair denials of care, i.e., denial of care that, in the physician's judgment, would materially benefit the patient. In such cases, the physician's duty as patient advocate requires that the physician challenge the denial and argue for the provision of treatment in the specific case. Cases may also arise when a health plan has an allocation guideline that is generally unfair in its operations. In such cases, the physician's duty as patient advocate requires not only a challenge to any denials of treatment from the guideline but also advocacy at the health plan's policy-making level to seek an elimination or modification of the guideline.

Physicians should assist patients who wish to seek additional, appropriate care outside the plan when the physician believes the care is in the patient's best interests.

E. Managed care plans must adhere to the requirement of informed consent that patients be given full disclosure of material information. Full disclosure requires that managed care plans inform potential subscribers of limitations or restrictions on the benefits package when they are considering entering the plan.

F. Physicians also should continue to promote full disclosure to patients enrolled in managed care organizations. The physician's obligation to disclose treatment alternatives to patients is not altered by any limitations in the coverage provided by the patient's managed care plan. Full disclosure includes informing patients of all of their treatment options, even those that may not be covered under the terms of the managed care plan. Patients may then determine whether an appeal is appropriate, or whether they wish to seek care outside the plan for treatment alternatives that are not covered.

G. Physicians should not participate in any plan that encourages or requires care at below minimum professional standards.

(3) When physicians are employed or reimbursed by managed care plans that offer financial incentives to limit care, serious potential conflicts are created between the physicians' personal financial interests and the needs of their patients. Efforts to contain health care costs should not place patient welfare at

risk. Thus, financial incentives are permissible only if they promote the cost-effective delivery of health care and not the withholding of medically necessary care.

A. Any incentives to limit care must be disclosed fully to patients by plan administrators upon enrollment and at least annually thereafter.

B. Limits should be placed on the magnitude of fee withholds, bonuses and other financial incentives to limit care. Calculating incentive payments according to the performance of a sizable group of physicians rather than on an individual basis should be encouraged.

C. Health plans or other groups should develop financial incentives based on quality of care. Such incentives should complement financial incentives based on the quantity of services used.

(4) Patients have an individual responsibility to be aware of the benefits and limitations of their health care coverage. Patients should exercise their autonomy by public participation in the formulation of benefits packages and by prudent selection of health care coverage that best suits their needs. Issued June 1996 based on the report "Ethical Issues in Managed Care," issued June 1994.

Senate Bill 2400

Testimony before the Senate Human Services Committee

Senator Russ Thane, Chairman

February 10, 1999

By Jon R. Rice, MD

Blue Cross Blue Shield of North Dakota

Chairman Thane and members of the Senate Human Services Committee, I appreciate the opportunity to appear before you. We support many of the principles expressed in Senate Bill 2400, but rise in opposition to the bill as written. My name is Jon Rice. I am one of the Medical Directors at Blue Cross Blue Shield of North Dakota. Having served as a practicing physician in this state for 20 years, as regulator during my tenure as the State Health Officer for five years and now for a year and a half with Blue Cross Blue Shield North Dakota as their Director of Managed Care, I feel I bring a comprehensive background to this issue. I have written about the parallels among Family Medicine, Public Health and Managed Care. One of the concepts that crosses the spectrum of those diverse fields is the management of populations and their health. This bill addresses some protections for patients but it also unduly controls the contracts of insurance companies and their duties. As a member of the North Dakota Medical Association, I appreciate the opportunity to participate in this bill's evolution and thank the Association for listening and acting on some of the concerns I have had from the insurers' point of view. This bill is a great improvement over its original draft but I feel there are several areas that need to be addressed before BCBSND can drop its opposition to the bill.

This is a long bill. It is extremely detailed in some areas; it is very broad in other areas. I will make some comments and recommendations for improvement section by section.

Section 1:
This section contains a new definition for medically necessary care. This definition establishes medically necessary as those services that a physician or other health care provider who is reasonably prudent would provide for the prevention, diagnosis, or treatment.... As an example, I am currently in the process of placing some prior approval requirements on a new cancer medication call Herceptin. Because this drug costs $13,400 for 23 weeks of therapy, our medical division felt that it was appropriate to require that the stated criteria in the medical literature and the FDA authorization be met before instituting this treatment. We requested input from all the practicing oncology specialists in the state. We consider these reasonably prudent physicians. One response was, "Should be up to the decision of the oncologist. There are too many complicating factors in a patients' care to restrict these new medications in this way." As I read the bill this reasonably prudent physician could use this $13,400 intervention as long as it was used "in a manner in accordance with generally accepted standards...".

Could this provision be interpreted to mean that insurer's must pay for all "medically necessary" services? Our current company practices of researching the proposed intervention, looking at the medical literature, looking for reviews by authorities such as the Technical Advisory Committee of BCBSA, which is funded in part by the Association for Health Care Policy Review of HCFA, and consulting with practicing physicians in the state to determine medically appropriate and necessary services could be bypassed by the will of a "reasonably prudent physician."

Section 2:
Paragraph 1 is also addressed in HB 1178 as amended and passed by the House. The second paragraph is also covered in HB 1178, but is more comprehensive in this bill. Paragraphs three and four of this section relate to contracting issues and should be the decision of the parties involved, not a matter of state law.

Paragraph 4 causes us a specific concern since this provision could limit our member's choice of health plans. We currently require provider networks to participate in our SelectChoice plan in order to be a BlueChoice provider. BlueChoice is our newest product but we want to assure access for those groups who wish to remain in SelectChoice. I would recommend that they be stricken from the bill.

Section 3:
We agree with this language, as it is becoming the national standard for emergency treatment. We are in the process of rewriting our benefits booklets to reflect this change. I am unaware of any emergency claims we have denied in the past, and do not anticipate any policy or practice change based on this language.

Section 4:
The definition of medical necessity again comes in this section. With that exception we have no objection to the language.

Section 5:
Paragraph 1.c. requires that all program descriptions and procedures be filed with the Insurance Commissioner. Is the Commissioner going to review this information? Does he have criteria to assess these procedures or is this a paperwork collection exercise? What is the role of the Commissioner? Does he have adequate staff to be proactive with this information?

The new language in lines 17-22 of page 5 potentially poses a great administrative burden on health plans. The language of "substantially or materially altering" poses a significant challenge. Replacing this language with "significantly" improves the situation. "Practicing in the relevant specialty areas" can be very burdensome. We recently had a request for a review by a pediatric pulmonologist on a specific issue. Where would we find two in the state? Will physicians voluntarily provide this service? Should there be a requirement to do so? If input is obtained about criteria from a physician practicing in the state and he is reimbursed for his time for providing that service, is he a consultant to the agent? I recommend that this language be deleted.

Section 6:
This section is the most complex and detailed of the bill. It covers over six pages. The Utilization Review Accrediting Committee (URAC) is a nationally recognized accrediting body in the area of utilization review. It accredits our Utilization Review Program at BCBSND so we feel we meet the intent of this section currently. However, this section raises the bar on these national standards by shortening some of the time frames and exceeding the national protocols. Couple that with the language "that imposes standards that meet or exceed the standards imposed by this chapter, as determined by the Commissioner", and the value of our accreditation efforts come into question.

Several areas of this bill exceed the standards that are accepted by URAC and the current practices of BCBSND as an accredited agency. Direct implementation of this section rather than the accreditation standard could be burdensome and expensive to the policyholders. Some examples are:

- **10. b.** We currently have a time frame of 30 days rather than 20 days.
  10.c. (1) We do not routinely use "physicians trained in the same or similar specialty." This is not required under URAC. We use generalist physician reviewers and work directly with the attending physician and specialists on an "as needed basis."

14.b. This language means to me that BCBSND must pay for any emergency services that a participating physician or other provider referred to the emergency room. A physician or the physician's nurse could refer a patient to the emergency room for routine care and it would have to be covered by the insurer because of the referral, regardless of the need for the service.
15.c. We do not provide direct appearances at this time. Physicians assisting us with these determinations have been reluctant to participate under these conditions.
16. This language effectively makes URAC accreditation meaningless since I am not aware that URAC or the National Committee on Quality Assurance (NCQA) requires these standards. We believe the language in current law should be retained.

Section 7:
This is already addressed in HB 1178.

Section 8:
Information disclosure is an important part of our subscribers' ability to obtain information about our plans. Each participant is provided a booklet explaining their benefits and the restrictions of those benefits. The Insurance Commissioner approves this booklet. We have no concerns about the type of information mentioned. Almost all of this is currently available. Paragraph 1.k. requires a general description of any methods used by the insurer for providing financial payment incentives or other payment arrangements to reimburse health care providers. One of our concerns and difficulties with producing incentive arrangements is that we do not pay most of the physician providers directly. Arrangements are made with clinics or integrated delivery systems for the receipt of monies for all the physicians within that group. How those dollars are distributed is based on contracts or employment agreements about which we have no knowledge. Perhaps those arrangements also should be disclosed to our subscribers.

Section 9:
Confidentiality of information is an important aspect of our activities at BCBSND. We are currently revising our corporate-wide confidentiality policy. Does this policy as written prevent the Disease Management programs BCBSND is developing? We desire to identify high risk patients based on claims history, monitor them for preventive interventions and therapies such as eye exams and blood cholesterol determinations for diabetic patients and inform the primary care physicians when these activities are not undertaken. Can we provide that information if this section of the bill becomes law? Can we provide information about the performance of the physician to his group medical director or administrator? These are day to day activities for the benefit of the patients of this state that I feel will be prohibited. In addition, confidentiality issues are due to be addressed at the national level. If Congress fails to act by August 1999, the Secretary of Health and Human Services is to promulgate regulations regarding confidentiality of medical records. This will assure a national standard protecting confidentiality and not a patchwork of fifty state laws.

Section 10:
This section effectively handcuffs an insurance plan from controlling the providers within the plan.

Section 11:
The definition of grievance is absent. Does it mean "questions and concerns regarding any aspect of the plan..."? We do keep track and monitor written complaints, which we call grievances. Is this what is meant, or is every question about the availability of service to be documented and reported? Who will look at this information? What will they do with it? Are we doing something for the benefit of the citizens or simply adding more bureaucracy?

Section 12:
This added language should be a contracting issue. We are not sure that this enhances services much other than improving the employment of lawyers. "Unfairly deny, reduce, limit, or delay ..." again all relate to an extremely broad definition of medical necessity.

Section 13:
What is an unfair reduction or limit in payment for out of network services? Who will decide? How will they decide? Some plans allow no payment for out of network services in preferred provider arrangements. I assume that will be illegal in North Dakota. Where will the dividing line be?

We recommend that Sections 9, 10, 11,12, and 13 be entirely deleted.

Ladies and gentlemen, I have taken this opportunity to point out many of the concerns that I personally, and BCBSND as a company, have with this bill. We see that patient protection acts are being considered on the national level, as are patient confidentiality laws. We support proposals that truly are patient protections. This bill affects health plan interactions with providers more than patients. Are you as legislators hearing from your constituents about problems in ND which this bill addresses? It is important that our policy makers look closely at the benefits obtained from legislative actions and whether they will be justified by the increased costs in inefficiency and dollars for health care premiums that will result.

I appreciate your attention and interest in this bill. I want you to know that I am available to help you with your deliberations by phone at 701-282-1048 or email at jon.rice@noridian.com. Are there any questions you would like me to address at this time?

Senate Bill 2400

Testimony before the Senate Human Services Committee

Mr. Russ Thane, Chairman

February 10, 1999

By Altru Health Plan

Presented by Representative Ken Svedjan

Chairman Thane and members of the Senate Human Services Committee. Today I stand before you on behalf of Altru Health Plan, a division of Altru Health System, Grand Forks, N.D. The Altru Health Plan is a not for profit HMO serving 13,500 persons in Northeast N.D. and Northwest MN. The Plan is in opposition to Senate Bill 2400. As the Plan is unable to attend today's hearing I submit to you several of their concerns regarding the bill.

In principle, Altru Health Plan supports the idea of patient rights and the role of physicians in advocating for patients. This is evidenced in their support of recent legislation relating to their Minnesota membership. However the bill before you is in their view-lengthy, extremely detailed and will carry a significant administrative cost which will be passed to plan members. The following represent specific observations regarding the bill.

Section 1:

The definition of medically necessary care is very broad. What is the corresponding definition of "prudent physician"? Presently the Plan subscribes to a nationally accepted technical resource as a basis for making recommendations to the Plan's medical policy committee, which is comprised of participating physicians. Whose criteria will take precedent, the Plan's or that of the "prudent physician"?

Section 2:

Paragraph 2 of the section discusses retaliation for patient advocacy. Altru Health Plan expects physicians to advocate for their members. However, the proposed definition will make it easy to claim that any change in contractual terms is in retaliation for grieving a Plan policy or decision. How will we define "good faith" advocacy on behalf of members? This law will allow physicians to undermine a plan and it's enrollee relationship with impunity.

Paragraph 5 suggests that plans should not create contract provisions, which require physicians to participate in all products. While Altru Health Plan does not presently have such contractual terms it would like to retain the opportunity to reward those who are willing to participate in all products by making them preferred providers for certain markets. For example, some providers do not wish to serve medical assistance members. It would seem reasonable that as Altru creates new commercial products it would reward those providers already serving these enrollees by giving them the first opportunity to participate.

Section 5:

Part 2 requires that medical review criteria be developed with input from physicians who are not employees of Altru. While local physicians including those who are not Altru employees approve plan criteria, this requirement will be very difficult to meet. The Plan would need input from physicians who do not serve enrollees in the Altru Health Plan service area. The criteria utilized by most plans including Altru are already nationally accepted standards for medical review.

Section 6:

While the Plan takes issue with a majority of section 6 most problematic is the appeals process outlined in part 9 and 10. The process adds significant administrative requirements to the health plan. The proposed process is excessive in that it mandates three increasingly complex steps for appealing decisions by the Plan's medical director. While an appeal process is certainly appropriate the proposed method is extraordinarily prescriptive and will be a burden that will add to the cost of administrating the Plan.

Section 8:

The section discusses the disclosure of information to Plan enrollees. Altru believes that member documents, which describe the plan in layman language, is appropriate. However it needs to be clarified if this information is part of the subscription certificate or is a supplemental document. Some requirements seem duplicative with other Plan documents and existing statutory requirements.

Section 10:

The contract limitations proposed in Section 10 are substantially too restrictive. This provision will essentially disallow global reimbursement changes for providers. It will also make it difficult to remove physicians from the network for any reason. The section is overly prescriptive in how it will allow plans to utilize profile information as a tool to inform and educate physicians. While the Plan agrees in principle that profiling information must be used appropriately, it can not agree with the significant

administrative requirements of the section and how it has been connected to the contracting process.

Generally the Plan has concerns with how language in the bill may be interpreted and the impact it will have on the Plan and member costs. Is this bill addressing problems that exist in the state? The providers and patients that Altru Health Plan represents have not expressed many of the concerns reflected in the proposed legislation. Legislators must remember that consumers ultimately carry the burden of paying administrative costs incurred by the Plan. At a time when there are increased concerns regarding the cost of health plan premiums it is prudent to study the appropriateness of the proposed requirement and respective affordability for consumers.

The Plan appreciates your acceptance of it's concerns through Representative Svedjan and if you have questions please contact either Tim Sayler, Executive Director, or Dr. Charlotte Hovet, Medical Director, or Camille Karpen, Health Services Manager, Altru Health Plan by phone at 701-780-1600 or at E-mail tsayler@medpark.grand-forks.nd.us.

Senate Human Services Committee
Testimony on Senate Bill No. 2400
Wednesday, February 10, 1999

Chairman Thane, Members of the Senate Human Services Committee

I am Dr. Matt Layman, President of the North Dakota Medical Association. The Association represents over one thousand physicians in the State and supports Senate Bill 2400.

While no recording of national trends of complaints against HMO's are kept, the National Association of Insurance Commissioners estimates that 35,000 complaints were filed last year. In the mostly populous states, with dense concentration of managed care (NY, Connecticut, Illinois, Texas, Ohio and Maryland), insurance departments report that complaints have grown 50% over the last 1 - 3 years, far faster than the growth of enrollment. Patients need to be protected and the patient-physician relationship needs to be preserved in this new health care environment.

Rather than discuss the bill by each section, (Mr. Levi who drafted the bill will do that) I would like to show you how the bill protects the patient and will preserve the patient-physician relationship. I will also give you examples of why this bill is needed.

The bill begins to protect the patient even before they decide to enroll in an insurance plan. The bill requires that a plan description must be given to each prospective enrollee or enrollee in the plan. The description "must use plain and ordinary meaning of words so as to reasonably ensure comprehension by a lay person and must be made available to each insured prior to the delivery, issuance, execution, or renewal of the policy on the contract." This protects the patient by requiring that the insurance plan is written so that people can understand it and can make a decision as to whether that plan fits his/her needs.

The bill also defines the term "medically necessary care." This ensures that whatever plan is chosen by the patient, he/she can be assured that if care is to be provided or covered that it will meet a minimum standard of medical necessity that is consistent with generally accepted standards of medical practice.

Once a patient has enrolled in a plan, this bill provides protection in times of emergency. The bill specifies that a plan may not deny coverage for emergency services and may not require prior authorization of these services. The bill defines an emergency medical condition as "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 or her unborn child, in serious jeopardy."

This was not the case in Maryland in 1996, when a Betheseda woman hiking in the Shenandoah Mountains suffered skull, arm and pelvic fractures in falling from a forty foot high cliff. She had to be evacuated from the site by helicopter and treated in a nearby Virginia hospital. When her Maryland-based HMO refused to pay the bill because it had not granted "pre-authorization," efforts were made to force collection of $10,000 in outstanding medical bills.

This was certainly not the case in March of 1993 when a distraught mother in Georgia called her managed care company's hotline because she felt her plan wouldn't let her go directly to an emergency room. Her six month old son had a temperature of 104 degrees F and was panting and moaning. Her managed care company instructed her to drive the child to a hospital more than thirty miles away, passing by several hospitals in downtown Atlanta. During that drive the child worsened and suffered a cardiac arrest requiring CPR. The family found a closer hospital emergency room, the child eventually recovered but required amputations of both hands and feet because of gangrene caused by the serious infection the child had. Had this child's health care plan allowed for the mother to decide that this was an emergency according to the standards under Senate Bill 2400, she may have felt she could have gone directly to the nearest emergency room in the first place.

Our bill protects patients during these times of emergency.

This bill protects the patient from health care plans that provide incentive plans to providers to limit, reduce, deny or delay medically necessary care. In a recent New England Journal of Medicine article (11/98) "Primary Care Physicians' Experience of Financial Incentives in Managed Care Systems," a two year survey of 766 primary care, office based, independent doctors who have HMO contracts, found that 38% of those doctors were subject to financial incentives to control cost. These include limiting referrals of patients to specialists and limiting the use of hospitals and prescriptions. Twenty-eight percent of the doctors reported that they felt pressure to limit what they told patients about treatment options. Of the physicians studied, more than 20% felt care was compromised in this environment.

Senate Bill 2400 protects the physician-patient relationship by allowing the physician to be a patient advocate in decisions about the patient's care without fear of retaliation by the health plan. Retaliation would include refusal to contract with the health care provider, termination or refusal to renew a contract, refusal to refer patients or to allow others to refer patients, or refusal to compensate the health care provider for covered services.

If services or care requested is denied by insurance plans, Senate Bill 2400 protects the patient by giving the patient and their physicians an appeals process that is timely depending on the patients condition and requires that the appeals process use physicians who are trained in the same or similar specialty that would normally treat the patient's condition. This process would hopefully prevent horror stories like Phyllis Cannon, whose health insurance delayed her medically appropriate cancer treatment for three months. By that time her cancer developed beyond treatment and she died weeks later. Or the more famous case of David Goodrich, whose widow recently won a $120 million dollar judgment against Aetna\US Healthcare for delaying a decision for six months, instead of their standard 48 hours, on bone marrow transplant therapy despite the fact that Aetna doctors recommended it to help treat Mr. Goodrich. The jury stated that Aetna's conduct was a substantial factor in shortening Mr. Goodrich's life.

The bill also prohibits an insurance plan from requiring a physician to participate in each of the insurance products offered by the carrier, even if the doctor wants to participate in some of the products but not all of them. If a physician feels a certain insurance product is inappropriate for his or her patients or makes it difficult for the physician to provide adequate health care, the physician could not be forced to participate in that specific plan, but could care for patients who are enrolled in the carrier's other products. Such is not the case in Texas where 26,000 patients were left without a doctor, because Dallas area physicians could no longer work under an Aetna HMO product, citing Aetna's failure to provide accurate and necessary economic and clinical data and its inability to process claims for its HMO product. When the physicians pulled out of that particular product, Aetna invoked its "all-products clause" to prevent the physicians from taking care of any Aetna patient they had previously cared for under other Aetna products. This bill would not allow this practice and would allow physicians to protect their patients from these adverse scenarios.

Senate Bill 2400 allows for insurance companies to review physicians, not based on how much they are costing the health care plan, but based on whether they are providing medically necessary and appropriate care. It is important that physicians are reviewed, but it is also important that due process is followed, so good physicians are protected. Senate Bill 2400 requires that review of a physician be done by a panel which includes a majority representation of the reviewed physician's specialty and that the insurance plan must disclose the criteria, data and methodology for evaluating physicians in its physician contracts.

Senate Bill 2400 contains other protections, including assurances that medical records that identify patients are kept confidential and not disclosed without the consent of the patient, that carriers adopt procedures to handle grievances or complaints raised by patients or providers, and that a more level table is available for providers when they negotiate contract terms with carriers (away from the "take-it-or-leave-it" contracts of the past).

Who would have thought fifteen years ago that a physician would have to plead for the protection of patient rights. As health care costs have skyrocketed, everyone has looked for ways to control costs. In this health care revolution, large insurance "monopolies" are being formed, patients have become contracts and covered lives to be bought or sold, and physicians have become "providers of services." The woman on the mountain needing emergency care, the baby in the car struggling to stay alive, the people with cancer looking for treatment and the thousands of patients looking for new doctors because their own doctors were watching out for them, are all vulnerable, need their rights protected, and need an advocate. We do not hear the daily reports of managed care abuses in North Dakota, but Senate Bill 2400 sends a strong message to health care plans that this behavior will not be tolerated in our state. "An ounce of prevention is worth a pound of cure." We ask that you actively support protection for the patient physician relationship, and vote a "do pass" on Senate Bill 2400.

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H.M.O. Fiscal Incentives Linked to Doctors' Discontent

By PETER T. KILBORN

Many California doctors say the bonuses and other financial incentives that **managed care** organizations give them for speeding up office visits and restricting **care** compromise the quality of **care**, according to a survey of doctors reported in The New England Journal of Medicine today.

But, the survey added, when health maintenance organizations include incentives based on patient satisfaction and quality, or the theory that better **care** is often cheaper **care**, doctors believe the quality does indeed improve, along with their satisfaction.

Anecdotal accounts of physician discontent with **managed care** are commonplace, but The New England Journal's editor, Dr. Jerome P. Kassirer, said this analysis, by a doctor-led group of researchers at the University of California at San Francisco, broke ground in examining the link of financial incentives to such unhappiness.

The article, "Primary **Care Physicians**' Experience of Financial Incentives in **Managed Care** Systems," is based on a two-year-old survey of 766 primary **care**, office-based, independent doctors who have H.M.O. contracts and of salaried doctors for California's large H.M.O. Kaiser Permanente, which provides all of its member patients' **care**.

The average age of the doctors -- pediatricians, internists, family practitioners and obstetrical-gynecologists -- was 49, and an average of 56 percent of their patients were members of H.M.O.'s. The doctors' average salary is $130,000 a year, which includes bonuses and other incentives that typically accounted for 7 percent of their pay, or $10,500.

The Blue Cross and Blue Shield Association, made up of 55 state and local affiliates, saw the study less as a rebuke than as fodder to support changes in the health **care** system that it has begun to endorse.

"**Managed care** is a work in progress," said Patrick Hayes, the association's president and chief executive. "There's no question about our needing to reinvent **managed care** as it has been implemented in the last 10 or 15 years."

The study does not try to establish whether the incentives have led to an actual decline in the quality of **care**, but it warns that they may.

In analyzing the survey, Dr. Kevin Brumbach, Dr. Andrew B. Bindman and their team found that 38 percent of the doctors, or 291, were subject to financial incentives to control costs. These included limiting referrals of patients to specialists, limiting the use of hospitals and prescriptions and raising their productivity by seeing more patients.

Of the 291 doctors, the study said 28 percent "reported that they felt pressure to limit what they told patients about treatment options."

A much higher proportion, 57 percent, felt pressured to restrict their referrals, and a nearly a third of these doctors said the pressure was severe enough to compromise the quality of **care**. And 75 percent of the doctors, or 575, said they felt pressured to see more patients. A third of these doctors, too, said **care** was compromised.

By contrast two other incentives, quality and patient satisfaction, pleased the doctors, particularly at Kaiser. Ten percent of the office-based doctors and 31 percent of those at Kaiser said the quality of **care** was an incentive. Patient satisfaction was a criterion for 11 percent of the independent doctors and for 45 percent of those at Kaiser.

The study added that the Kaiser doctors felt more pressure than the independent doctors to see more patients, and faster. But it also said that "they were the least likely to report feeling pressure to limit referrals or to restrict what they told patients about treatment options."

The California Medical Association saw today's report of the study as ammunition to force changes in laws governing H.M.O. contracts with provisions that the association says undermine good **care**. On Tuesday, the California Department of Corporations rejected an association petition urging the changes; within a week, the association plans to appeal.

"This state has gone from the leading edge in **managed care** to the bleeding edge," said Dr. Jack Lewin, the association's chief executive. "Doctors are at this point burnt out."

Concluding a two-page editorial on discontent among doctors that was based on the study, Dr. Kassirer of The New England Journal writes: "There has been an

undercurrent of unhappiness among **physicians** for many years, but the complaints seem more widespread and strident now. One thing we know: disgruntled, cranky doctors are not likely to provide outstanding medical **care**."

Correction: November 21, 1998, Saturday

An article on Thursday about doctors' discontent with managed care groups misstated the surname of an author of an article in The New England Journal of Medicine on the subject. He is Dr. Kevin Grumbach, not Brumbach.

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Complaints About H.M.O.'s Rise as Awareness Grows

By PETER T. KILBORN

State health insurance regulators are reporting surging numbers of formal complaints from patients and doctors against health insurers, primarily health maintenance organizations.

They say they doubt that the rise implies a deterioration in care. They tie much of it to greater public readiness to fight H.M.O.'s and to the insurance commissioners' efforts to encourage people to file complaints. "We are beating the bushes," said Neil D. Levin, New York State's Insurance Superintendent.

What troubles the commissioners more than the volume of complaints is a broad shift in the nature of them. Disputes with insurers have changed from conflicts over who should pay for care, usually after it has been provided, to conflicts over denials and delay of care and over medication and forms of treatment.

"Before it was about who pays," said Patricia Butler of Boulder, Colo., a health care analyst and consultant to insurance commissioners. "Now it's about whether you get the service at all. You might have your health hanging in the balance, so it's a little more frightening."

Commissioners say the formal complaints represent possible violations of law and health-plan provisions, and are culled from many more trivial and unsupportable claims. Depending on the state, 40 percent to 80 percent of the complaints are resolved in favor of the patient or the physician.

No one records national trends in the number of complaints, but the National Association of Insurance Commissioners predicts that 35,000 will be filed by the end of this year.

In interviews with 12 insurance departments of mostly populous states with dense concentrations of managed care, those of New York, Connecticut, Illinois, Texas, Ohio and Maryland said complaints had grown at least 50 percent over the last one to three years, far faster than the growth of enrollment in managed care plans. Only one state, Minnesota, reported a decline; other states with increases included Arizona, Florida, New Hampshire, Oregon and Washington.

New York reported a sixfold increase in claims against managed care organizations from 1996 through September of this year. It said that 76 percent of the 20,089 claims filed over the period had been settled in favor of the consumers and doctors bringing them. Mr. Levin ascribed much of the increase to the travails of one leading H.M.O., Oxford Health Plans, and to fee disputes with physicians.

In Texas, complaints from consumers have been climbing for several years, to 846 in 1996 from 131 in 1993. In the fiscal year ended in August, the number leaped to 4,914, largely because of a new law allowing complaints by physicians.

Insurance industry executives say that in spite of the rise, independent surveys regularly show that 80 percent to 90 percent of managed care organizations' enrollees are satisfied with their care, a figure that has changed little over the last decade.

"It's way too simplistic to equate" the rise in complaints with the quality of care and reach the conclusion, " 'Aha! Things are getting worse,' " said Bill Pierce, spokesman for the Blue Cross and Blue Shield Association, which represents 55 organizations that sell both managed care and fee-for-service plans. And as enrollees become accustomed to H.M.O.'s, he said, they find less to complain about. Mr. Pierce said candidates for state and Federal office had fanned public fears of H.M.O.'s. "It's in Hollywood," he said. "On the campaign trail."

Charles N. Kahn 3d, chief operating officer of the Health Insurance Association of America, said that 35,000 complaints a year from the 77 million enrollees whose insurance is subject to state regulation was not a large number. "You should have zero tolerance for problems," he said. "Inevitably there are going to be some."

That 80 percent of managed care enrollees are satisfied with their care obscures the views of a less satisfied 10 percent or 15 percent who make much use of the organizations, said Karen Pollitz, an analyst at the Institute for Health Care Research and Policy at Georgetown University. "In any health plan," Ms. Pollitz said, "the vast majority are healthy and are not using the services. If you're just carrying their card in your pocket, what are you going to complain about?"

Commissioners add that dwelling on the number of complaints masks an issue they say is more ominous: the changing nature of complaints. Kansas, for

instance, had only 145 complaints through September. "But I'm not sure numbers are the best indicator," the State Insurance Commissioner, Kathleen Sebelius, said.

"A mother called us," Ms. Sebelius said. "Her 15-year-old son had attempted suicide and was going to be released from the hospital in 24 hours. She was absolutely frantic.

"She was afraid he'd be dead if he were released. We got him permission to stay an additional week with extra evaluation and to have a plan in place prior to any release."

Charles N. Blossom, New Hampshire's Insurance Commissioner, cited a woman who had had a mastectomy under a fee-for-service plan. After switching to an H.M.O., she needed another mastectomy, but was not allowed to see the same doctor. "We got involved and they permitted it," Mr. Blossom said.

In Oregon, which reports a comparatively small 17 percent increase in complaints from 1996 to 1997, Joel Ario, consumer protection manager for the Oregon Insurance Division, sees two forces at work. "There are more genuine problems in the marketplace," he said, and "people are more aware of us."

Many insurance commissions have installed consumer hot lines and many have put complaint forms on their Web pages. Some publish "report cards," disclosing H.M.O. accreditation levels, levels of patient satisfaction and details of charges and services.

"The public is learning to use the system," said Kip May, deputy director of the Ohio insurance department.

Through August, 17 states had also opened a new channel for complaints in creating courts of third-party review -- nonpartisan arbitrators, unaffiliated with the industry.

Commissioners also report wide variations in complaints from company to company. Using ratios of complaints and plan enrollments to permit fair comparisons, the Texas Department of Insurance reports that last year, Foundation Health received three times the complaints brought against Cigna Healthcare and 10 times those against the Kaiser Foundation Health Plan. Some small H.M.O.'s had no recorded complaints.

One striking exception to the surge in complaints is Minnesota, which has had H.M.O.'s for more than two decades. After years of tight regulation, complaints have dropped over the last few years to 600 or 700, from an average of 1,300 a year in the late 1980's, said Kent Peterson, director for managed care systems in the Department of Health. "Every member has had the phone number of this office on their membership card for 10 years," he said.

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Managed care showdown in Texas

By Jeffrey Barg

Genesis Physicians Practice Association's Stanley Pomarantz, M.D.

Published February 1999

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Texas has been a fertile breeding ground for measures designed to curb the excesses of managed care. In 1997, Texas was the first state to pass a law to enable medical malpractice lawsuits against health insurers, as well as other patient protections providing for stricter regulation of managed care. The Texas Department of Insurance has forced HMOs to strip gag clauses and certain financial incentives for limiting care from provider contracts. And the outgoing Texas attorney general has filed suit against six HMOs for using illegal financial incentives for physicians to limit care and penalizing physicians for not limiting care.

This may seem like a medical paradise to physicians from other states. But not all is well in paradise.

Many North Texas physicians are mad as hell and are dropping out of managed care plans in droves. One managed care plan in particular. As a former president of the Dallas County Medical Society put it in an essay written in 1997: "Aetna, I'm sorry I met ya'."

After years of escalating hostility and mistrust, two large integrated physician organizations have terminated their HMO contracts with Aetna U.S. Healthcare, which is poised to become the largest health insurance company in Texas and the nation with its purchase of Prudential HealthCare. In return, Aetna has invoked its "all products policy," which requires

physicians to participate in all of Aetna's products in order to participate in any. And in the case of the larger physician organization, Genesis Physicians Practice Association, Aetna has sent letters threatening to bring in the Federal Trade Commission for an antitrust investigation of the 560 physicians. The dispute has percolated up to the Dallas County Medical Society, the Texas Medical Association and the American Medical Association (AMA), which is using the Aetna actions here as a basis for opposing the purchase of Prudential HealthCare in a filing with the Justice Department.

By most accounts, these problems began in 1996 when Aetna purchased U.S. Healthcare in order to jumpstart their HMO business. According to a *Wall Street Journal* account published in July, 1998, Aetna adopted U.S. Healthcare's more aggressive, stingy approach by replacing senior management positions with people from U.S. Healthcare, who in turn made drastic changes in customer service personnel, computer systems and provider contracts, resulting in widespread dissatisfaction among providers, patients and employers. In Westchester County, NY, for example, 37 percent of physicians chose not to renew their provider agreements with the company.

In Dallas, **F. David Winter, Jr., M.D.**, a Baylor internist, said that prior to the purchase of U.S. Healthcare, Aetna was the best insurer he worked with in terms of approving referrals, getting reimbursed promptly and having a reasonable list of approved medications. Shortly after the purchase, however, getting approvals for referrals became problematic, approved medications kept changing, payments were delayed or sent to the wrong address, and it became difficult to get through on the telephone to Aetna, Winter said in an interview with *Physician's News Digest*.

A decisive moment came last spring for Winter and his colleagues at HealthTexas Provider Network, a fully integrated joint venture between 220 physicians and Baylor Healthcare System. Aetna unilaterally lowered physician reimbursements despite the fact that they were in the middle of a contract that specified rates, according to Winter. Physicians were told that they could either accept the lower fee schedule or drop out of the contract. The physicians gave Aetna 90 days

notice of termination, as required in their contract. In the last week of the 90 day period, Aetna said they would return to the original fee schedule and most of the physicians re-joined, except for certain specialties such as orthopedic surgery and gastroenterology.

Two months later, Winter and his colleagues discovered that Aetna was still reimbursing physicians under the reduced fee schedule. At first, Aetna denied doing this. After being confronted with proof, Aetna said that they would change to the original fee schedule, but that claims for the prior two months needed to be resubmitted in order to gain the difference for that period. Physicians complained that resubmitting every claim would be extremely costly and unnecessary. Aetna only relented on this condition when they found out that the *Dallas Morning News* was working on a story on the dispute, Winter said.

Winter also discovered that Aetna had sent a $30,000 payment to the wrong address. Aetna belatedly acknowledged their mistake and agreed to resend the payment, but it has yet to arrive seven months later.

In the meantime, because many Baylor specialists did not rejoin Aetna, Winter and his primary care colleagues were forced to refer their patients to specialists they did not know or that required patients to travel a long distance. Given the growing level of mistrust and hostility, as well as the toll of the hassles endured, the HealthTexas physicians again gave Aetna 90 days notice of the termination of their provider agreements. As of the first of the year, approximately 175 primary care physicians of HealthTexas are no longer seeing Aetna patients.

The dispute between the Presbyterian Hospital System physicians and Aetna is similar but far more polarized. In October of 1995, Genesis Physicians Practice Association entered into a risk contract with Aetna at Aetna's insistence, according to **Stanley Pomarantz, M.D.**, vice president of medical affairs for System Health Providers, Genesis' management company. For a year-and-a-half, as Pomarantz tells it, all was well. Genesis received the financial and clinical data from Aetna it needed to effectively manage the risk contract. Payments were prompt and accurate.

But on April 1, 1997, the flow of financial and clinical

data suddenly stopped. The number of problems getting claims paid grew exponentially. Genesis experienced a nine to twelve month information blackout and Aetna's share of the group's reimbursement problems ballooned to 50 percent although Aetna represented only 13 percent of Genesis' business, Pomarantz said.

Pomarantz later found that these problems coincided with Aetna's shift to U.S. Healthcare's software.

Genesis sent a letter to Aetna in August of 1997 asserting that these problems constituted a breach of their HMO contract. Genesis and Aetna then set up work groups from both companies that met every other week. But the situation did not improve.

From November 1997 through January 1998, Aetna could not accept electronic claims, even though that was the method of filing claims encouraged by Aetna. When confronted with the problem, Aetna denied any responsibility. Later Pomarantz discovered that Aetna's electronic gateway had been inadvertently closed while trying to correct another problem.

In the spring of 1998, Genesis began to see some pharmacy data from Aetna. But less than half had physician identifiers. Financial data came through, but was rife with errors and frequently was in unauditable form.

On June 12, Genesis sent Aetna notice of how these problems constituted a breach in their HMO contract, giving 30 days to correct the problems. At the end of June, Genesis made a seven-point proposal of ways the problems could be resolved. The proposal was rejected and 560 Genesis physicians gave 90-day notice of the termination of their HMO contract on July 12. Pomarantz said they were shocked that Aetna had not made a counter-proposal or accepted some of the seven points, since they had already adopted some of the points in their contracts with other Dallas physicians.

Aetna then attempted to sign up the Genesis physicians individually with hardball tactics. They invoked their "all products policy," shutting the Genesis physicians out of all of Aetna's products even though the physicians only terminated their HMO

contract. They sent out "hit squads" comprised of an Aetna representative and a NYLCare representative (Aetna purchased NYLCare in July 1998) to doctor's offices with a bounty for each Genesis physician they could sign up, Pomarantz said. Pomarantz believes that Aetna thought they could break up the Genesis group. But when Aetna could not get physicians back individually, they charged that Genesis was putting undue pressure on members and threatened to ask the Federal Trade Commission to conduct an antitrust investigation.

By this point, the dispute had caught the interest of the Dallas County Medical Society (DCMS) and the Texas Medical Association. In July, the DCMS held a press conference opposing Aetna's "all products policy," blaming it for interfering with the continuity of care of nearly 300,000 Genesis patients. Then-DCMS President **Robert T. Gunby Jr., M.D.**, compared Aetna's failure to provide economic and clinical data to asking physicians to practice medicine "blindfolded and handcuffed" and to driving a car at night without headlights.

While the invocation of the "all products policy" seemed to spark a flame, the threat of an antitrust investigation fueled a firestorm that reached the American Medical Association. DCMS Executive Director Michael Darrouzet likens the threat to that of someone pulling a gun on you in a parking lot: They may not be willing to pull the trigger, but you have to take it seriously. In November, Gunby fired off a letter-to-the-editor to the *Dallas Morning News* saying that it is "ludicrous when a $19 billion corporate giant cries for government protection against an obviously overmatched opponent because it knows current laws favor it. . . Aetna is using the threat of the antitrust laws to intimidate individual physicians into signing contracts that they may or may not wish to sign and that may or may not be in the best interests of their patients." Gunby called for legislative hearings on "these unfair laws and what they mean to patient choice and patient care."

When Aetna announced a deal in December to purchase Prudential HealthCare, it provided a rallying point for physicians inside and outside of Texas. On December 18, eight days after the announcement of the deal, both the AMA and the Texas Medical

Association (TMA) released statements opposing the merger on antitrust grounds. In a letter to the Justice Department sent on the same day, the AMA asserted that "the market power that would be created or exacerbated by this merger would limit the choices of patients and employers, reduce competition and further erode the ability of physicians to make medical decisions based on science and the medical needs of their patients, not share price."

The TMA statement cited support for the AMA statement and continued: "TMA reminds the public that this is the same $25 billion conglomerate that has spent millions of dollars fighting virtually every patient protection initiative in state legislatures across the country and the Patients' Bill of Rights now pending in the U.S. Congress, and sued the State of Texas last fall to block the only law in the country that would hold managed care plans accountable for injuring patients. This corporate giant has steadfastly maintained that insurance companies should decide whether the treatments ordered by your doctor are medically necessary. It's been difficult enough for Texas physicians and their patients to endure the bottom-line motivations of Aetna/U.S. Healthcare. If this merger goes unchallenged, it would create a piece of the rock large enough to flatten the health care systems of Dallas, Houston and the rest of the Lone Star State."

While Aetna had been a relatively small player in Houston, its combination with NYLCare and Prudential would give it a greater than 50 percent market share, and Houston physicians have been calling the Harris County Medical Society (HCMS) to lodge their concerns, according to immediate past president **Paul Handel, M.D.** While Handel has not had any direct experience with Aetna, he is well aware of their "slash and burn technique" and he has vowed to "fight them in this community for as long as I can." HCMS is also urging the Justice Department to review Aetna's purchase of Prudential.

The AMA's opposition to Aetna's purchase of Prudential is the first time they have publicly opposed a health insurance consolidation. **Randolph Smoak, M.D.**, chairman of the AMA Board of Trustees, identified three reasons for the AMA's action in this case. First, the consolidated Aetna would have a huge

market share, particularly in certain local markets such as Houston, Dallas and San Antonio. Second, this market power is particularly disturbing in light of the difficulties physicians are already having with Aetna, including the coercive "all products policy," failure to provide adequate data to physicians and one-sided contracts. These problems might be particularly acute in Dallas, but they are also being experienced in six to eight other states. Third, the transition in delivery systems has swung the pendulum so drastically toward managed care that many physicians are on the verge of needing to close their practices.

Todd Vande Hey, the AMA's vice president for private-sector advocacy, is preparing a filing for the Justice Department, which will contain information from local markets where Aetna or Aetna plus Prudential have significant market penetration and the behavior of the plans may have significant impact on competition, as well as the doctor-patient relationship and quality of patient care. Would it be possible for Genesis physicians, for example, to reject an Aetna contract they feel would be bad for themselves and bad for patient care after Aetna acquires Prudential? And if they were to reject such a contract, what sort of dislocation would that present to patients, questioned Vande Hey.

While this may be the first time the AMA has opposed a health insurance consolidation, it almost certainly will not be the last. Vande Hey said that if they find a similar situation to the Aetna acquisition of Prudential, the AMA will take its concerns to the Justice Department as well as to the public and business community. Bigger has not proven to be better, Vande Hey contends, leading neither to lower premiums nor to improved patient care. The AMA will challenge anti-competitive consolidation in health care and help physicians to collectively bargain with consolidated insurance and hospital entities.

Aetna U.S. Healthcare declined to comment for this story. Aetna Inc. CEO Richard Huber has acknowledged "serious service degradations" and that Aetna has utilized overly aggressive tactics in negotiations with physicians in several 1998 interviews with the *Wall Street Journal* and the *Dallas Morning News*. Oddly enough the flare up with Genesis physicians occurred after Huber acknowledged being

overly aggressive with Baylor physicians in the fall of 1997. In a December 1998 interview with the *Dallas Morning News* Huber vowed to improve relations with physicians: "I'm probably too old to ever see the day when doctors love us. . . . I am going to live to see the day when they dislike us less. And that, in itself, is a challenge."

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September 7, 1998

Doctors vs. Aetna: Was insurer `coercive' ...

Dr. Ralph Turner Guest Columnist

As president of the Genesis Physicians Practice Association, a 760-physician group associated with Presbyterian Hospitals in Dallas, I want to explain why we recently terminated our Aetna U.S. Healthcare HMO contract. We did this to improve the quality of health care.

When we first contracted with Aetna in 1995, they agreed to accept the responsibilities of managing the utilization of services, credentialing our physicians, paying all claims and providing all financial and medical information from those claims to Genesis. Initial problems were manageable, and the system seemed to be working until April 1997.

Since that time, it has become clear that Aetna's utilization management services under the contract were inadequate to manage the health care needs of our patients. During the past year, Aetna ceased providing us with timely, adequate, verifiable data as required by the contract. Furthermore, Aetna has failed to process physician claims in an accurate and timely fashion.

So, in June, after 10 months of intense meetings with Aetna -- including biweekly joint meetings which failed to achieve resolution of the problems -- the Genesis board of directors sent notification of intent to terminate the HMO contract for what Genesis considers material breaches of the contract.

After rejecting our settlement proposal, Aetna's reaction included what Genesis considers a retaliatory move: the invocation of their national "all products," or "all or nothing," policy.

The policy forces cancellation of Aetna Preferred Provider and Point of Service contracts with Genesis doctors. The PPO and POS products are in a completely different physician contract from the HMO contract. Aetna's policy states that if doctors do not participate in one product offered by Aetna, the doctors cannot participate in any of the Aetna products.

We believe that this is a coercive policy which endangers patients, physicians and our health care delivery system. Thousands of our loyal patients may be forced needlessly to find new doctors. Many businesses may be compelled to find new coverage for their employees.

Aetna has informed Genesis physicians that, even though we consider Aetna to have breached the HMO contract, Aetna has disregarded this allegation and is terminating the PPO, although Genesis believes no breach occurred on that contract.

Such intimidation and reprisal may work in an aggressive business environment, but not when we are talking about patients' health. Our physicians belong to many other health plans that do not impose the same "all products" mandate.

Aetna's "all products" policy reflects a business goal that intrudes on the patient/physician relationship. Here is how this unacceptable policy works:

Let's say an Aetna PPO patient has found a physician with whom she relates well. After many years of care, she has confidence in her doctor and her doctor knows her history well. The doctor has trouble with the performance of another of the insurer's plans, the HMO plan; the PPO plan is less problematic. Because of Aetna's "all products" policy, Aetna informs the doctor that if he or she leaves the HMO, the company will terminate his participation in the PPO.

Through that action, Genesis doctors have been placed in a terrible bind. Either they retain their patients by tolerating such onerous rules, or they walk away from the HMO in order to preserve the integrity of the manner in which they practice medicine -- in the process losing many cherished patients.

We believe our patients, the D-FW business community and many interested national observers want us to stand up for quality patient care and not accept less.

Toward that end, our doctors will continue to work diligently with those health plans that value sustainable relationships with physician groups. It is through collaboration with all parties in the health care delivery system that we will achieve the highest quality, most cost-effective health care.

Turner is chairman and president of the Genesis Physicians Practice Association.

Week of September 7, 1998 | Commentary | Top of the page

PROPOSED AMENDMENT TO SENATE BILL NO. 2400

Page 16, line 18, after "purposes" insert "<u>, epidemiological or outcomes research</u>" and remove "<u>only</u>"

Page 17, after line 2, insert:

"<u>4. This section does not apply to data or information disclosed by an insurer as part of a biomedical research project approved by an institutional review board established under federal law.</u>"

Renumber accordingly

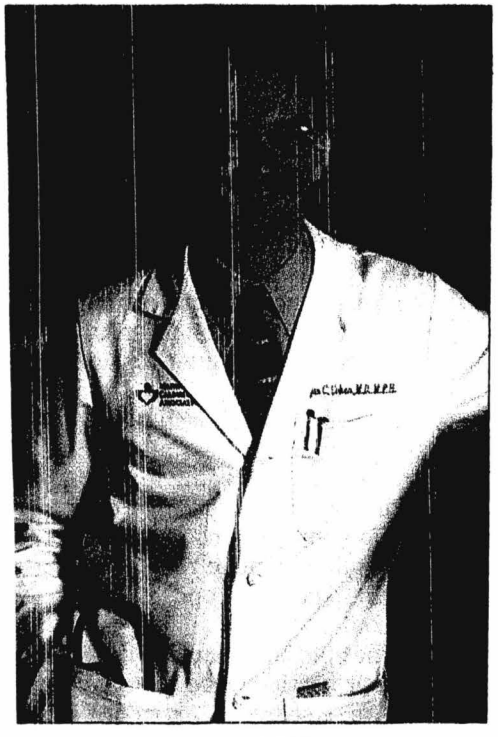

PHOTO BY C.J. GUNTHER

YSICIANS AND HOSPITALS should guard patients' ivacy, said Mylan Cohen, MD, MPH, of Maine Car- logy Associates.

Maine patient privacy law poses case study in unintended effects

AT A GLANCE

States considering confidentiality laws should look to Maine, where a sweeping law went into effect — and was quickly put on hold.

Bonnie Booth
AMNEWS STAFF

ON JAN. 1, THE NATION'S MOST SWEEPING PATIENT privacy law went into effect in Maine, thanks in large part to lobbying by the Maine Medical Assn. and Maine Hospital Assn.

By Jan. 15, the state Legislature had voted unanimously to suspend implementation of the law until at least Oct. 1 to deal with the law's unintended consequences, which have doctors, clergy and even florists in an uproar.

Health care practitioners who enthusiastically endorsed the legislation in theory were less than enthusiastic with the burden of compliance.

"The whole move from theory to practical implementation showed that our members have very little tolerance left for any additional administrative burden," said Gordon Smith, MMA executive vice president.

Maine's law is the only comprehensive patient confidentiality legislation passed in 1998. It designates as confidential all health care information that directly identifies the individual, and it restricts the disclosure of confidential information unless the patient provides written authorization. Violations can cost an individual between $1,000 and $5,000. Health care workers can be fined up to $10,000, and facilities as much as $50,000.

Smith said many of the physicians who called his office have been concerned about the need to rewrite their authorization forms to conform with the law. And he acknowledged that the MMA made a mistake in working with hospital attorneys to come up with one release form that could be used by both hospitals and physician offices.

"The hospital form was more complex than physicians needed," he said. "We are now developing a one-page form. Under the law, you can have a form that in-

Continued on page 8

Maine privacy law: case study in unintended effects

Continued from page 5

cludes several statements and patients simply sign."

One of those voicing concern was Mylan Cohen, MD, MPH, of Maine Cardiology Associates in Portland.

"The ethical obligations of physicians and hospitals shouldn't be legislated," he said. "I'd like to see physicians and hospitals take it upon themselves to guard patients' privacy, and they should. On the other hand, I can understand how third-party payers might be getting information they shouldn't."

For the 14 days the law was in effect, his practice set out to conform to the letter of the law — a move that resulted in some confusion about the proper way to communicate prescribing information to pharmacies and the best way to contact patients with test results. There were also delays in filling requests for medical records.

"A conservative approach was warranted," Dr. Cohen said. "When you're faced with up to $50,000 in fines, what else are you supposed to do?"

The practice designed a new release form for patients. "We settled on a form that states this is what we are going to do unless you tell us otherwise," Dr. Cohen said. "The release is good for 30 months unless the patient specifies otherwise, and information will be released to first-degree relatives unless stated otherwise."

Forms that ask patients to specify what information they do not want released have had mixed results, Smith said: At a large orthopedic practice, 40 of 150 patients wrote "weight" when asked if there was specific medical information they didn't want released.

Doctors also worry about the administrative burden of keeping track of the myriad different items patients may choose not to have released.

"To confirm there is a release and what is to be released and to read through every record is going to be a burden for office staff and the staff of smaller hospitals," Dr. Cohen said.

Smith said the MHA drafted the legislation in response to the public's growing concern about the disclosure of medical information, the Maine Psychiatric Assn.'s complaint that behavioral management companies were demanding more information than necessary, and MMA member complaints that pharmacies were selling prescribing data. However, the law's stiff fines seem to be generating the most concern.

"This is a very onerous, scary law to the average health care worker," said Steven Michaud, interim president of the MHA. "They have been told, 'When in doubt, do not divulge information.' What we saw was a freezing of action over the couple of weeks it was law, and much of it is very understandable."

Michaud said that under the new law, patients were not even listed in a hospital directory without consent. "Clergy, flower-delivery people, the media and visitors had access to that information. Without a signed, written consent from the patient, we weren't even acknowledging presence within the institution. This has sent fur flying everywhere."

Another problem that hospital attorneys found when they began scrutinizing the law was that it didn't give clear guidance about whether family members could get detailed diagnosis and treatment information in the event a patient is severely injured or too ill to sign a consent form. The law allows hospitals to disclose "only the presence and general health condition of the individual."

This "begs the hypothetical scenario that your family member is in a car crash and is comatose and you can get no information about his or her condition," said Indiana University School of Law Professor Fred H. Cate, who specializes in privacy law. "Information needed to proceed with treatment is a key issue for the family."

David Stuchiner, MD, director of emergency medicine at Central Maine Medical Center, said he has directed his staff to follow implied consent guidelines when a comatose patient arrives in the emergency department. Under those guidelines, medical information needed to make treatment decisions has always been shared with the family.

"A lot of the trouble we ended up with is from a misunderstanding of the law," said Dr. Stuchiner, who says the law leaves it up to physicians to define a medical condition. "We still have to use physician judgment."

Cate said the key to a successful patient confidentiality law is to be more specific about what information cannot be disclosed.

"States should look at the law in terms of what types of information it would bother patients to have disclosed," he said. A law should list that information, rather than stating that any information not specifically exempted will not be disclosed. ◆

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2/10/99

PROPOSED AMENDMENTS TO SENATE BILL 2400

Page 7, line 11, replace ", if appropriate, a licensed psychologist" with "other health care provider trained in the same or similar specialty as typically manages the medical condition, procedure, or treatment under review"

Page 7, line 12, replace "licensed psychologist" with "other health care provider trained in the same or similar specialty as typically manages the medical condition, procedure, or treatment under review"

Page 8, line 12, after "physician" insert "or other health care provider trained in the same or similar specialty as typically manages the medical condition, procedure, or treatment under review"

Page 10, line 11, after the underscored period insert "Any other health care provider making utilization review determinations must have a current license from the state board regulating such health care provider."

Page 12, line 26, after "services" insert ", and also to issuers of limited benefit policies as defined in section 26.1-02-01.1"

TESTIMONY on SB 2400

Prepared by Senator Ralph Kilzer

March 3, 1999

Good morning Madam Chairman. For the record, my name is Ralph Kilzer, Senator from District 47 in Northwest Bismarck. SB 2400 is called The Fairness in Health Care Act. It is submitted at the request of the North Dakota Medical Association. President Clinton and Congress is also optimistic about passing a Patient Protection Act this year. The question then becomes, is this necessary? I say that it is. The reason I say so is because managed care has become such a large factor in the delivery of healthcare. If you would look at the patient days per thousand enrollees of North Dakota Blue Cross/Blue Shield fifteen years ago, you would see that it approached 900. Today I am sure that it is less than 500 in spite of more major surgeries, etc. Managed care, of course, is the cost containment arm of the insurance companies. It is one of the major ways in which insurance companies keep down the amount of money that they pay out for benefits. Generations ago, the patient-physician relationship was a strong one-on-one bond. As technology came along and new expensive treatments were unaffordable, insurance was developed in the 1940s to spread the risk and make these new expensive treatments available to the premium payers who needed them. This premium was originally developed for individuals and families. As the decades went along with tax incentives, the payment of the premiums shifted largely to the employer. In the early 1970s we saw incentives to control the rapidly rising premiums. These included deductibles, copays, indemnity plans, and the most recent approaches of DRGs, RBRVS, HMOs, and managed care. All of these developments affect the original and still very necessary patient-physician relationship. All of these arrangements are designed to control costs by controlling utilization and eliminating what may be deemed unnecessary and inappropriate care. We have found out that there must be safeguards because the profit motive is too strong with many third party payers. We must put in place safeguards in order to prevent excess cutting of corners.

All of you serving in the legislature have access to this magazine. As you note, the March 1999 issue is devoted to managed care. I am handing out a page that I took from that magazine. You will note that North Dakota did pass some legislation in 1997 putting a ban on gag clauses and also putting a ban on hold harmless clauses which shift all the liability from the managed care vendor to the doctor or health facility.

As you know, practically every third party payer nowadays has a managed care department in order to assist them, control utilization, and to control costs. For example, I work as a consultant at the North Dakota Worker's Compensation Bureau, and one of the enactments by the legislature three or four sessions ago was to put in place a managed care vendor. At the present time, the bureau lets out this contract and it is run by a company called Encompass. All insurance companies also have managed care. Blue Cross/Blue Shield of North Dakota has an in-house functioning unit that does this job.

SB 2400 originally was about 20 pages. Of course insurance companies don't like any control on managed care. Because the insurance companies were particularly opposed to the utilization review components, those sections have been amended out. What you have before you is really only about half of the original bill. I would strongly urge you to not allow further deletions from the bill. In North Dakota's situation where we have one large, dominant company in the market, I would especially urge you to keep in place Section 2 which retains the ability of the patient to select his healthcare provider. In my opinion, an insurance company should not be able to dictate among their various health plans that they offer which doctors, as a condition of participation, might be restricted to providing services in one plan but not in another. This certainly would be a terrible hindrance to a patient who chose a different health product even from the same company, and then was told that their provider would no longer be able to see the patient.

There are additional people to testify. I would be happy to attempt to respond to any questions. Thank you very much.

TESTIMONY: SB 2400

March 3, 1999

Presented by: Senator Judy L. DeMers

Presented to: House Human Services Committee

Representative Clara Sue Price, Chairman

Madam Chairman and members of the House Human Services Committee. For the record, I am Senator Judy L. DeMers. I represent District 18, consisting of part of Grand Forks and part of the Grand Forks Air Force Base. I am appearing this morning as a co-sponsor of SB 2400.

Madam Chairman, the doctor-patient relationship is fundamental to quality care and to trust. Patients must have confidence that their physician is acting in their best interests and that their health insurance plan has not been inserted inappropriately into the doctor-patient relationship. In 1997, the Legislature took a big step in supporting the doctor-patient relationship by prohibiting the abusive practice of gag rules -- that is, rules preventing physicians from telling patients about uncovered services or making referrals to the specialists they consider most appropriate to treat a patient's condition. SB 2400 builds on that accomplishment by providing the means for taking several more important steps to preventing interference in the doctor-patient relationship.

SB 2400, as amended, offers patients and their health care providers strong, basic protections without unnecessary or costly regulation. SB 2400 includes:

- protections that ensure coverage for a person's emergency care based on a prudent layperson standard, and ensure that a patient's medical information is kept confidential.
- Protections that make basic information available to patients so that they can compare health plans before they enroll and determine what is best for their families.
- Protections that assure that a physician can advocate for a patient without the threat of retaliation by an insurance carrier, and ensure that a carrier does not offer financial incentives to providers that might reduce or deny necessary health care services.

- Protections that make sure patients will not lose access to their choice of physician if their physician decides that he or she cannot participate in a carrier's other plans and products.
- Protections to assure that mechanisms are in place to resolve complaints patients have about their care.
- And protections for health care providers -- your physician, optometrist, advanced practice nurse, or chiropractor -- that assure they are treated fairly by insurance carriers.

In compromising with the insurance industry, the amendments removed substantial provision of the original bill. These were major concessions and included:

- the removal of the definition of "medical necessity"
- the removal of language that prohibits an insurance carrier from retaliating against a health care provider for patient advocacy with respect to the carrier's policies
- the removal of all provisions relating to utilization review except provisions relating to emergency services and the prudent layperson standard
- the expansion of a provision that gives a health care provider a reasonable opportunity for a hearing if that provider is terminated from a plan or designated as nonpayable (including physicians, advanced practice registered nurses, optometrists, and chiropractors)
- and the clarification of the kinds of information to be disclosed by insurance companies to their subscribers.

Madam Chairman and Committee Members, the goal of SB 2400 as amended is to ensure that medical and health decisions will continue to be made by the patient and the patient's health care provider. I ask for your favorable consideration of SB 2400.

Thank you.

House Human Services Committee
Testimony on Engrossed Senate Bill No. 2400
Wednesday, March 3, 1999

Madame Chairman Price, Members of the House Human Services Committee

I am Dr. Matt Layman, President of the North Dakota Medical Association. The Association represents over one thousand physicians in the State and supports Senate Bill 2400.

While no recording of national trends of complaints against HMO's are kept, the National Association of Insurance Commissioners estimates that 35,000 complaints were filed last year. In the mostly populous states, with dense concentration of managed care (NY, Connecticut, Illinois, Texas, Ohio and Maryland), insurance departments report that complaints have grown 50% over the last 1 - 3 years, far faster than the growth of enrollment. Patients need to be protected and the patient-physician relationship needs to be preserved in this new health care environment.

Rather than discuss the bill by each section, (Mr. Levi who drafted the bill will do that) I would like to show you how the bill protects the patient and will preserve the patient-physician relationship. I will also give you examples of why this bill is needed.

The bill begins to protect the patient even before they decide to enroll in an insurance plan. The bill requires that a plan description must be given to each prospective enrollee or enrollee in the plan. The description "must use the plain and ordinary meaning of words so as to reasonably ensure comprehension by a lay person" and must be made available to each insured prior to enrolling in the plan. This protects the patient by requiring that the insurance plan is

written so that people can understand it and can make a decision as to whether that plan fits his/her needs.

Once a patient has enrolled in a plan, this bill provides protection in times of emergency. The bill specifies that a plan may not deny coverage for emergency services and may not require prior authorization of these services. The bill defines an emergency medical condition as "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 or her unborn child, in serious jeopardy."

This was not the case in Maryland in 1996, when a Betheseda woman hiking in the Shenandoah Mountains suffered skull, arm and pelvic fractures in falling from a forty foot high cliff. She had to be evacuated from the site by helicopter and treated in a nearby Virginia hospital. When her Maryland-based HMO refused to pay the bill because it had not granted "pre-authorization," efforts were made to force collection of $10,000 in outstanding medical bills.

This was certainly not the case in March of 1993 when a distraught mother in Georgia called her managed care company's hotline because she felt her plan wouldn't let her go directly to an emergency room. Her six month old son had a temperature of 104 degrees F and was panting and moaning. Her managed care company instructed her to drive the child to a hospital more than thirty miles away, passing by several hospitals in downtown Atlanta. During that drive the child worsened and suffered a cardiac arrest requiring CPR. The family found a closer hospital emergency room, the child eventually recovered but required amputations of both hands

and feet because of gangrene caused by the serious infection the child had. Had this child's health care plan allowed for the mother to decide that this was an emergency according to the standards under Senate Bill 2400, she may have felt she could have gone directly to the nearest emergency room in the first place.

Our bill protects patients during these times of emergency.

This bill protects the patient from health care plans that provide incentive plans to providers to limit, reduce, deny or delay medically necessary care. In a recent New England Journal of Medicine article (11/98) "Primary Care Physicians' Experience of Financial Incentives in Managed Care Systems," a two year survey of 766 primary care, office based, independent doctors who have HMO contracts, found that 38% of those doctors were subject to financial incentives to control cost. These include limiting referrals of patients to specialists and limiting the use of hospitals and prescriptions. Twenty-eight percent of the doctors reported that they felt pressure to limit what they told patients about treatment options. Of the physicians studied, more than 20% felt care was compromised in this environment.

Senate Bill 2400 protects the physician-patient relationship by allowing the physician to be a patient advocate in decisions about the patient's care without fear of retaliation by the health plan. Retaliation would include refusal to contract with the health care provider, termination or refusal to renew a contract, refusal to refer patients or to allow others to refer patients, or refusal to compensate the health care provider for covered services.

The bill also prohibits an insurance plan from requiring a physician to participate in each of the insurance products offered by the carrier, even if the doctor wants to participate in some of the products but not all of them. If a physician feels a certain insurance product is inappropriate

for his or her patients or makes it difficult for the physician to provide adequate health care, the physician could not be forced to participate in that specific plan, but could care for patients who are enrolled in the carrier's other products. Such is not the case in Texas where 26,000 patients were left without a doctor, because Dallas area physicians could no longer work under an Aetna HMO product, citing Aetna's failure to provide accurate and necessary economic and clinical data and its inability to process claims for its HMO product. When the physicians pulled out of that particular product, Aetna invoked its "all-products clause" to prevent the physicians from taking care of any Aetna patient they had previously cared for under other Aetna products. This bill would not allow this practice and would allow physicians to protect their patients from these adverse scenarios.

In North Dakota physicians also have problems with obtaining necessary data. Physicians have seen incorrect patient data and provider data in certain managed care products (for example: providers being held accountable for services they did not provide, patients given diagnoses they in fact do not have, patients placed in the wrong network.) Physicians feel this all products prohibition allows physicians to keep patients in plans that allow for their health and illness to be managed correctly and forces insurance carriers to work with providers to provide good plans instead of funneling them into cost effective but not health effective care. This is especially true in health care markets where one insurance carrier controls the majority of care in the state, as in North Dakota, and negotiations are done in a "take it or leave it" atmosphere.

Senate Bill 2400 allows insurance companies to review physicians and other health care providers, not based on how much they are costing the health care plan, but based on whether they are providing appropriate care. It is important that physicians are reviewed, but it is also important that due process is followed, so good physicians are protected. Senate Bill 2400 requires that review of a health care provider be done by a panel which includes at least one representative of the reviewed provider's specialty and that the insurance plan must disclose the criteria, data and methodology for evaluating health care providers.

Senate Bill 2400 contains other protections, including assurances that medical records that identify patients are kept confidential and not disclosed without the consent of the patient. This would prevent cases like the one in California, when a college student's confidentiality was betrayed when she sought therapy regarding problems with an abusive father. The health plan let the father know about the visits; he angrily put a stop to further care. This section would also prevent inaccurate patient date (that we see in this state) from becoming public and potentially being used against the patient or employee.

Who would have thought fifteen years ago that a physician would have to plead for the protection of patient rights. As health care costs have skyrocketed all interested parties have looked for ways to control costs. As this health care revolution has proceeded, insurance monopolies are being formed. Patients have become contracts and covered lives to be bought or sold or pushed into marginal health care plans, and physicians have become "providers of services." The woman at the mountain needing emergency care, the baby in the car struggling to stay alive, the patients trusting their health plan to maintain their confidentiality and the thousands of patients in Texas looking for new doctors because their original doctors were looking out for them, are all patients at vulnerable times in their lives who need their rights protected and need an advocate. While the public does not hear the daily reports of managed care abuses in North Dakota, providers are beginning to see problems with managed care products. We have a health care environment that could be prone to abuse. We have a single large insurance company (with no meaningful outside provider input) and majority of patients that are covered by that insurance company. This creates an atmosphere in which the patient and the provider can be coerced into accepting unacceptable health care in our state. "An ounce of prevention is worth a pound of cure." We ask that you actively support protection for the patient physician relationship, and vote a "do pass" on Senate Bill 2400.

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1. Anders, George, "Health Against Wealth; HMO's and The Breakdown of Medical Trust," Houghton Mifflin Company, New York, NY 1996

2. National Association of Insurance Commissioners: Insurance Consumer Alert, 1998

3. Barg, Jeffrey, "Managed Care Showdown in Texas," Physician News Digest, February 1999

4. Kilborn, Peter, "Complaints About H.M.O.'s Rise as Awareness Grows", New York Times, October 11, 1998

5. Consumers for Quality Care, "ERISA Casualty of the Day", 1998

Senate Bill 2400 Protects the Patient

Patient receives insurance plan

Plan description must be written in easily understandable language

No incentives that deny, limit, reduce, or delay medically necessary care

Patient requires medical care

Assures confidentiality of patient medical information maintained by carrier

Requires carriers to provide grievance procedures

Patient requires emergency care

Prudent layperson standard used to determine covered emergency services

Prohibits any preauthorization requirement

Existing utilization review standards

SB 2400 Protects the Patient-Physician Relationship

Patient requires medical care

Patient denied coverage for medical care

Allows physician to be a patient advocate without fear of retaliation

Requires a record of grievances and appeals

Existing utilization review standards

Patient receives medical care

Assures confidentiality of identifiable patient information

Requires carriers to provide grievance procedures

No incentives that deny, limit, reduce, or delay medically necessary care

SB 2400 Protects Medical Service Providers

Patient requires medical care

Patient denied medical care

Preferred provider protection

Existing utilization review standards

Patient receives medical care

Informed up front about administrative duties and what responsibilities will be required.

March 3, 1999

"Fairness in Health Care"
Testimony of Bruce Levi, North Dakota Medical Association, in Support of Engrossed Senate Bill No. 2400 Before the House Human Services Committee

On behalf of the physician members of the North Dakota Medical Association, I'm pleased to have this opportunity to present comments and an explanation of the provisions of Engrossed Senate Bill 2400, relating to fairness in health care between North Dakota patients, health care providers, and insurance carriers.

This is a bill about relationships – relationships between a patient and that patient's physician or other health care provider, between a patient and that patient's insurance carrier, and between a health care provider and insurance carriers. The relationships are not what they have been in the past, and SB 2400 looks to the future to provide some measure of fairness in our healthcare relationships.

A brief summary of the bill was distributed. There are basically six subjects addressed by SB 2400:

--In sections 1 and 2 of the bill, protections that assure that a physician can advocate for a patient without the threat of retaliation by an insurance carrier, ensure that a carrier does not offer financial incentives to providers that might reduce or deny necessary health care services, and make sure patients will not lose access to their choice of physician if their physician decides that he or she cannot participate in a carrier's other plans and products.
--In sections 3 and 4 of the bill, protections that ensure that coverage for a person's emergency care is based on a prudent layperson standard.
--In section 5 of the bill, protections that make basic information available to patients so that they can compare health plans before they enroll and determine what is best for their families, as well as provide important information about the plan if requested by a patient.
--In section 6 of the bill, protections that ensure that medical information maintained by a carrier that identifies a patient is kept confidential or disclosed appropriately.
--In section 8 of the bill, protections to assure that carriers have mechanisms in place to resolve complaints patients have about their care.
--And, in sections 7 and 9, protections for health care providers – your physician, optometrist, advanced practice nurse, or chiropractor – that assure they are treated fairly by insurance carriers when they are terminated from a plan or when their practice patterns are being evaluated.

The primary purpose of SB 2400 is to recognize and protect individual patient interests in medical decisionmaking in the face of a changing healthcare environment

Senator Kilzer, Senator DeMers, and Dr. Layman have focused on the reasons for this bill – the impact of our changing healthcare environment on patient care and the need to be proactive in continuing to recognize and protect individual patient interests in medical decisionmaking. SB 2400 was introduced at the request of the North Dakota Medical Association to address the rising concerns of physicians and other health care providers and their patients about managed care and other insurance practices that could interfere in the patient-physician relationship.

In recent years, we have witnessed a rapid growth throughout the United States in the number of people who receive health care through some form of managed care or other similar health care arrangement.

While these arrangements are designed to control health care utilization and curb "unnecessary or inappropriate" care, the changes have been quite unsettling for many patients and physicians. They have also raised fears that economic and other incentives may result in the denial of necessary care, infringe unfairly on the patient-physician relationship, or trap physicians in ethical dilemmas (See the appendix). We watched the inability of the Congress to pass meaningful patient protection legislation last year. But the real story in this country is how individual states – state lawmakers and state medical societies and other patient advocates – have been very successful in passing patient protection legislation and legislation banning unfair insurance practices.

Last session, we worked with this committee to pass legislation that prohibits contract clauses and insurance carrier policies that interfere with medical communications between a patient and the patient's health care provider (gag clauses), and clauses or policies that attempt to inappropriately shift the liability for a health carrier's negligence, misconduct, or breach of contract to the health care provider (hold-harmless clauses). While these provisions are helpful and draw a line on what is an appropriate insurance practice, they do not go far enough in providing for fairness in our health care system in North Dakota.

SB 2400 was developed over the past year by the North Dakota Medical Association's Legislation Commission as a product of the combined experience and concerns of many physicians and their patients in our state. The bill addresses real issues and concerns of North Dakota patients and their health care providers. SB 2400 offers patients and their health care providers strong, basic protections without unnecessary or costly regulation.

Much of what we will talk about today centers around a challenge to a core principle underlying the legal structure in this country for health care delivery and finance – that principle is the supremacy of individual patient interests in medical decisions. The challenging value is a societal interest in conserving resources expended on health care. In the past our legal system has historically treated medical decisions for patients and coverage decisions by health plans as independent activities. Coverage decisions are considered as a transaction between the patient and the health plan and medical decisions are viewed as transactions between the physician and the patient. These two transactions are considered independent because the coverage decision is not supposed to affect the physician's judgment in medical decisions about what is best for the patient, and a refusal to cover treatment recommended by a physician does not bar the patient from obtaining the services with the patient's own funds. What has occurred, however, as a practical matter, is that the medical decision made as part of the coverage decision is not independent from the medical decisions made by the physician and patient. Because medical care can be very expensive, many patients cannot afford to purchase care that a physician recommends but the health plan will not cover and therefore, they have to accept the medical decision of the health plan. The coverage decision becomes the treatment decision. And today, insurance carriers use a variety of techniques to influence or control medical decisions made by physicians or other health care providers.

That is the reality. What is occurring nationally today is a recognition of the true role that insurance carriers are playing in medical decisionmaking, as states develop mechanisms to appropriately balance the societal interest in conserving resources with the individual patient interest.

Changes need to be made to the legal structure to recognize the realities of insurance carrier control over medical decisions and to maintain a patient-centered system of health care. The current structure does not recognize the economic leverage that insurance carriers have over physicians and other health care providers, and the difficulty that physicians will have in resisting pressures to withhold care. Changes

should focus on restoring a better balance between insurance carriers, physicians, and patients in medical decisions.

In short, SB 2400 as amended helps ensure that medical decisions will continue to be made by the patient and the patient's health care provider.

The Senate amendments represent major concessions to BCBSND, which wants even more protections removed from the bill

In compromising with the insurance industry, which opposed the bill in the Senate Human Services Committee, we worked with the Altru Health Plan (a Grand Forks-based HMO), and offered amendments to the Committee removing many substantial provisions in the bill, including a large portion of the bill that addressed how carriers might influence medical decisions made by health care providers through utilization review. BlueCross BlueShield of North Dakota (BCBSND) asked that more protections be removed, but the Senate Human Services Committee decided not to further diminish the scope of the bill. Not all health plans in this state share the same concerns as BCBSND.

A floor amendment in the Senate was unsuccessful, and the Senate approved the bill as amended in Committee by a vote of 42 to 3.

BCBSND said in the Senate that it would support SB 2400 if two additional provisions were removed from the bill – the provision prohibiting carriers from coercing participation in their health plans and products by providers through mandatory participation requirements (what we call "all products" policies or contract clauses on page 3, lines 13-17) and the provision that would assure that identifiable medical information that is maintained by a carrier is kept confidential (Section 6). As I review the bill, I will place particular emphasis on these two provisions – not because they are more important than the other provisions in the bill, but because there is opposition to those provisions.

It is important to point out what this bill does not include. It does not include a provision like Texas, that allows a patient to sue an insurance company for inappropriate medical decisionmaking. This is the hot topic in the public debate about patient protections that will likely be settled at the federal level and, if not, in the courts. And the bill does not include provisions, like one out of every three states has now, that provide an external, independent review of decisions by insurance carriers to deny coverage for medical care. And now, with the substantial amendments in the Senate, SB 2400 does not strengthen our utilization review statutes or even define "medically necessary care."

Prohibited Insurance Practices (Sections 1 &2)

Last session, the prohibition on gag clauses and hold harmless clauses was placed in that part of the Century Code that identifies prohibited insurance practices. Chapter 26.1-04 sets monetary penalties and gives the Insurance Commissioner the ability to issue a cease and desist order to require that a certain practice be stopped. This bill would create four new prohibited practices.

Incentives to withhold medically necessary care (Page 2, line 18)
This provision prohibits a financial incentive that would induce a provider to deny, reduce, limit, or delay medically necessary care that is otherwise covered by the plan. It does not give health care providers the discretion to decide what services are covered by a health plan.

The Senate amendments removed the definition of "medically necessary care." That definition would have included three distinct components – services provided in accordance with generally accepted

standards of medical practice, clinically appropriate services, and those not provided primarily for the convenience of the patient or the provider. This is a definition advocated by the American Medical Association and incorporated in several patient protection statutes from other states. What it excludes is specific criteria that incorporates a "lowest cost" standard. As this bill now reads, the definition of "medical necessity" in any given situation would be a matter for the Insurance Commissioner in deciding to enforce this provision.

Again, this provision does not set a definition of "medical necessity" for all insurance carriers to adhere to in setting benefits and coverage under a plan. But it does prohibit financial incentives that would deny medically necessary care that is covered by the insurance carrier. This was a fundamental misunderstanding by insurance carriers that opposed the definition. Nevertheless, the definition was removed.

Recently, the Texas Attorney General filed a lawsuit against six HMOs in that state contending they used financial incentives to encourage doctors to limit medical treatment, penalizing doctors who exceed budgets for medical treatments, and giving patients untruthful or misleading information about emergency coverage, prescription drug coverage and referrals to specialists.

We have one particular concern in this area. In North Dakota, BCBSND has been suggesting for two years that it will implement a "tiered" reimbursement system that would tie financial incentives or disincentives for physicians to the health care utilization of the physicians' patients. The concept has not been described to our Association in any detail. Physicians are very concerned about what form those financial incentives and disincentives will take. The North Dakota Medical Association has not been asked to provide physician input into the design of those incentives or disincentives, nor is it clear what impact the incentive plan will have on patient care. We were told that the new system is scheduled to take effect in January, 2000. This provision would give providers a tool to challenge incentives that go too far in attempting to influence medical decisions between the patient and their health care provider.

Many other states have enacted provisions to prohibit financial incentives that impact patient care, including Alaska, Arizona, California, Georgia, Idaho, Kansas, Minnesota, Missouri, Montana, Louisiana, Maryland, Nebraska, Nevada, New Jersey, New Mexico, Ohio, Pennsylvania, Rhode Island, Texas, Utah, Vermont, and West Virginia.

Retaliation for patient advocacy (Page 2, line 27)
The bill would prohibit retaliation for patient advocacy by a health care provider, including grievances and utilization review appeals. The Senate amendments removed language that would also prohibit retaliation for advocacy that involves the protest of any carrier decision, policy, or practice on behalf of a patient.

Most insurance carriers do not have good vehicles to involve their participating physicians in providing input into their medical policies or other policies that affect how the physicians practice. Carriers generally have a medical director or even a panel of physicians with whom they consult, but they do not obtain broad-based input. Regardless, vehicles for input into health plans by participating physicians will not be of any benefit to patients unless the physicians feel free to advocate their beliefs about what constitutes good patient care. They should not have to fear being terminated from a health plan if they advocate policies that the management of an insurance carrier does not want or advocate for a coverage decision on behalf of a patient. Therefore, there should be procedures for physicians to use if they believe they have been terminated or sanctioned by a carrier because of their advocacy efforts.

This provision uses language similar to the 1997 law in describing the kind of retaliation that would be prohibited, if that retaliation were the result of a good faith report to state or federal authorities about an act or practice by the carrier that jeopardizes patient care.

A number states have enacted similar protections, including Colorado, Connecticut, Kansas, Maryland, Missouri, Montana, Nebraska, Nevada, New Jersey, Ohio, Oregon, Pennsylvania, Tennessee, Texas, and Virginia.

"Most-favored nation" policies (Page 3, line 7)
The bill would prohibit "most-favored nation" clauses in contracts or policies that require health care providers to charge a carrier the lowest payment for care that the provider charges or receives from any other carrier. This kind of practice is prevalent in other states. It's an especially effective tool for health carriers that dominate a health care market.

This kind of practice puts the provider at significant financial risk. For example, consider the case of physician who participates in an insurance carrier's plan with a most-favored nation clause in its contract and whose enrollees constitute 25% of the physician's patient population, or 1,000 patients. Under the agreement, the physician would be paid $90 for an office visit unless the physician agrees to accept a lower price from another plan, at which point the physician would be required to offer the original plan the same lower price. If the physician contracts with another managed care organization for a $65 office visit, he or she will have to reduce fees for an office visit by $25 for all 1,000 patients of the first plan.

This kind of a practice would discourage competition because it would be difficult for physicians to participating in competitor plans. It is difficult to imagine any other business in which the price paid to a "supplier" can be reduced just because the supplier agreed with someone else to be paid at a lower rate. Insurance carriers should be held to their contracts. We did not hear any opposition to this provision in the Senate.

"All-products" policies (Page 3, line 13)
The bill would prohibit contract clauses or policies that require participation by a health care provider in any of a health carrier's insurance products as a condition to participate in any one of the carrier's other products. This is one of two provisions that BCBSND continues to oppose in this bill. BCBSND has suggested that it requires, or would like to require, health care providers to participate in their SelectChoice product as a condition for participating in their BlueChoice product. The implication of this policy is borne out in the leverage a carrier like BCBSND with its dominant market share has in forcing providers to participate in plans or products against their will, and in the leverage a carrier like BCBSND would have if one of its plans or products experiences serious problems which would continue to force providers to either (1) participate against their will, or (2) to leave the plan and risk termination in BCBSND's other plans or products and leaving patients without their chosen provider. In either case, our major concern with this kind of practice is two-fold:

(1) This coercive practice, particularly when used by a carrier like BCBSND which accounts for almost 80% of the premium volume of all insurers in this state, fosters a "take-it-or-leave it" environment, not an environment in which the insurance carrier, providers, employers, and employees work together to develop insurance products and health plans that meet the needs of patients and the needs of employers to reduce costs. BCBSND continually comes before this committee and opposes mandates on "philosophical" grounds, but yet in this instance wants to continue to impose its own mandate on

providers to participate involuntarily in plans rather than working with providers so that they feel comfortable with the plans and participate on a voluntary basis.
(2) This practice, again particularly in the context of BCBSND, fosters a concentration of market share, and not competition in the marketplace. We know of at least one other plan, the Altru Health Plan in Grand Forks, that believes this kind of "all products" prohibition, like the provision in SB 2400, fosters a more competitive environment and restricts a carrier like BCBSND with a dominant market share from using their dominance to coerce providers to participate in their products to the detriment of small plans.

Physicians and other health care providers have concerns about some of the health plans in this state. This past fall, many providers expressed serious concerns to BCBSND about the benefit design, marketing/enrollment, medical management and policy, underlying data, and targets/risk-sharing components of the BlueChoice product. What this provision of the bill does is assure that BCBSND and other carriers will work together with the providers of health care in this state to work through the problems in these plans rather than allow carriers to use this coercive "all products" practice that bypasses the health care provider and forces providers and patients to participate in plans that may not be appropriate.

This is becoming a major issue in many states. At least one insurance commissioner recently decided that this practice constitutes coercion and restrains the business of insurance, and issued a bulletin indicating that the practice would be considered an unfair trade practice (Nevada – October 12, 1998).

An "all products" policy is a coercive practice
One of the articles attached to Dr. Layman's testimony describes what is occurring in another state with the Aetna insurance company and how Aetna used an all-products policy to shut physicians out of all of Aetna's plans after physicians left an Aetna HMO that was experiencing all kinds of problems, and the impact that action had on patients who no longer had access to their physician. This is an excellent example of how an all products policy can directly impact patient care.

This kind of intimidation and reprisal may work in an aggressive business environment, but not when we're talking about patients' health. Other health plans in the state and in other states do not impose the same "all products" mandate. BCBSND's desire for an "all products" policy reflects a business goal that intrudes on the patient-physician relationship. Here is how this unacceptable policy works:

Lets say a BCBSND BlueChoice patient has found a physician with whom she relates well. After many years of care, she has confidence in her doctor and her doctor knows her history well. The doctor has trouble with the performance of BCBSND's SelectChoice plan. Because of BCBSND's "all products" policy, BCBSND informs the doctor that if he or she leaves SelectChoice, the company will terminate the doctor's participation in BlueChoice. The doctor either has to continue to participate in a flawed plan, or terminate participation under the contract leaving the BlueChoice patient without a doctor.

As a more practical matter in this real world in North Dakota with an insurance carrier that commands almost 80% of the premium volume of all insurers in the state, the real rub is in the negotiation stage of these plans and products where BCBSND can simply maintain a "take it or leave it" mentality with providers, and providers are not given the opportunity to be involved in the development of benefit design of the plan or even the development of appropriate risk-sharing arrangements. Physicians and other providers cannot simply "walk away" or even "negotiate," as BCBSND would want you to believe. Obviously, BCBSND constitutes a substantial portion of any provider's practice in this state and any attempts by physicians to challenge unreasonable practices need not be considered fairly.

An all products clause by definition eliminates physician choice of widely varying plan options. It may not be in a provider's financial interst to accept a plan that represents a serious actuarial risk to his or her practice, imposes unreasonable or below cost fee schedules subject to change without the physician's consent, or establishes financial incentives that deter appropriate referrals or other medically necessary treatment. No other kind of business would accept, under duress, a proposed contract so demonstrably adverse to their economic interests. Moreover, physicians are not merely a business. They have an ethical and legal duty to treat their patient regardless of their economic interests, a fact I believe can be routinely exploited by health plans in their pricing and actuarial strategies.

An "all products" policy impedes competition in the marketplace

If BCBSND, with its dominant market share, imposes an "all products" policy, there are physicians in North Dakota who would undoubtedly reach their full patient load with BCBSND subscribers. If providers are able to reject some of BCBSND's plans, they might be willing to provide services for a competitive health insurance plan. However, if they sign a contract with an all products clause, they will no longer have the capacity to accept a competitive plan. Since BCBSND is the dominant health insurer in the state, no provider can afford to reject it completely. Therefore, there are physicians who would be amenable to servicing a competitor who would be prevented from doing so if BCBSND were to insist on an all products clause.

If a potential competitor is precluded from obtaining the services of certain physicians, not because of the inherent undesirability of its fee schedule or other benefits but merely because of the market dominance of BCBSND, then it is harder for that potential competitor to compete. Perhaps an insurance company that does not now do business in North Dakota will decide not to break into this market. Perhaps an insurer already doing business in the state will decide not to market its products more aggressively because it knows that it will not have sufficient physicians available to service additional patients if the marketing effort is successful. Because of the barrier to competition created by the all products policy, the competitor would suffer, the physicians would suffer, and the health insurance purchasers would suffer.

Given BCBSND's domination of the North Dakota market, their insistence that physicians must contract with all their managed care products or none at all is simply an unfair insurance practice.

Toward that end, physicians in North Dakota will continue to work diligently with health plans that value sustainable relationships with physician groups. It is through collaboration with all parties in the health care delivery system that we will achieve the highest quality, most cost-effective health care.

On this "all products" issue, we're simply left with a question:

Why do insurance carriers need policies to coerce health care providers to participate in the carrier's insurance products, particularly from a carrier with a dominant market share? Isn't it better for everyone to have a health care environment in which the dominant carrier works together with health care providers, as well as employers and patients, to develop insurance products that result in the highest quality, most cost-effective health care?

Emergency Services (Sections 3 & 4)

The bill, in sections 3 and 4, requires insurance carriers to use the prudent layperson standard in determining coverage for emergency services, and prohibits carriers from requiring prior authorization for emergency services. There was no opposition to this provision in the Senate.

In an effort to curb the inappropriate use of hospital emergency rooms for routine health care, many health plans across the country have instituted policies regulating emergency room care. These policies, while effective in discouraging inappropriate use of emergency rooms, can also discourage appropriate use. And, they can delay medically necessary care.

In addition, some insurance carriers require members to obtain approval from the plan before they receive emergency care. These prior authorizations are at best a burden on someone who is ill and, at worst, the cause of potentially dangerous delay for someone who needs immediate medical attention. A person having a heart attack should get to a hospital as quickly as possible, without stopping first to find a telephone to call his or her insurance carrier for authorization of treatment.

Carriers also may refuse to pay for an emergency room visit unless the condition turns out to be a genuine emergency. But only a trained professional can determine what is, and what is not, an emergency. Are chest pains caused by a heart attack or by indigestion? Does abdominal pain with a fever and vomiting signal appendicitis or a virus? Patients who fear that they will have to pay a large emergency room bill themselves if they guess wrong may decide to forgo care—possibly complicating their condition or even threatening their lives.

The standard is met when a prudent or reasonable layperson, with an average knowledge of medical care, is experiencing the sudden onset of symptoms (including pain) so severe that he or she could reasonably believe his or her health would be in serious jeopardy without medical treatment (Page 3, line 20). This standard is advocated by the American Academy of Emergency Room Physicians and is consistent with the definitions in HB 1039, which you considered with regard to ambulance services, and HB 1038, the Department of Human Services appropriations bill which was amended to provide a comparable provision with respect to the state's Medicaid program.

The emergency care would still be subject to a plan's applicable copayments, coinsurance, and deductibles (Page 4, line 10).

More than three-fifths of the states have passed laws requiring carriers to pay for emergency care based on a prudent layperson standard. Those states include Arkansas, California, Colorado, Connecticut, the District of Columbia, Georgia, Hawaii, Idaho, Indiana, Iowa, Kentucky, Louisiana, Maine, Maryland, Michigan, Minnesota, Missouri, Nebraska, Nevada, New Mexico, New York, North Carolina, Ohio, Oregon, Pennsylvania, South Carolina, Texas, Vermont, Virginia, Washington, West Virginia, and Wisconsin.

Utilization Review

The Senate amendments removed a substantial part of the bill that would have strengthened existing law that sets standards for carriers and other organizations that perform utilization review. Some of those provisions duplicated other bills, including the in-state licensure issue that you addressed in HB 1136.

Patient Information Disclosure (Section 5)

Consumers need accurate, reliable, and understandable information that will allow them to assess differences in the quality and cost of health plans, the health care providers who will treat them, and the facilities that the plan uses. Consumers need this information to choose the health plan that is best for

their families and, once they are in the plan, they need information to allow them to use the plan effectively.

The bill sets up a two tier process for sharing information. The first tier is information that must be disclosed in plain and ordinary language to prospective or current subscribers, including a summary of all covered benefits and exclusions, the carrier's definition of "medical necessity," the subscriber's financial responsibilities under the plan, how a subscriber might obtain services from a provider who doesn't participate in the plan, a description of prescription drug coverage, information on the plan's internal procedures and policies, the procedures for emergency services, a description of any methods the carrier uses in giving providers financial payment incentives, important mailing addresses and telephone numbers, and other basic plan information (Page 4, line 22, through page 6, line 8).

A second tier (Page 6, line 9) requires a plan to disclose certain kinds of information upon request, including information about the plan's credentialing process, information about confidentiality policies and procedures, information on how the plan deals with experimental treatments or drugs, whether a particular drug is covered under the plan, and a list of providers.

It just makes good sense do what we can do to assist patients in understanding their health plan and controlling their own utilization.

Confidentiality (Section 6)

People are concerned about the confidentiality of their medical records and whether the most intimate details of their health and health care will be passed on to their employer or others, threatening their jobs and privacy. Section 6 provides confidentiality protections regarding identifiable information about patients and providers maintained by the insurance carrier.

Although there is agreement on the need for confidentiality of patient records and the Congress is under a self-imposed deadline to pass health privacy legislation by August 1999, there is disagreement on how it should be done. Nevertheless, in the last few years a number of states have enacted legislation addressing confidentiality issues. BCBSND opposed this provision in the Senate because of the potential for federal legislation on this issue. However, the bill itself uses language that anticipates the possibility of federal legislation.

The bill provides some basic protections. It imposes a duty on insurance carriers to adopt procedures that ensure that all identifiable information maintained by the carrier regarding the health, diagnosis, and treatment of a patient is kept confidential in compliance with federal and state laws (Page 7, line 2), subject to some clearly delineated exceptions (Page 7, line 7).

With regard to identifiable information relating to a patient, the bill allows for disclosure if the person consents in writing or consent is received in writing from a person authorized to consent for an incapacitated person or a minor (Page 7, line 13).

With regard to identifiable information relating to a health care provider, the bill allows for disclosure if the provider consents to disclosure in writing or if there is provision for disclosure in any contract between the physician and the insurance carrier (Page 7, line 17). There is also a specific exception relating to an insurer's duty under chapter 23-01.1 to provide data to the health care data committee.

The confidentiality provision would provide a number of clarifications of activity that would not be considered prohibited or subject to a requirement for obtaining written consent, including disclosures necessary to conduct utilization review, to facilitate payment of a claim, or to reconcile or verify claims under a shared risk or capitation arrangement. There is also a provision that clarifies that the Insurance Commissioner would still have access to an insurance carrier's records for purposes of enforcing the insurance laws and that any medical records acquired by the Commissioner as part of an examination would remain confidential (Page 7, line 8). This clarification was suggested by the Insurance Commissioner.

Due Process (Section 7(1))

Physicians and other health care providers in North Dakota need to be protected from inappropriate second-guessing, and deserve some level of due process on decisions that impact their livelihood, particularly under circumstances in which the carrier is questioning the utilization experience or practice patterns of the provider. The bill provides a fair process of review for health care providers who are sanctioned, terminated, or designated as nonpayable by an insurance carrier. It is modeled with some variations after NDCC 26.1-17-12(2) (the nonprofit health service corporation law that applied to BCBSND prior to mutualization). The process includes reasonable notice of an inappropriate practice pattern (6 months), and the opportunity for a hearing by a committee comprised of at least one representative of the same specialty as the affected provider. It applies to optometrists, physicians, advanced registered nurse practitioners, and chiropractors.

Practice Profiles (Section 7(2))

A rising concern among physicians and other health care providers in North Dakota is the inability to correct inaccurate data portrayed in individual practice profiles, or flawed methodologies in the analysis of data used to evaluate a physician or other provider. The bill requires that any practice profiling meet certain safeguards and standards (Page 9, line 14):

Any physician or other provider would, at any time, be able to request a description of the criteria used to evaluate that provider (Page 9, line 14). The Senate amendments removed a requirement that the information be included in physician contracts.

A physician or other provider would be able to review the information and specific data underlying any findings by the carrier to terminate, sanction, or designate the provider as nonpayable (Page 9, line 18).

Any evaluation or practice profile would be required to consider additional factors, including allowances for the severity of illness or condition of the patient mix and for patients with multiple illnesses or conditions (Page 9, line 27).

An insurance carrier would be required to periodically evaluate the quality and accuracy of practice profiles, data sources, and methodologies, and have safeguards in place to protect against the unauthorized use or disclosure of practice profiles (Page 10, line 1).

A physician or other health care provider would be allowed to examine a practice profile at any time and prepare a written response to any inaccuracies. The carrier would be required to negotiate in good faith to correct any inaccuracies or to make the profile complete. If the profile is not corrected, the carrier would be required to include the provider's response in any disclosure of the profile to a

third party that is disclosed consistent with the confidentiality provision in the bill or in a proceeding to terminate or sanction the provider (Page 10, line 6).

Grievance Procedures (Section 8)

The bill, in section 8, requires insurance carriers to adopt grievance procedures for complaints by patients or providers regarding issues not related to utilization review, including access to and availability of services, quality of care, the choice and accessibility of providers, and the adequacy of the plan's network of providers (Page 10, line 15). This provision was amended in the Senate so that it is similar to another North Dakota statute that requires grievance procedures for HMOs – section 26.1-18.1-10.

Preferred Provider Arrangements (Section 9)

Many health care arrangements today employ a shared risk concept in which the provider is placed at risk for the cost or utilization of health care services. These risk sharing arrangements are more prevalent today in North Dakota. For example, BCBSND's BlueChoice product is that company's managed care, provider risk sharing product. BCBSND has noted that over 50% of their fully insured employer group business in September, 1998, was enrolled in either a shared-risk product or a limited provider network product such as SelectChoice.

Administrative cost shifting

Physicians in North Dakota have expressed concern about the cost shifting that has occurred in some shared risk arrangements. With shared risk products such as BlueChoice, more and more administrative costs are being absorbed or expected to be incurred by the provider, including referral authorization, pre-certification, and case management. In order to be a successful participant in BlueChoice, the provider must take on more workload and more discounts. Often, the physician must contract, credential, and negotiate with all providers within their network.

The bill, in section 9, requires insurance carriers in preferred provider arrangements to specifically identify in the preferred provider contract any administrative responsibilities that are shifted to the health care provider. Any responsibilities not identified are deemed to be the responsibility of the carrier (Page 11, line 16). The bill does not limit the ability to contract on these issues. It simply clarifies the contracting process.

Interference with medical care

The Senate amendments removed language that would have expanded the specific prohibition, within the context of preferred provider arrangements, of any interference with a treating physician regarding the manner or setting in which particular services are covered and medically necessary for treatment or diagnosis, as objected to by BCBSND. Some existing statutory language remains (Page 11, line 26).

Exclusive arrangements

The bill would prohibit any preferred provider arrangement that requires an exclusive arrangement, i.e., any restriction on a health care provider from entering into an arrangement with other health care insurers (Page 11, line 28). This kind of arrangement restricts competition and disrupts continuity of care for patients.

Health care in North Dakota is at a crossroads. The challenges to medical decisionmaking and the patient-physician relationship are real and they are here in North Dakota. Senate Bill 2400 provides basic protections for patients and ensures fairness in health care. The North Dakota Medical Association and the physicians of North Dakota ask you, on behalf of their patients, to actively support this bill and give it a "do pass" recommendation.

Appendix
American Medical Association Code of Medical Ethics

E-8.13 Managed Care.

The expansion of managed care has brought a variety of changes to medicine including new and different reimbursement systems for physicians with complex referral restrictions and benefits packages for patients. Some of these changes have raised concerns that a physician's ability to practice ethical medicine will be adversely affected by the modifications in the system. In response to these concerns, the following points were developed to provide physicians with general guidelines that will assist them in fulfilling their ethical responsibilities to patients given the changes heralded by managed care.

(1) The duty of patient advocacy is a fundamental element of the physician-patient relationship that should not be altered by the system of health care delivery in which physicians practice. Physicians must continue to place the interests of their patients first.

(2) When managed care plans place restrictions on the care that physicians in the plan may provide to their patients, the following principles should be followed:

A. Any broad allocation guidelines that restrict care and choices - which go beyond the cost/benefit judgments made by physicians as a part of their normal professional responsibilities - should be established at a policy making level so that individual physicians are not asked to engage in bedside rationing.

B. Regardless of any allocation guidelines or gatekeeper directives, physicians must advocate for any care they believe will materially benefit their patients.

C. Physicians should be given an active role in contributing their expertise to any allocation process and should advocate for guidelines that are sensitive to differences among patients. Managed care plans should create structures similar to hospital medical staffs that allow physicians to have meaningful input into the plan's development of allocation guidelines. Guidelines for allocating health care should be reviewed on a regular basis and updated to reflect advances in medical knowledge and changes in relative costs.

D. Adequate appellate mechanisms for both patients and physicians should be in place to address disputes regarding medically necessary care. In some circumstances, physicians have an obligation to initiate appeals on behalf of their patients. Cases may arise in which a health plan has an allocation guideline that is generally fair but in particular circumstances results in unfair denials of care, i.e., denial of care that, in the physician's judgment, would materially benefit the patient. In such cases, the physician's duty as patient advocate requires that the physician challenge the denial and argue for the provision of treatment in the specific case. Cases may also arise when a health plan has an allocation guideline that is generally unfair in its operations. In such cases, the physician's duty as patient advocate requires not only a challenge to any denials of treatment from the guideline but also advocacy at the health plan's policy-making level to seek an elimination or modification of the guideline.

Physicians should assist patients who wish to seek additional, appropriate care outside the plan when the physician believes the care is in the patient's best interests.

E. Managed care plans must adhere to the requirement of informed consent that patients be given full disclosure of material information. Full disclosure requires that managed care plans inform potential subscribers of limitations or restrictions on the benefits package when they are considering entering the plan.

F. Physicians also should continue to promote full disclosure to patients enrolled in managed care organizations. The physician's obligation to disclose treatment alternatives to patients is not altered by any limitations in the coverage provided by the patient's managed care plan. Full disclosure includes informing patients of all of their treatment options, even those that may not be covered under the terms of the managed care plan. Patients may then determine whether an appeal is appropriate, or whether they wish to seek care outside the plan for treatment alternatives that are not covered.

G. Physicians should not participate in any plan that encourages or requires care at below minimum professional standards.

(3) When physicians are employed or reimbursed by managed care plans that offer financial incentives to limit care, serious potential conflicts are created between the physicians' personal financial interests and the needs of their patients. Efforts to contain health care costs should not place patient welfare at risk. Thus, financial incentives are permissible only if they promote the cost-effective delivery of health care and not the withholding of medically necessary care.

A. Any incentives to limit care must be disclosed fully to patients by plan administrators upon enrollment and at least annually thereafter.

B. Limits should be placed on the magnitude of fee withholds, bonuses and other financial incentives to limit care. Calculating incentive payments according to the performance of a sizable group of physicians rather than on an individual basis should be encouraged.

C. Health plans or other groups should develop financial incentives based on quality of care. Such incentives should complement financial incentives based on the quantity of services used.

(4) Patients have an individual responsibility to be aware of the benefits and limitations of their health care coverage. Patients should exercise their autonomy by public participation in the formulation of benefits packages and by prudent selection of health care coverage that best suits their needs. Issued June 1996 based on the report "Ethical Issues in Managed Care," issued June 1994.

Bruce Levi Summary Page

"Fairness in Health Care"
Summary of Engrossed Senate Bill No. 2400
North Dakota Medical Association

- Engrossed Senate Bill No. 2400, in sections 1 and 2, expands the list of prohibited insurance carrier practices:

  Prohibits incentive plans that may induce a health care provider to deny, reduce, limit, or delay medically necessary care.

  Prohibits retaliation for patient advocacy by a health care provider, including advocacy on grievances and in utilization review appeals.

  Prohibits "most-favored nation" clauses in contracts or policies that require health care providers to charge a carrier the lowest payment for care that the provider charges or receives from any other carrier.

  Prohibits "all-products" contract clauses or policies that require a health care provider that participates in a carrier's health plan or product to participate in any of the carrier's other health plans or products.

- The bill, in sections 3 and 4, requires insurance carriers to use the prudent layperson standard in determining coverage for emergency services, and prohibits carriers from requiring prior authorization for emergency services.

- The bill, in section 5, requires insurance carriers to disclose information about their health plan in plain language to potential enrollees and requires that other information be available to enrollees upon request.

- The bill, in section 6, ensures the confidentiality of identifiable patient or provider information maintained by insurance carriers, unless appropriate written consent is provided to disclose the information.

- The bill, in section 7, provides due process for health care providers who are sanctioned, terminated, or designated as nonpayable by an insurance carrier, including the opportunity for a hearing. The bill also places standards on the carrier's use of practice profiles for evaluating health care providers.

- The bill, in section 8, requires insurance carriers to adopt grievance procedures for complaints by patients or providers regarding issues not related to utilization review, including access to and availability of services, quality of care, the choice and accessibility of providers, and the adequacy of the plan's network of providers.

- The bill, in section 9, requires insurance carriers in preferred provider arrangements to specifically identify any administrative responsibilities that are shifted to the health care provider, and prohibits carriers from requiring an exclusive arrangement with providers, i.e., restricting a provider from entering into an arrangement with other insurers.

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"Patient Protection & Fairness in Healthcare"

Testimony
of
Stephan Podrygula, Ph.D.

on
Senate Bill 2400
Relating to Fairness in Health Insurance Practices

Before the
North Dakota House of Representatives
Human Services Committee

on
Wednesday, March 3, 1999
at the
State Capitol
in
Bismarck, North Dakota

Introduction

Good morning, Representative Price and members of the Committee. My name is Dr. Stephan Podrygula, and I'm a clinical psychologist from Minot. I appreciate the opportunity to testify before you this morning on the subject of patient protection and fairness in healthcare.

Specifically, I would ask you to support Senate Bill 2400, which assures some minimum standards of protection for those whose care is covered by health insurance and affected by what we generally call "managed care".

In my remarks, I want to try to explain why patients - and even providers - need protection, and outline some steps that can be taken to safeguard patient rights and restore some fundamental fairness in the healthcare system.

My remarks come from the perspective of a full-time clinician in private practice, who obtained his doctoral training at UND, and has lived and worked in Minot for 20 years. I have held leadership positions in my profession at both the state and national levels, for example, I have served as president of the North Dakota Psychological Association and one of the divisions of the American Psychological Association (APA). I serve on the editorial boards of two national journals (including APA's *Professional Psychology: Research & Practice*), and have made over 65 presentations at regional and national conferences. My doctoral dissertation research was in the area of patient rights, and I have maintained an active interest in the area of ethics and professional practice.

In addition to being a practicing clinical psychologist, I am also a small businessman - I started my own private practice 10 years ago, and employ a staff of 3 - and also a public servant - I was elected an Alderman, in the City of Minot, last June. Believe me, as a small businessman, I don't like unnecessary government regulation and interference in people's lives. As a City Councilman, I don't like the fact that our employee healthcare costs keep going up, and that the burden on the taxpayer keeps increasing.

So why am I here supporting legislation that would further regulate the healthcare industry? The primary reason is because my patients are being harmed, and providers are finding it harder to deliver the healthcare that our patients need.

Before I go further, I want to offer three disclaimers. First of all, I want to emphasize that I do not intend to be critical of Blue Cross/Blue Shield of North Dakota. As far as I'm concerned, they're the proverbial "Cadillac" of the health insurance industry. They're easy to deal with, pay claims promptly, and seem to respect the rights of patients and providers. I trust them and their good faith. Second, I want to say that I do not oppose managed care. In fact, I think that some of its underlying principles really hold the promise of improving both the quality and efficiency of healthcare. What I do oppose are some of the excesses of this industry. And, finally, I want to point out that I will be referring to actual situations that I have encountered in my clinical practice. When I talk about a specific patient, I've either obtained their permission, or else disguised their identity (to protect their privacy).

In trying to explain why legislation such as SB 2400 is needed, let me divide my remarks up into three areas, those having to do with the patient, the provider, and the healthcare system.

One Patient's Story

To give you a feel for what managed care is actually like, let me tell you the story of a patient of mine. For the sake of discussion, let's call her Mary. Mary came to see me over a year ago, for help with a variety of serious personal problems, particularly depression. She was the victim of childhood sexual abuse, and had a lot of traumatic things happen to her while she was an adult. Because of the shame and embarrassment that she felt over her past, she had never shared the details with anyone else. Years of struggle, and serious disruption in many parts of her life, finally led her to seek treatment. Although therapy was a difficult process, she was a highly motivated individual and was showing significant improvement.

One day, however, she came to my office experiencing a great deal of distress. She was shaking like a leaf, sat curled up in the chair, and was having a very hard time concentrating on anything. It turned out that some very stressful things had recently happened to her, and that these events brought up some very difficult memories. As the session progressed, Mary told me that she had been raped at gunpoint, many years ago: she was asleep, woke up to find a gun barrel in her mouth, and was then brutally raped. As a result, she had fearfulness, depression, nightmares, flashbacks, and intrusive thoughts about the event. She had kept this a secret from everyone, but the stress that she was under just pushed her over the edge. Mary was sobbing uncontrollably, and told me that she just did not see any point in going on anymore.

It took all of the skill I had acquired, in almost 25 years of doing crisis intervention work, to help her pull herself together. Quite frankly, I was very afraid that she would kill herself, given how badly she felt and the fact that she had had thoughts of suicide for many years (and, on one occasion, had come very close to killing herself). Things were so close to falling apart that I came very close to arranging immediate psychiatric hospitalization. After 2 1/2 hours of very hard work, I managed to help her calm down, and some level of stability returned. I kept in close touch with her for the rest of the week, and saw her the next day for another lengthy session. Pretty soon, she was able to regain control of the very powerful emotions that had been stirred up.

Although Mary's emotional crisis was resolving, the managed care one was just beginning. This patient's insurance only covers hour-long therapy sessions - generally only once a week - unless there is some unusual crisis. During the time I was treating her, I had to request additional therapy sessions (beyond the 8 originally allowed), on several occasions. I kept careful records, sent the managed care company copies of my progress notes, regularly filled out the forms they required, wrote memos to Mary's case manager, and even spoke with the case manager on the telephone. I did everything that I was asked to do, and followed all of the rules.

Immediately after the lengthy crisis intervention session, I completed a thorough progress note, and wrote the case manager a memo (explaining what had happened, and why Mary needed a lengthy session). I sent all of this documentation into the managed care company, at my own expense, by fax. A few days later, they told me that they would not authorize payment for such sessions, because they weren't medically necessary. The case manager suggested that I schedule a telephone conference, with one of her organization's medical staff, to discuss the situation.

A few days later, the conference took place, and I spent over 20 minutes trying to explain what was going on, and answering the assistant medical director's questions. He didn't feel this was really a crisis and believed that hour-long therapy sessions, twice a week, would be more than sufficient. When I tried to explain to him that it was very hard to

arbitrarily limit her sessions, he was unsympathetic. When someone is talking about being raped, and is showing a great deal of pain and emotion, it seems inhumane to tell them, after 45 minutes, that their time is up. He told me that I simply had to limit the time that I spent with her; if I did not, he warned me that "she could be an eternal spigot" (endlessly sharing her pain and distress). Eventually, he told me that he would allow reimbursement for the lengthy crisis intervention session.

Three and one half hours later, I received a fax from the managed care organization, ordering me to produce a copy of the patient's entire file. They told me that there was concern about the quality of care that I was providing, but did not inform me the nature of the concern or who raised it. I was given 10 days to respond, and warned that if I did not send the company absolutely everything in my records, that they would not pay for any further services (for this patient), and could drop me from the insurance company's list of providers.

In my 19 1/2 years of clinical practice, I have never had an insurance company request all of a patient's file. I have never been accused, by anyone, of providing inadequate care, and have never had any malpractice suits or ethics complaints filed against me. Is it simply a coincidence that I was "audited" after I advocated for my patient, or was it retaliation?

The next time that Mary came in, I shared with her what the managed care company was doing. As you can imagine, she was very upset about the situation: "I'm just really angry that I'm reduced to a pile of paper...a case needing to be managed". She told me that she felt betrayed, victimized, and totally powerless, just like when she had been raped. She felt that her privacy was being violated and that the managed care company was acting in an extremely intrusive manner: "my life isn't their business". Mary told me that she had always been very satisfied with the quality of care that I had provided: if it had not been for my help, she told me that she would have been dead.

After considerable discussion of the matter, during several lengthy therapy sessions, Mary agreed to let me send a copy of her entire case file to the managed care company. Neither she nor I know what will happen to the file or the information in it. Presumably, some case manager - whose qualifications and background we know nothing about - will go over the materials and let us know whether the services I provided were "medically necessary". This individual will never have seen the patient or even talked with her, and yet will decide if she deserves further care.

If the managed care company decides that I have not been providing adequate care, I am very afraid of what this might do to my career. At the very least, they could drop me from their provider panel and make it much harder for me to be a part of other panels. What recourse do I have, if I disagree with their decision? More importantly, what will happen to Mary if they refuse to allow further treatment? What rights does she have?

Why is Patient Protection Needed?

In terms of the patient, some of the excesses of managed care and changes in the insurance industry can cause significant harm. Examples of these are given below:

* Loss of privacy. Most of the information that psychiatrists and clinical psychologists deal with is of a very personal and intimate nature. To provide adequate care, we have to keep careful records of what our patients or clients tell us. Unfortunately, when this information is

requested by a third party, particularly a managed care entity, no one really knows what may happen to the information. People come to see clinical psychologists and psychiatrists because they are experiencing emotional distress. They typically struggle with painful and disturbing issues, such as the following: childhood sexual abuse, concerns about sexual orientation, incest, doubts about spirituality and religion, the aftereffects of trauma, marital infidelity, domestic violence, etc. People tell us things that they have never shared with anyone before in their whole lives.

Think of the things that you are most frightened of, ashamed of, or embarrassed about. Imagine summoning up the courage to finally share these with a therapist. Then imagine that all the things you have said - your most intimate thoughts, secrets, and feelings - are now being shared with some bureaucrat in an office 1,000 miles away, and that that individual has the power to decide whether or not you can get help for something that has troubled you for perhaps decades. That isn't a very comforting position to be in, is it? And yet this is exactly what the patients of clinical psychologists and psychiatrists have to experience on a daily basis.

Think of the most intimate and embarrassing medical procedure that you have ever gone through, and ask yourself how you would like some managed care reviewer or committee to be aware of the most explicit details of what went on. Unless you are a healthcare provider, you probably have no idea of how detailed and explicit your medical records are. If you are a woman, think back to your last annual gynecological examination, or your last mammogram. If you are a man, think of your last digital rectal examination, checking for prostate cancer. Now think of what it would be like to have those examinations or procedures done in public, perhaps even in this room. That's the kind of exposure that patients face. Obviously, no one would want to have their privacy and dignity violated in such a way.

* Gender Bias. For a variety of reasons, women are more likely to receive mental health services than men. Unfortunately, they are also much more likely to be victims of various kinds of abuse. Research suggests that from one out of four to one out of three American women will be abused at some point during their lives. Hopefully, they will consult a psychologist or a psychiatrist for treatment. The treatment that they need may well take quite a long time and require a lot of resources. Because of this, they are more likely to attract the scrutiny of managed care reviewers. The same situation would apply to just about any victim of trauma. Care has to be given in an individualized and sensitive manner, something which is very hard to fit into established utilization review protocols.

* Decrease in Freedom of Choice. As medical care becomes increasingly "industrialized", and vast provider networks are developed by insurance companies and other entities, individuals patients have progressively fewer options to choose from, when it comes to seeking healthcare. Providers who stand up for their patients, or don't happen to agree with managed care values (especially, sharp limits on treatment) are likely to be excluded from those networks. In something as important and

personal as our physical and mental well-being, it makes sense to allow maximum freedom of choice, yet managed care increasingly limits our choice of providers.

* Loyalty Conflicts. Sophisticated consumers are starting to learn about some of the problems with managed care. In particular, they wonder whether their provider is acting on their behalf, or on behalf of the insurance company. If there is any conflict in what is best for the patient, who will the doctor side with? These kinds of questions jeopardize the centuries-old doctor-patient relationship, and the trust that the patient needs to have, that the doctor will act only in their best interest.

* Difficulty in Filing a Grievance. Even if grievance and appeals procedures are present, it's often hard for individuals with emotional problems to take advantage of them. This is because of the nature of the problems and the social stigma that often accompanies emotional difficulties. For example, it's really hard for someone to call an 800 number, tell the case manager that they are a victim of childhood sexual abuse, anorexia, or whatever other embarrassing condition you can think of, and then negotiate additional therapy sessions, the right to see another provider, or whatever.

* Disrespect. One of the problems with managed care is the assumption that doctors and patients somehow need to be "managed". It's as if they don't have the common sense and professional judgment to make their own decisions regarding healthcare. One of my own patients put this rather eloquently: "I don't need a company to manage my care, I can do that myself...I don't need some committee to tell me what I need and to evaluate my life".

Why Do Providers Need Protection?

Although patients are in the most vulnerable position, and deserve the most protection, providers also could use some protection. Some of the problems we face include the following:

* Conflict in Loyalties. To many providers, it seems that the primary, if not exclusive, goal of managed care is to control costs. What happens if the patient needs services and the managed care organization or insurance company will not pay for them? What happens if the insurance company or utilization review agency disagrees with what you and the patient think is best? The success of psychotherapy, one of the major procedures that we use, depends on an open and trusting relationship between doctor and patient, and the patient's confidence that the doctor will do whatever is best for them (rather than what might be cheapest).

* Lack of Collegiality. Often, it seems that managed care organizations do not recognize the expertise of doctors, to decide what is in a given patient's best interest. Review procedures are often cumbersome and based on a review of the case file, rather than a professional dialogue. Whenever there is a conflict between a doctor and a managed care organization, the latter wins. There is also the matter of not being treated with professional respect. For example, during one

(rather uncommon) telephone conversation with a case reviewer, she told me "that a boy, Steve!" when I shared some aspect of the treatment plan that she happened to agree with. I'm not a child or a dog, and I found it rather condescending that she would talk to me in such a manner. I try to treat utilization reviewers with respect, and wish they would do the same to us. In another case, the reviewer (in this case, a physician) seemed to be treating me as if I were the patient. In talking about the carefulness with which I keep records, he told me that "you're thorough to the point of being obsessional about it". I wasn't the patient, and I certainly didn't appreciate that kind of diagnostic labeling.

* Inefficiency. Applying to join a managed care provider network, or "panel", is very time-consuming. Right now, for example, I'm in the process of filling out an application for one of these networks: it is over 55 pages long, and will easily take me several hours to complete. Needless to say, this time could be better spent in caring for patients. Once you work with a managed care entity, these organizations often require very detailed reports on the status of their patients. If you want to perform certain services (e.g., conduct a psychological evaluation, to be sure you have a better understanding of the patient's problems and can more effectively plan treatment), or provide services beyond a certain limit, you need to obtain the managed care organization's prior approval. Generally, each company has its own specific forms that need to be filled out: there is no uniformity. Essentially, you have to sit down at a typewriter and fill out a rather complicated form, send it into the company, and then wait (sometimes up to three weeks) to hear back from them (as to whether or not they will approve what you propose doing). These forms contain a lot of sensitive information, and it's never clear where they will end up. Attached, please find copies of two of these forms, which should give you a better idea of the kind of information that is routinely requested. I doubt that most patients or non-providers really appreciate how much paperwork, time, and expense managed care involves.

* Fear of Retaliation. If we advocate for the needs of our clients/patients, there is always the fear that retaliation will ensue. With the rapid pace of mergers in the healthcare industry, there is an increasing concentration of power, and a smaller number of provider organizations, insurance companies, and managed care entities. Competition among providers is very keen, and most people feel there is an "over-supply" of physicians and psychologists. There is always the fear that if you don't go along with the decision of the third-party payer, then they'll drop you from their network, or, even worse, blackball you throughout the entire industry. Lest this sound overly suspicious, let me point out that most provider network application forms specifically ask if you have ever been refused or denied membership in a health plan. With so many providers to choose from, why would a managed care organization even take the time and trouble to follow up on a provider who admits that he or she has been denied membership somewhere?

Problems For the Healthcare System

There are also some general reasons why I believe greater oversight over the managed care industry is desirable. Let me review some of these, below:

* Motivation. Many healthcare providers believe that a primary motivating force, behind many recent changes in the healthcare industry, is economics, and not concern about high quality care. In particular, many providers believe that "managed care" is simply an euphemism for cost control.

If quality really were an important motivating factor in managed care, you'd expect these entities to sometimes determine that a doctor needed to provide more services (e.g., a longer stay in the hospital, more diagnostic tests, lengthier therapy, or whatever). Logically, you'd expect providers to sometimes err on the side of delivering too much care, and sometimes for them to err on the side of delivering too little care. Let me ask the providers in this room the following questions - Has a managed care reviewer ever complained that you provided too little care? Have any of your colleagues ever been criticized for providing too little care? In fact, have you ever even heard of any provider being criticized for providing too little care, and being urged to provide more care? I suspect that the answer to all of these questions is a resounding "no". If this is indeed the case, you wonder how fair managed care organizations are being and what their real motives are.

Let's at least be honest with people. If saving money is the primary motivation for managed care, then at least let doctors, patients, employers, and legislators know that this is really the case. If economics really is a major issue, then maybe we need to look at other solutions. For example, if we really are concerned about rising healthcare costs, then maybe we need to pay more attention to prevention, the behavioral factors in disease (e.g., smoking, poor diet, unhealthy lifestyles, etc.), better pre-natal care, etc. I'm really proud that the Minot City Council recently changed over to a self-funded health insurance program for City employees. As part of this change, we are emphasizing preventive programs. Last month, for example, we held a preventive health screening for all City employees, to try to alert them to factors that might lead to illness and disability. Over 175 of our 285 employees participated in this screening, and quite a few have already started to make significant changes in their lifestyle or healthcare. There are other alternatives besides just rationing healthcare.

* Honesty. Most managed care documents - particularly those involving some sort of denial or limitation of benefits - contain a disclaimer, claiming that the ultimate decisions for healthcare rest with the provider and the patient, and trying to absolve the managed care organization from any responsibility (if some adverse outcome should take place). Attached, please find samples of two such documents. This really is misleading. The reality is that doctors will rarely provide care unless they are paid for it. When an insurance company or managed care entity denies reimbursement, that effectively ends treatment. Allowing these organizations to be the sole judges of what they will pay for has a profound impact on the quantity and quality of healthcare.

* Practicing Medicine Without a License. Because insurance companies and managed care organizations make decisions about treatment, they are, in a very real sense, practicing medicine. The decisions that managers make, even those without any formal training in the healthcare professions, really are the practice of medicine, psychology, nursing, or whatever other discipline we might be talking about. Logically, it would make sense that the people making these decisions would have to have training in healthcare and be licensed themselves.

* Redress of Grievances. If I, as a clinical psychologist, make some terrible mistake treating one of my patients, I fully expect that I will be held accountable. An aggrieved patient might file an ethics complaint, refuse to pay my bill, or even file a lawsuit against me. Quite frankly, I practice in a defensive manner and carry as much malpractice insurance as I can possibly afford. However, what happens when a managed care reviewer makes a mistake? How is he or she held accountable? In some cases, Federal law (i.e., ERISA) even prevents the consumer from suing! At the very least, consumers need to have well-defined and realistic mechanisms by which they can seek redress of their grievances.

* Concentration of Power. With the growing "industrialization" of healthcare, I believe we are seeing a situation much like that which existed at the turn of the century, when it came to large industrial corporations. We're seeing a concentration of power, and a reduction in competition, to the point where only a few very large corporations will run most of our country's medical care. We're starting to again approach the era of conglomerates, trusts, and monopolies. If corporations are going to become so large and powerful, we can't simply depend on their presumed good will to make sure that people aren't hurt.

* Inconsistency. If doctors and patients need to be monitored and managed, why should bureaucrats and managers be exempt from a similar kind of scrutiny? Who manages the managers? If doctors and patients need oversight, why should administrators be any different?

* Hypocrisy. The famous Roman author, Juvenal, raised an even more fundamental version of this concern. Writing in the first century, he asked the following: "sed quis custodiet ipsos custodes", or, in English, "but who will guard the guardians?". Juvenal was a famous satirist, who took particular aim at the "high and mighty". He, and many other writers, have taught us to be cautious of those who appoint themselves as guardians of the public good or the public morals. Perhaps it is those who claim a higher level of authority that are the ones who really deserve the closest oversight.

* Bureaucracy and Inefficiency. One of the biggest arguments for managed care has always been the amount of money that it supposedly saves. I, and most other healthcare providers, strongly question whether this is the case. For example, look at all of our time that is diverted toward filling out applications, responding to reviewers, completing forms, etc. Provider credentialing, alone, has become a major industry. Within the industry itself, bureaucracy is rampant.

One case manager I recently spoke with told me that every level of reviewer was being subject to more review: "it's the wave of the future". As a businessman, a City Councilman, and a taxpayer, this is not the way I want healthcare dollars to be spent. If we don't like bureaucracy in government, why should we accept it in healthcare, particularly when premiums are often paid by hard-pressed employers, or by government itself (to buy health insurance for municipal and state employees).

* Problems With the Notion of "Medical Necessity". Insurance companies will only pay for services that are "medically necessary". The problem is that this term is rarely, if ever, clearly defined. Basically, medical necessity is whatever the company or reviewer says it is. These standards are typically unpublicized and often even proprietary (meaning that the company refuses to release them to anyone). How can a patient or provider decide upon a course of treatment, or challenge an adverse decision, if they don't know the criteria by which the decision is made? Many providers feel that criteria for medical necessary are arbitrary and designed to safeguard the economic interests of the insurance companies, rather than assure high quality of care.

The secret nature of determining medical necessity reminds me of a scene in the movie *Animal House*. A college president and a student body leader are meeting to decide what to do about a particularly offensive fraternity. The student body president suggests that the fraternity be put on probation, and when they (inevitably) violate the terms of that probation, they can be disbanded (which is what both of them want). The college president suggests going one step further - putting the fraternity on "double secret probation". This way, they can be disbanded for doing something they don't even know is against the rules.

Another problem with the definition of medical necessity is that it is often circular: medical necessity is whatever the reviewer says it is, and what the reviewer says is automatically medical necessity. It kind of reminds me of the situation children often face when they are growing up. When they question why they need to follow some rule, their exasperated parent sometimes ends up saying "because I'm your mother" or "because I said so". Doctors and patients aren't children, and deserve some logical explanation, and clear justification, of what constitutes medical necessity. It shouldn't just be what the reviewer says it is.

Part of the irony is that medicine, psychology, and the other healthcare disciplines have done a great deal of research on what sorts of treatments are effective for what sorts of conditions. There is a large scientific literature which can help us determine medical necessity. In fact, several professional organizations have issued what are called "practice guidelines", which represent a consensus as to the kinds of interventions that are appropriate for certain problems. It really isn't that hard to define "medical necessity" in clear, objective, and reliable terms, and there is no reason why managed care organizations shouldn't use such criteria and also publicly disseminate them.

* Oppressive Aspects. As I deal with managed care practices on a daily basis, I'm starting to believe that there is a bizarre, oppressive, and almost totalitarian aspect to what goes on.

For example, one of the things that particularly irritates me is the right that managed care organizations feel they have to closely scrutinize the provider, in ways that no other company or organization would be allowed to do. In particular, when you apply to be on a managed care panel, you give the organization permission to check on your background. One of the most oppressive aspects of the permission statement is that you authorize them to check on your "character and moral and ethical qualifications". I've attached a couple of samples of these statements, for your information. What right does the managed care company have to inquiry into my character and morals? What business is it of theirs? As long as I'm licensed and practicing in a competent manner, that really should be all they care about.

When a farmer sells a bushel of wheat at the elevator, does the elevator manager ask him or her about their ethics or morals? Of course not! All they care about is that the crop is the farmer's to sell and that it really is wheat. When a small manufacturer sells screws to Case, to help build their tractors, does Case care anything about the ethics or character of that machine shop? Of course not! All they care is that the screws meet the specifications that are called for.

Since ethics, character, and morality are such subjective terms, how can we ever be assured that the provider will be treated fairly? The use of such vague and subjective terms lets the managed care organization do basically what it pleases. We don't allow arbitrary and capricious treatment of citizens by the government, why should be allow managed care organizations to determine, in an arbitrary and capricious manner, who will provide healthcare services?

There is also another troubling aspect to many managed care documents. When you sign up as part of a provider panel, you typically have to agree to keep the various materials that the company provides you secret. Companies spend a lot of time and money developing their own policies, procedures, and forms; they don't want these disseminated. To be perfectly honest, I'm not sure that I can even share some of these forms with you. If you look at the lower left hand corner of one of these forms, you will notice the statement that "this document and the contents therein are confidential and the proprietary information of (the company)". Activities that affect people's lives shouldn't be conducted in secret.

* Fundamental Unfairness. There is something fundamentally unfair - and, to be perfectly frank, almost un-American - about many managed care practices.

I'm particularly concerned about the lack of checks and balances. If you don't like what the managed care company does, there's really nothing you can do about it.

Lack of due process is also a very serious problem. When we, as citizens, deal with the government, we're entitled to a certain basic level of fairness, a concept which lawyers refer to as "due process". The problem is that private organizations are not bound by this doctrine: they don't have to treat us fairly. If our livelihood, health, and even our life depend

on decisions made by these organizations, shouldn't they have to treat us with some fundamental fairness?

Recall Juvenal's warning: "but who will guard the guardians?".

It might be even more relevant to recall a famous saying about human nature, Lord Acton's remark that "power tends to corrupt and absolute power corrupts absolutely".

To summarize, common managed care practices create serious problems for patients, providers, and the whole healthcare system.

So What Can We Do About All Of This?

Having listened to all of this, hopefully you can now see why it is so important to have:

* Guarantees of privacy and confidentiality.
* Protection against retaliation.
* Treatment decisions being made by licensed providers.
* Clear, public, and objective definitions of medical necessity.
* A prudent layperson's standard of what a crisis or emergency is.
* Meaningful appeal and grievance procedures.
* And, in general, checks and balances, and guarantees of fairness and due process.

In terms of specific remedies, I would respectfully suggest the following: strict privacy and confidentiality safeguards; protection against retaliation, for both provider and patient; a fundamental adherence to due process; reasonable appeals mechanisms; greater collaboration between providers, patients, insurers, and managed care entities; more efficient reporting mechanisms and requirements (e.g., agreement by managed care companies to use standard forms for credentialing, requests for further services, etc.); use of licensed healthcare professionals to make determinations of medical necessity; a clear statement of utilization review policies and procedures; having a reviewer in the same discipline or specialty review the work of a provider (in that discipline or specialty); reimbursement of any photocopying, mailing, or other expenses that might be incurred by the provider (in submitting materials for review); an objective, clear, consistent, and scientifically-based definition of medical necessity; using the reasonable layperson's standard for determining what is a crisis or emergency; requiring appeals (of an initial adverse decision) to be made by a professional not connected with the initial decision; recourse to an independent outside review panel, to settle differences between the provider and the organization; use of mediation and arbitration to settle differences, avoiding resort to litigation if at all possible; and treating patients and providers with a certain minimal level of dignity and respect.

Conclusions

Given the nature of change in America's healthcare system, particularly current practices in the area of managed care, I strongly believe that patients, healthcare providers, and the healthcare delivery system need a greater level of protection.

SB 2400 certainly isn't perfect, but it represents a very good first step in trying to assure some minimal level of fair treatment.

In my testimony today, I have tried to give you a picture of what managed care really is like, particularly in terms of the excesses and oppressive practices that providers of mental health services, and their patients, encounter on a daily basis.

When it comes time to cast your vote, I would ask you to think of the patient I spoke about earlier, the woman who woke up to find a gun barrel in her mouth, and was then brutally raped. Think of the suffering that she went through, and the courage that it took to finally talk about this horrendous event and to get help for the destruction it caused in her life. Then think of the managed care reviewer who felt that this really wasn't a crisis and that she should be expected to deal with it in a 45-minute-long therapy session. Look back on the reviewer who showed her such disdain and disrespect, by saying that "she could be an eternal spigot". And most of all, think of her emotional reaction when she learned that her innermost secrets were now being shared with some anonymous bureaucrats, who would decide whether she deserved help for the devastation that a brutal rape caused in her life.

My patient isn't some abstract term or concept, she is a human being who deserves the highest quality care I can give her, and a healthcare system that treats her with dignity and respect. She may be a neighbor of yours, a constituent, or even a friend.

On behalf of this patient, and all the others like her, I ask for your vote in support of SB 2400. Thank you, again, for listening.

SP/ls
03/03/99

VALUE BEHAVIORAL HEALTH OUTPATIENT TREATMENT REPORT

Check One: ☐ Initial Outpatient Treatment Report ☐ Continuing Outpatient Treatment Report

DEMOGRAPHICS

Patient's Name _____

Date of Birth ____/____/____ Age _____ Gender _____

Insured's Name _____ Insured's SSN ____-____-____

Insured's Address _____

City _____ State _____ Zip _____

Patient's Relationship to Insured _____

Patient's Telephone Number: Home _____ Work _____

Insured's Employer *(Must be completed)* _____

DSM IV DIAGNOSIS

Axis I: /__/__/__/__ . /__/__/__ /__/__/__/__ . /__/__/__ /__/__/__/__ . /__/__/__

Axis II: /__/__/__/__ . /__/__/__ /__/__/__/__ . /__/__/__

Axis III: _____

Axis IV: _____

Axis V: Current ____ ____ Highest in last year ____ ____ Expected GAF at discharge ____ ____

(Document specific GAF score - not range)

91-100	Superior function	81-90	Minimal symptoms	71-80	Mild/transient symptoms
61- 70	Mild symptoms	51-60	Moderate symptoms	41-50	Serious symptoms
31- 40	Impaired Reality Testing	21-30	Inability to function	11-20	Some danger
01- 10	Serious danger of hurting self or others				

Name of Practitioner/Structured Program _____

Practitioner's Address _____

City _____ State _____ Zip _____

Telephone Number _____

Are you independently licensed? ☐ Yes ☐ No

Discipline, State License and Number _____

Federal Tax I.D. Number _____

ASSESSMENT

Previous Treatment *(Please check all that apply)*

Psychiatric	Substance Abuse	Treatment Outcomes:
☐ None	☐ None	_____
☐ Outpatient	☐ Outpatient	_____
☐ Inpatient	☐ Inpatient	_____
☐ within last 12 months	☐ within last 12 months	_____
☐ one prior admission	☐ one prior admission	_____
☐ 2 or more prior admissions	☐ 2 or more prior admissions	_____

Symptoms *(Please check all that apply. Those not checked will be assumed absent.)*

- ☐ Depressed Mood
- ☐ Decreased Energy
- ☐ Grief
- ☐ Hopelessness
- ☐ Worthlessness
- ☐ Guilt
- ☐ Anxiousness
- ☐ Panic Attacks
- ☐ Obsessions/Compulsions
- ☐ Elevated Mood
- ☐ Irritability
- ☐ Impulsiveness
- ☐ Hyperactivity
- ☐ Disruption of Thought Process/Content
- ☐ Delusions
- ☐ Hallucinations
- ☐ Paranoia
- ☐ Dissociative States
- ☐ Oppositionalism
- ☐ Somatic Complaints
- ☐ Concomitant Medical Condition
- ☐ Emotional/Physical/Sexual Trauma Victim
- ☐ Emotional/Physical/Sexual Trauma Perpetrator
- ☐ Substance Use *(check one)*
  - ☐ Active Substance Abuse
  - ☐ Early Full Remission
  - ☐ Early Partial Remission
  - ☐ Sustained Full Remission
  - ☐ Sustained Partial Remission
- ☐ Other (specify): _____
- ☐ Other (specify): _____

Symptoms have been present for:

☐ Less than 1 month ☐ 1-6 months ☐ 7-11 months ☐ more than 1 year

Functioning

(Please assess how current symptoms have affected the level of impairment in the following categories and indicate anticipated impairment at discharge.)

Categories	Impairment Level (circle level)					Anticipated Impairment at Discharge
	No Impairment	Mild Impairment	Moderate Impairment	Marked Impairment	Extreme Impairment	Impairment Level (i.e., 2)
Marriage/Relationship/Family	1	2	3	4	5	_____
Job/School/Performance	1	2	3	4	5	_____
☐ Disability/Leave	☐ Job Jeopardy					
Friendships/Peer Relationships	1	2	3	4	5	_____
Financial Situation	1	2	3	4	5	_____
Hobbies/Interests/Play Activities	1	2	3	4	5	_____
Physical Health	1	2	3	4	5	_____
Activities of Daily Living (personal hygiene, bathing, etc.)	1	2	3	4	5	_____
Eating Habits	1	2	3	4	5	_____
☐ Weight Loss ____ lbs.	☐ Weight Gain ____ lbs.		Current Weight ____ lbs.			Height _____
Sleeping Habits	1	2	3	4	5	_____
☐ Difficulty Falling Asleep	☐ Difficulty Staying Asleep			☐ Early Morning Awakening		
Sexual Functioning	1	2	3	4	5	_____
Ability to Concentrate	1	2	3	4	5	_____
Ability to Control His/Her Temper	1	2	3	4	5	_____

Risk Assessment *(Check all that apply)*

Suicidality: ☐ Not present ☐ Ideation ☐ Plan ☐ Means ☐ Prior Attempt Date _____

Homicidality: ☐ Not present ☐ Ideation ☐ Plan ☐ Means ☐ Prior Attempt Date _____

Other risk behaviors _____

VALUE BEHAVIORAL HEALTH OUTPATIENT TREATMENT REPORT

TREATMENT PLAN

Patient's Name _____

Primary Treatment Approach *(Check one (1). Refer to VBH Clinical Protocol Manual for description)*

- ☐ Problem Focused
- ☐ Symptom Focused
- ☐ Complex Case
- ☐ Therapeutic Stabilization
- ☐ Medication Management Only

Progress In Treatment *(Check one (1))*

- ☐ Continues with/or recurrence of acute presenting symptoms
- ☐ Somewhat improved
- ☐ Much improved
- ☐ Needs support/maintenance only
- ☐ Near completion of treatment
- ☐ Other _____

Expected Treatment Outcomes *(Check all that apply)*

- ☐ Reduction in symptoms and discharge from active treatment
- ☐ Return to highest GAF and discharge from active treatment
- ☐ Transfer to self help/other supports and discharge from active treatment
- ☐ Provide ongoing supportive counseling and maintain stabilization of symptoms
- ☐ Provide ongoing medication management

Did patient concur with goals and strategies of treatment plan? ☐ Yes ☐ No

Medication *(List all psychotropic and other medications)*

Has patient been evaluated for medication? ☐ Yes ☐ No

Current MEDICATION: ☐ None ☐ Psychotropic ☐ Medical ☐ Other _____

Does patient follow medication regime? ☐ Yes ☐ No ☐ N/A

Prescribing physician (indicate if PCP or Psychiatrist): _____

Name of Medication	Current Dosage/Frequency	Start Date	Side Effects
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Describe side effects/interventions: _____

Clinical Formulation

Use specific behavioral descriptors to address additional clinical information that impacts treatment (e.g. progression of symptoms, test results/lab values, pertinent history, concomitant issues, factors impeding progress, effectiveness of current strategies).

_____

_____

Clinical Formulation *(continued)*

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Treatment Frequency & Duration

Date First Seen _____ Date Last Seen _____

Total Number of Visits Used to Date for this Course of Treatment _____

Estimated **Total** Visits for entire Course of Treatment _____

	Frequency (i.e., 1x/wk., 1x/mo., etc.)	Estimated Discharge Date
☐ Medication Management 90862		
☐ Psychotherapy (20-30 min) 90843		
☐ Psychotherapy (45-50 min) 90844		
☐ Family Psychotherapy (45-50 min) 90847		
☐ Group Therapy (60-90 min) 90853		
☐ Other		
☐ Other		

What other treatment or community services is the patient receiving?

- ☐ None
- ☐ Individual
- ☐ Group
- ☐ EAP
- ☐ Medication Management
- ☐ Family
- ☐ AA/NA
- ☐ Structured Program
- ☐ Other _____
- ☐ Medical Treatment (Date of Last Physical Examination) _____

Last date of contact to coordinate treatment: Behavioral ___/___/___/ Medical ___/___/___/

Are other family members in treatment? ☐ Yes ☐ No With You? ☐ Yes ☐ No

Treating Provider's Signature: _____ Date: _____

MBC TRICARE CENTRAL REGION

REQUEST FOR OUTPATIENT TREATMENT SESSIONS

TO BE COMPLETED AT LEAST 2 WEEKS PRIOR TO END OF AUTHORIZATION

10/24/97

Completed by:	**Date Completed:**
Patient's Name:	**Sponsor's SSN°:**

DOB: (/ /)Age: _____ ❑ Prime ❑ Standard

Patient's Address: _____ Phone N°: (___) _____

City: _____ State: _____ Zip: _____

Sponsor's Name: Phone N°: ( )

Other Insurance: ❑ yes ❑ no (Specify):

Provider's Name: Phone N°: ( ) Fax N°: ( )

Provider's Address: _____

City: _____ State: _____ Zip: _____

Tax ID N°: License N°:

Referring MD (if applicable):

DSM IV Diagnosis (Please complete all axes)

Axis I: _____ Description: _____

Axis I: _____ Description: _____

Axis II: _____ Description: _____

❑ Developmental Issues: _____

Axis III: Medical Problems: _____

Axis IV: Problems with: (please check all that apply)

❑ Primary Support Group ❑ Social Environment ❑ Education

❑ Occupational ❑ Housing ❑ Economic

❑ Access to health care ❑ Legal system/crime

❑ Other: _____

Axis V: Global Assessment of Functioning Score (on DSM-IV Scale, 1-100)

Current GAF: _____ Highest GAF in past year: _____

List **current symptoms** of distress, dysfunction; results of mental status exam: _____

Prior Treatment Episodes: Provide information from prior treatment episodes that you or others have delivered

Date(s)	Diagnosis	Interventions (level of care)	Response

How long has the patient been in treatment with you: ***Years*** _____ **and/or *Months*** _____

Specify targeted treatment completion date: ***Month*** _____ **of *What Year*** _____

Forward completed form to: MBC TRICARE ▬ P.O. Box 42150 ▬ Phoenix, AZ 85080-2150
Telephone: (888) 910-9378 ▬ Local: (602) 564-2550 ▬ Fax: (602) 564-2464

MBC TRICARE CENTRAL REGION
REQUEST FOR OUTPATIENT TREATMENT SESSIONS

TO BE COMPLETED AT LEAST 2 WEEKS PRIOR TO END OF AUTHORIZATION

Completed by:	**Date Completed:**
Patient's Name:	**Sponsor's SSN#:**

WHY does the patient need continuing therapy **NOW**: _____

_____

_____

Risk areas (please check all that apply):

❑ Reportable child abuse ❑ Reportable elder abuse ❑ Danger to self ❑ Danger to others

❑ Substance abuse Please explain: _____

_____

_____

Detail level of lethality to self or others:

Current plan? _____

Means available? _____ Previous attempts? _____

Substance abuse a contributing factor? ❑ yes ❑ no

Barriers to progress in treatment: _____

_____

_____

What form of treatment are you rendering (e.g. Psychodynamic, cognitive behavioral, Behavior Mod, etc)? _____

_____

_____

Short term (measurable, achievable, objective) treatment goals: _____

_____

_____

_____

Has the patient or guardian reviewed the treatment plan and indicated both understanding and agreement?

❑ yes ❑ no

If the patient has not made progress, how will the treatment change to address and correct barriers? _____

_____

_____

Is patient in treatment with other providers: ❑ yes ❑ no

If **yes,** who and why? _____

If **yes**, are you coordinating care? ❑ yes ❑ no

Coordination:			
	Have you communicated with the Primary Care Physician?	❑ yes	❑ no
	Have you communicated with other providers/agencies/schools?	❑ yes	❑ no
	Does the patient need a psychopharmacological evaluation?	❑ yes	❑ no
	Referral to psychopharmacological evaluation made?	❑ yes	❑ no

MBC

MBC TRICARE CENTRAL REGION
REQUEST FOR OUTPATIENT TREATMENT SESSIONS

TO BE COMPLETED AT LEAST 2 WEEKS PRIOR TO END OF AUTHORIZATION

Completed by:	**Date Completed:**
Patient's Name:	**Sponsor's SSN#:**

Medical risk factors: ❑ yes ❑ no If **yes**, please list: _____

_____

_____

Date of last history and physical: Physician:

List **Current** Medications Below:

Medication	Dosage	Schedule	Route	Start Date/End Date
				/
				/
				/
				/
				/

Name and phone number of prescribing physician for above medications:
Name: Phone #: ( )

List **Past** Medications Used:

Planned Treatment and Interventions

CPT Code	Treatment	Start date for this auth	Frequency (per week)	Unit of sessions required	Estimated length of intervention
90801	Initial Psychiatric Assessment				
90843	Individual Psychotherapy (25-30 min)				
90844	Individual Psychotherapy (45-50 min)				
90847	Family Conjoint Psychotherapy				
90853	Group Medical Psychotherapy				
90862	Medication Management				
Other Code					
Other Code					
Other Code					

Discharge Plan/Discharge Criteria: _____

_____

_____

Signature of Attending Clinician: Date:

Forward completed form to: MBC TRICARE ▬ P.O. Box 42150 ▬ Phoenix, AZ 85080-2150
Telephone: (888) 910-9378 ▬ Local: (602) 564-2550 ▬ Fax: (602) 564-2464

VA 22116-1002

Value Behavioral

A Value Health Company

RECEIVED JAN 2 9 1999

22 JAN 1999

STEPHAN PODRYGULA PHD
13 1ST AVE SW
STE 504
MINOT, ND 58701

RE: CASE NO.
PATIENT:
SUBSCRIBER:
SSN:
GROUP NO:

Dear STEPHAN PODRYGULA PHD:

Value Behavioral Health (VBH) has been selected by the Employees National Health and Welfare Plan (Plan) to review all proposed treatment for Mental Health or Substance Abuse Care to determine if the proposed treatment is Medically Appropriate.

Based upon all of the information provided to VBH, a determination has been made to certify the proposed outpatient treatment for the above named patient for 25 visits from 12-14-98 to 06-01-99. If further visits are necessary, please submit an updated Outpatient Treatment Report (OTR) within three weeks prior to the last Certified visit.

The purpose of this VBH review is only to assess whether the proposed outpatient treatment can be Certified as Medically Appropriate in accordance with the Plan's requirements. Certification should not be considered a guarantee of payment by the Plan. Payment by the Plan is subject to all Plan provisions including, but not limited to the requirements that all treatment must be a Covered Service and that eligibility for Plan coverage must be effective on the date that the specific treatment is provided.*[We want to remind you that treatment decisions are always the responsibility of the patient and the attending provider, not VBH or the Plan.]*

Thank you for following the Certification procedures required by the Plan. If you have any questions, please call VBH at 1-800-934-7245.

Sincerely,
Clinical Operations R019 Enclosed: OTR

Provider Standards

MBC will establish and monitor scheduling standards for network providers. Scheduling availability must meet or exceed the following standards:

TYPE OF CARE	APPOINTMENT STANDARD
Emergency*	less than 6 hours
Initial Outpatient Visit & Assessment	within 3 days
Routine Non-emergency**	within 14 days

*Emergency: Acute symptoms of sufficient severity that could result either in permanent jeopardy to the patient's health or physical harm to the patient or others.

**Routine Non-emergency: A condition for which treatment can be postponed without undue risk to the patient or others.

Clinical Appeals Process

Providers, clients or their representative may request reconsideration of medical necessity determinations when they disagree with a clinical decision. MBC will respond to all MH/CD treatment appeals.

APPEALS LEVEL I	NOTIFICATION REQUIRED	DECISION RENDERED
Standard	60 days	3 business days*
Expedited**	Immediately	1 business day*
APPEALS LEVEL II	**NOTIFICATION REQUIRED**	**DECISION RENDERED**
Standard	30 days	3 business days*
Expedited**	Immediately	1 business day*

*Following receipt of all pertinent clinical records.

**Offered when client remains in level of care appealed.

Under no circumstances should a decision regarding the certification of treatment replace the provider's independent clinical judgment. The clinical decision to initiate or withhold care lies solely with the provider.

Please contact the MBC PROVIDER RELATIONS DEPARTMENT at (800) 999-9772 for information regarding:

- Provider Grievance Procedures
- Provider Credentialing/Recredentialing Criteria
- Facility Credentialing/Recredentialing Criteria
- Specialty Verification
- Provider Status
- Change of address or phone number; addition or deletion of a service location; or to update any personal information in your MBC provider file

Please contact the MBC/LUCENT TECHNOLOGIES INC. HELPLINE at (888) 314-4017 for:

- Certification of Benefits
- Coordination with other Lucent Technologies Inc. Programs
- Utilization Management
- Guidelines for Clinical Reviews
- Client Confidentiality Issues

If the client directly contacts the provider for outpatient services, the provider must call a Lucent Technologies Inc. Care Manager before treatment begins. All outpatient services, including evaluation, must be precertified for reimbursement.

PROVIDERS WHO FAIL TO OBTAIN CERTIFICATION PRIOR TO INITIATION OF TREATMENT WILL NOT BE REIMBURSED.

Please use this Summary Sheet in conjunction with your AT&T Provider Manual

COPY

ATTESTATION/PARTICIPATION STATEMENT

I fully understand that if any matter stated in this application is or becomes false, *Value Behavioral Health* will be entitled to terminate my provider agreement for breach. All information submitted by me in this application is warranted to be true, correct and complete.

I authorize *Value Behavioral Health* and its Credentialing Verification Organization (CVO) to consult with the National Practitioner Data Bank, State licensing board(s), educational institutions, specialty boards, malpractice insurance carriers, Educational Commission for Foreign Medical Graduates, hospitals, professional references and any other person or entity from whom/which information may be needed to complete the credentialing process or to obtain and verify information concerning my membership, professional competence, character and moral and ethical qualifications, and I also authorize all of them to release such information to *Value Behavioral Health* and its CVO. I release *Value Behavioral Health* and its CVO and its employees and agents and all those whom *Value Behavioral Health* and its CVO contacts from any and all liability for their acts performed in good faith and without malice in obtaining and verifying such information and in evaluating my application.

I consent to the release by any person to *Value Behavioral Health* and its CVO of all information that may reasonably be relevant to an evaluation of my professional competency, character and moral and ethical qualifications, including any information relating to any disciplinary action or suspension or curtailment of privileges, and hereby release any such person providing such information from any and all liability for doing so.

_____ Date (mm/dd/yy):___/___/___

Signature of Applicant

_____

Name (Please Print)

RETURN COMPLETED APPLICATION TO:

Value Behavioral Health
National Network Management
PO Box 4080
Virginia Beach, Virginia 23454

1-800-397-1630

FAX: (757) 412-6567 or (757) 412-6565

Value Behavioral Health is an equal opportunity organization which does not discriminate on the basis of race, color, sex, national origin, religion, age, disability, or veteran status in admission or access to, or treatment or employment in, its programs and activities. Applicants who may have inquiries regarding our policy and procedures should contact the National Network Management Department.

Magellan Behavioral Health, Inc.
Provider Information Form

I [redacted] to participate in the Magellan Behavioral Health, Inc. (MBH) Provider Network. I hereby certify that all information in this application and the copies of my state license(s), certificate(s) of insurance, and professional certificate(s) are correct and complete. I further understand that any information entered into this application which subsequently is found to be false could result in termination of any contract I may enter into with the MBH organization. I agree to maintain the professional liability insurance set forth in this application.

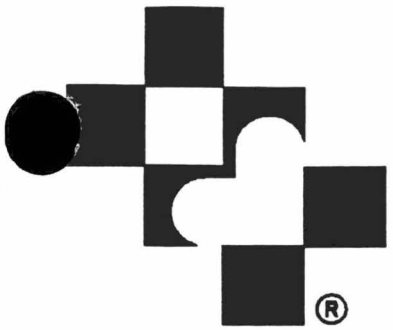
I agree to accept the fees listed in the fee schedule for my state, and will not balance-bill patients for any difference between my fees and those listed in the schedule(s) enclosed. I agree to abide by all MBH policies and procedures and to hold MBH patients harmless for payment for any care determined not to be medically necessary.

I hereby grant permission to, and consent for, MBH and/or its designee, to obtain and verify information contained on my application for membership and consent to the release by any person, organization, or other entity to MBH and/or its designee, of all information that may be reasonably relevant to an evaluation of my professional competence, ability to render clinical services in a cost-effective manner, character and moral and ethical qualifications and agree to hold harmless any such person or organization or other entity from any cause of action based on the release of such information to MBH and/or its designee. I understand that participation as a provider for MBH is dependent upon review of this application and completion of the credentialing process.

Signature _____ *Date* _____

Please Note: **This application is a time sensitive document based on signature date. Credentialing will begin only if this document is signed and when all materials requested are received. Therefore, please read all the instructions on the Instruction Sheet and collect and complete all documentation listed before signing the application. Once you have a *complete application packet*, sign the application above and mail immediately in the envelope provided.**

This document and the contents therein are confidential and the proprietary information of Magellan, Inc and its affiliates.



MeritCare

March 3, 1999

Good morning, Chairwoman Price, members of the Human Services Committee. My name is Arlette Preston. I am here representing MeritCare Health System to speak in support of SB 2400.

MeritCare Health System, being in Fargo, has the opportunity to contract with various insurance companies. Many of those companies are Minnesota based and are heavily influenced by managed care. Because of managed care, the environment in which our providers practice, and through which our patients have to navigate, can be quite complex. At times, the decisions made by those managed care companies do not make much sense and at the worst, can deter patients from accessing appropriate care.

SB 2400 provides some protection to the patient or provider who finds himself up against a powerful and bureaucratic system which is refusing to pay for services. Section 3 and 4, relating to emergency services, will reduce the concern for patients who are seeking emergency medical care. To give you an example, our staff recently intervened in a case which makes this point. A MeritCare patient was out of town, during a holiday. She presented to the emergency center in a smaller rural community for treatment. You all

may know that allergic reactions, hives being the first symptom to exhibit, can be life-threatening. She determined that she needed medical care, and the emergency center was the only option. Since it was a holiday, there were no doctor's offices or urgent care open. Payment was denied for this service, citing it was not emergent. A reasonable, prudent layperson, however, made the judgment that waiting 3 days was too long.

We frequently deal with patients who are out of network and they show up in our emergency room. A few managed care companies require a referral from the patient's primary care physician in order for payment to be approved. Occasionally, the designated primary care physician refuses to approve a referral since s/he has not examined the patient. The emergency treatment is always given, but payment has been denied on occasion. This bill would assist in ensuring that appropriate payment is made for appropriate emergency care.

Again, I urge you to support SB 2400. Thank you for your time and I'd be glad to answer any questions you may have.

Senate Bill 2400

Testimony before the House Human Services Committee

Representative Clara Sue Price, Chairman

March 3, 1999

By Jon R. Rice, MD

Blue Cross Blue Shield of North Dakota

Chairman Price and members of the House Human Services Committee, I appreciate the opportunity to appear before you. My name is Jon Rice. I am one of the Medical Directors at Blue Cross Blue Shield of North Dakota. Having served as a practicing physician in this state for 20 years, as regulator during my tenure as the State Health Officer for five years and now for a year and a half with Blue Cross Blue Shield North Dakota as their Director of Managed Care, I feel I bring a comprehensive background to this issue. I have written about the parallels among Family Medicine, Public Health and Managed Care. One of the concepts that crosses the spectrum of those diverse fields is the management of populations and their health. This bill addresses some protections for patients but it also unduly controls the contracts of insurance companies and their duties. As a member of the North Dakota Medical Association, I appreciate the opportunity to participate in this bill's evolution and thank the Association for listening and acting on some of the concerns I have had from the insurers' point of view. This bill is a great improvement over its original draft and greatly enhanced with the amendments passed on the Senate side, but I feel there are several areas that need to be addressed before BCBSND can drop its opposition to the bill.

Although the argument can be made that most of this activity is already accomplished and that the problems of patients are minimal in this state, I understand the concerns of the Medical Association and the "intrusion" of the insurers into the examination room. I will not address the bill section by section, but will focus on two areas that we find of particular concern. One area is not a patient protection at all, the other area will be covered by federal action, and passage of bills on a state basis may have unintended consequences.

On page three of the engrossed bill, the Medical Association has labeled the language starting on line 13 as an "all-products" clause prohibition. As I read this it is an "any-product" clause prohibition. This paragraph prevents an insurance company from requiring a provider to be in product A before he is in product B. I see this paragraph as a patient unfriendly provision. It allows the provider full choice as to whether or not he will participate in any given product. It can reduce consumers' choice for the types of products they may want to purchase because providers can "cherry pick" the contracts they prefer and make other contracts not available because of a lack of providers. This should be a contracting issue between the insurer and the provider, not a matter of state law. We have required BlueChoice providers to be providers in SelectChoice to assure access to a spectrum of managed care services. Likewise, the PERS plan requires participation as a preferred provider before allowing exclusive provider status. This provision would apply to these product combinations. We think this paragraph should be deleted.

Two options are available for amending this paragraph. One, the preferred one, is to delete it entirely. A second alternative is to replace the word *any* in line 15 with *all*, if the intent is truly to eliminate the all-products clause as suggested by the Medical Association.

Another area of concern is Section 6 on page 6. We are intent on protecting the confidentiality of patient health information. We are in the process of revising our corporate confidentiality policy. I am concerned that this section will have consequences far beyond its intent and could lead to inefficiencies in

the health care system and elimination of programs designed to improve the health status of the population. This section may also be patient unfriendly as it prevents an insurer from divulging information about the performance of a provider. Some insurers and states are actually issuing report cards about the performance of different health plans and providers. This information could well not be releasable about individual physicians according to this bill.

Let me give you a couple of examples of programs I think would be jeopardized by this section. We are involved in the development of disease management programs at BCBSND. These programs target patients at high risk for serious medical problems and try to help the patient's physician maximize their therapy.

We are in the process of completing an asthma study. This study looked at all BCBSND subscribers with a diagnosis of asthma. It will look at the hospitalizations, and emergency visits for asthma as well as medication usage. We will report to each physician in the state taking care of asthma patients how their patients are doing. We will report the rate their patients are using various medications and compare that to state and national norms. We will report any drug interactions that might be possible based on prescribing information and provide each physician with a list of the asthma patients that he or she is taking care of. We anticipate that clinics may well want to have information about the performance on such measures by the physicians of their group. We think this will be good for patient care. As we interpret this section, we will be unable to provide patient names to the physicians and we will be unable to provide physician information to the clinics without individually signed releases.

Another project we are discussing with the Department of Health would be to develop "report cards" about physician performance on indicators for diabetic care. We have reported to the large medical groups in the state participating in BlueChoice their performance on a series of measures about the care of diabetes. These measurements have been designed in cooperation with the Care Management Advisory Committee, a group of medical directors from around the state. We would like to report performance for individual patients on a quarterly basis to their primary physician. We have worked closely with North Dakota Health Care Review, Inc. and Medicaid to develop appropriate reports and information. We cannot do this according to this bill without the signed release from the patients individually. Likewise we could not give group reports which identified individual physicians.

I am not sure of the results of this law on information currently reported to the Department of Health.

I will hand out some additional information about unintended consequences of confidentiality legislation as experienced in Maine. The first act of their legislative session was to repeal the previous years' confidentiality legislation because of its implementation implications. We should also be aware that the Secretary of Health and Human Services has been instructed to prepare patient medical records confidentiality rules by September of this year if Congress does not pass such legislation.

Although I feel much of this bill is unnecessary because of the way business is done in this state and impending national actions, BCBSND can live with the bill if the unfair participation agreement and confidentiality areas are adequately addressed.

Chairman Price and committee members, it is my pleasure to discuss this with you. Should you have questions now I would be pleased to address them. If questions come up during your deliberations please feel free to call me at 701-282-1048 or send me email at jon.rice@noridian.com.

TESTIMONY

OF

SPARB COLLINS

SB 2400

Madame Chair, members of the Committee, good morning. My name is Sparb Collins. I appear before you today on behalf of the North Dakota Public Employees Retirement System and its health insurance plan. As you may be aware, PERS administers the State health insurance plan, which provides services not only to the State of North Dakota, but also to participating political subdivisions and retirees.

The Public Employees Retirement System (PERS) health insurance plan has three basic options: 1) the Basic plan, 2) the PPO plan and 3) the EPO plan. The Basic plan is available to all members when they enroll in the program. All providers in the State participate in the Basic plan. Our PPO plan is a Preferred Provider network. Members who use this plan can reduce their out-of-pocket expenses. A provider can participate in this program by signing a contract with PERS and Blue Cross Blue Shield (BCBS). This contract provides for a discount from their fee schedule, which is used to enhance the benefits to the members. The third option is our EPO plan, which is our managed care plan. Any provider who is a PPO provider may make application to participate in the EPO program. If they are accepted, a member may elect to join the EPO plan and participate with that provider.

The provisions of this bill that have implications for PERS concerns our methodology for the EPO program. As mentioned earlier, any provider who is a PPO provider may participate in our EPO program subject to meeting the necessary provisions. PERS has this provision for several reasons:

1) A PPO provider already has a contractual relationship with PERS whereas a Basic provider's contractual relationship is through BCBS.

2) By selecting EPO providers from our PPO network, we are selecting providers that are already viewed favorably by our membership as a result of their participation in the PPO.

The provisions of this bill, however, would require PERS to change its current practice in that we would no longer be able to select our EPO providers from our PPO network, but rather would require that we select them through our Basic network. In addition to changing our requirements, it could result in certain providers deciding not to participate in our PPO program. If that were the case, our members would end up paying more out-of-pocket for their health insurance costs. To the extent their health insurance costs continue to rise, this will increase membership dissatisfaction with their health insurance plan. Another concern is that, to the extent the availability and accessibility of health care is more costly, it may end up resulting in some of our members not seeking appropriate care when necessary. This could mean that certain

medical conditions could worsen, resulting in a more costly situation for the health insurance plan.

As a result of the above, PERS is requesting that consideration be given to excluding the state health insurance plan from this provision. We are therefore offering the attached amendment to SB 2400, which will accomplish this provision. If adopted, this amendment would:

- Continue to preserve the integrity of the health insurance plan
- Continue to maintain that EPO providers come from our PPO network
- Continue to make health insurance costs affordable for our members
- Ensure that our members continue to have the same availability and accessibility to health care that they have enjoyed over the last several years.

Madame Chair, members of the Committee, this concludes my testimony.

Attachment

ATTACHMENT 1

PROPOSED AMENDMENTS TO ENGROSSED SENATE BILL NO. 2400

Page 3, line 17, after the period, insert "This subsection does not apply to an entity providing a health plan through the public employees retirement system pursuant to chapter 54-52.1."

Renumber accordingly

SB2400
NDMA – Levi

March 16, 1999

These proposed amendments would:

1. Remove the "unfair participation requirements" provision in section 2
2. Retain the confidentiality provision in section 6 with a clarification that it does not apply to disease management programs and utilization management
3. Clarify that the plan description required in section 5 must be "made available" to the insured "in any manner that reasonably assures availability"
4. Incorporate Altru's proposed amendments regarding the definition of an insurance carrier as it applies to HMOs
5. Add the legal definition of "medical necessity" to the financial incentive prohibited practice in section 2, with code placement and language specifically limiting the definition to the financial incentive provision (which is limited to covered services) and not precluding an insurance carrier from establishing its own definition of medically-necessary care for determining what services are covered by a health plan
6. Remove language in section 9 requiring contractual references to provider responsibilities under state or federal programs

PROPOSED AMENDMENTS TO ENGROSSED SENATE BILL NO. 2400

Page 1, line 1, replace "four" with "three"

Page 1, line 16, after the underscored comma insert " a health maintenance organization,"

Page 1, line 17, remove "or health benefits"

Page 2, line 26, after the underscored period insert: "As used only in this subsection, "medically necessary care" means health care services, supplies, or treatments that a reasonably prudent physician or other health care provider would provide to a patient for the prevention, diagnosis, or treatment of illness, injury, disease or its symptoms which are in accordance with generally accepted standards of medical practice, clinically appropriate in terms of type, frequency, extent, site, and duration, and not primarily for the convenience of the patient, physician, or other health care provider. This definition does not preclude an entity from establishing a definition of "medically necessary care" for determining which services are covered by the health plan."

Page 2, line 30, after the underscored comma insert "or"

Page 3, remove lines 13 through 17

Page 4, line 15, remove the second "or"

Page 4, line 16, remove "health benefits"

Page 4, line 17, replace "provides the insured with" with "makes available to persons covered under the policy or contract"

Page 4, line 20, replace "insured" with "person covered under the policy or contract, in any manner reasonably assuring availability,"

Page 6, line 30, remove "or health"

Page 6, line 31, remove "benefits"

Page 8, line 4, after "review" insert "or management"

Page 8, line 5, after the second underscored comma insert "to analyze health plan claims or health care records data, to conduct disease management programs with health care providers,"

Page 8, line 20, remove "or health benefits"

Page 8, line 22, after "practitioner" insert "solely"

Page 10, line 20, remove "or health benefits"

Page 11, line 21, after the second comma insert "and" and remove "and any"

Page 11, line 22, remove "applicable federal or state programs"

Renumber accordingly

BOB MILLER
Governor

STATE OF NEVADA

CLAUDIA K. CORMIER
Director

ALICE A. MOLASKY-ARMAN
Commissioner of Insurance

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Bulletin Number 98-004 **October 12, 1998**

Unfair Trade Practices in Contracting for Providers

The Division of Insurance of the Department of Business and Industry has learned of an unfair practice by a Health Maintenance Organization (HMO) in its contracting with medical providers. The practice requires preferred providers of the HMO's Preferred Provider Organization (PPO), a non-HMO health insurance coverage, to contract with the HMO coverage provider network as well. Such PPO providers must contract with the HMO network as a condition of maintaining their preferred contractual status with the PPO.

Requiring a provider to become a member of a provider network for which he does not wish to contract in order to maintain a contractual relationship with an organization with which he chooses to contract is coercion. This practice violates the Unfair Trade Practices Act, Chapter 686A of the Nevada Revised Statutes (NRS), and in particular, NRS 686A.090.

NRS 686A.090 states that, "No person shall enter into any agreement to commit, or by any concerted action; commit any act of boycott, coercion or intimidation..." that would result in the unreasonable restraint of "any business of insurance." The effect of the coercion occurs when the HMO cancels the provider's PPO contract as a consequence of his not signing an HMO contract. Such termination unfairly prevents the provider from continuing to furnish PPO discounted medical care to the insured marketplace, which restrains the business of insurance.

The commissioner of insurance will pursue violations of NRS 686A.090 as they concern any such contractual requirement between an HMO and medical provider. Violations will be subject to fines per incident.

ALICE A. MOLASKY-ARMAN
COMMISSIONER OF INSURANCE

publishing, disseminating, or circulating of any oral or written statement or any pamphlet, circular, article, or literature which is false, or maliciously critical of or derogatory to the financial condition of any person, and which is calculated to injure any person engaged in the business of insurance.

4. Boycott, coercion, and intimidation. Entering into any agreement to commit, or by any concerted action committing, any act of boycott, coercion, or intimidation resulting in or tending to result in unreasonable restraint of, or monopoly in, the business of insurance.
5. False financial statements. Filing with any supervisory or other public official, or making, publishing, disseminating, circulating, or delivering to any person, or placing before the public, or causing directly or indirectly, to be made, published, disseminated, circulated, delivered to any person, or placed before the public, any false statement of financial condition of any person with intent to deceive.

   Making any false entry in any book, report, or statement of any person with intent to deceive any agent or examiner lawfully appointed to examine into its condition or into any of its affairs, or any public official to whom the person is required by law to report, or who has authority by law to examine into its condition or into any of its affairs, or, with like intent, willfully omitting to make a true entry of any material fact pertaining to the business of the person in any book, report, or statement of the person.
6. Stock operations and advisory board contracts. Issuing or delivering or permitting agents, officers, or employees to issue or deliver, agency company stock or other capital stock, or benefit certificates or shares in any common-law corporation, or securities or any special or advisory board contracts or other contracts of any kind promising returns and profits as an inducement to insurance.
7. Unfair discrimination.
   a. Making or permitting any unfair discrimination between individuals of the same class and equal expectation of life in the rates charged for any contract of life insurance or of life annuity or in the dividends or other benefits payable thereon, or in any other of the terms and conditions of such contract.
   b. Making or permitting any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, policy fees, or rates charged for any policy or contract of accident or health insurance or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatever.
   c. Refusing to insure, or refusing to continue to insure, or limiting the amount, extent, or kind of life insurance, accident and sickness insurance, health services, or health care protection insurance available to an individual, or charging an individual a different rate for the same coverage solely because of blindness or partial blindness. Refusal to insure includes denial by an insurer of disability insurance coverage on the grounds that the policy defines "disability" as being presumed in the event that the insured loses the insured's eyesight; however, an insurer may exclude from coverage disabilities consisting solely of blindness or partial blindness when such condition existed at the time the policy was issued. With respect to all other conditions, including the underlying cause of the blindness or partial blindness, persons who are blind or partially blind shall be subject to the same

TESTIMONY

OF

SCOTT MILLER

SB 2400

Madam Chairman, members of the Committee, good morning. My name is Scott Miller. I am an assistant attorney general and am general counsel for the North Dakota Public Employees Retirement System. I appear before you today on behalf of the North Dakota Public Employees Retirement System and its health insurance plan. As you may be aware, PERS administers the State health insurance plan, which provides services not only to the State of North Dakota, but also to participating political subdivisions and retirees. Sparb Collins, the Executive Director of PERS, and Kathy Allen, the health plan manager, are both testifying before different committees at this time.

The Public Employees Retirement System (PERS) health insurance plan has three basic options: 1) the Basic plan, 2) the PPO plan and 3) the EPO plan. The Basic plan is available to all members when they enroll in the program. All providers in the State participate in the Basic plan. Our PPO plan is a Preferred Provider network. Members who use this plan can reduce their out-of-pocket expenses. A provider can participate in this program by signing a contract with PERS and Blue Cross Blue Shield (BCBS). This contract provides for a discount from their fee schedule, which is used to enhance the benefits to the members. The third option is our EPO plan, which is our managed care plan. Any provider who is a PPO provider may make

application to participate in the EPO program. If the provider is accepted, a member may elect to join the EPO plan and participate with that provider.

The provisions of this bill that have implications for PERS concerns our methodology for the EPO program. As mentioned earlier, any provider who is a PPO provider may participate in our EPO program subject to meeting the necessary provisions. PERS has this provision for several reasons:

1) A PPO provider already has a contractual relationship with PERS whereas a Basic provider's contractual relationship is through BCBS.

2) By selecting EPO providers from our PPO network, we are selecting providers that are already viewed favorably by our membership as a result of their participation in the PPO.

The provisions of this bill, however, would require PERS to change it current practice in that we would no longer be able to select our EPO providers from our PPO network, but rather would require that we select them through our Basic network. In addition to changing our requirements, it could result in certain providers deciding not to participate in our PPO program. In that event, our members would end up paying more out-of-pocket for their health insurance costs. To the extent their health insurance costs continue to rise, this will increase membership dissatisfaction with their health insurance plan. Another concern is that, to the extent the

availability and accessibility of health care is more costly, it may end up resulting in some of our members not seeking appropriate care when necessary. This could mean that certain medical conditions could worsen, resulting in a more costly situation for the health insurance plan.

As a result of the above, PERS is requesting that consideration be given to excluding the state health insurance plan from this provision. We are therefore offering the attached amendment to SB 2400, which will accomplish this provision. If adopted, this amendment would:

- Continue to preserve the integrity of the health insurance plan
- Continue to maintain that EPO providers come from our PPO network
- Continue to make health insurance costs affordable for our members
- Ensure that our members continue to have the same availability and accessibility to health care that they have enjoyed over the last several years.

Thank you for allowing me to testify on this matter.

PROPOSED AMENDMENTS TO ENGROSSED SENATE BILL NO. 2400

Page 3, line 17, after the period, insert "This subsection does not apply to an entity providing a health plan through the public employees retirement system pursuant to chapter 54-52.1."

Renumber accordingly

Opinion

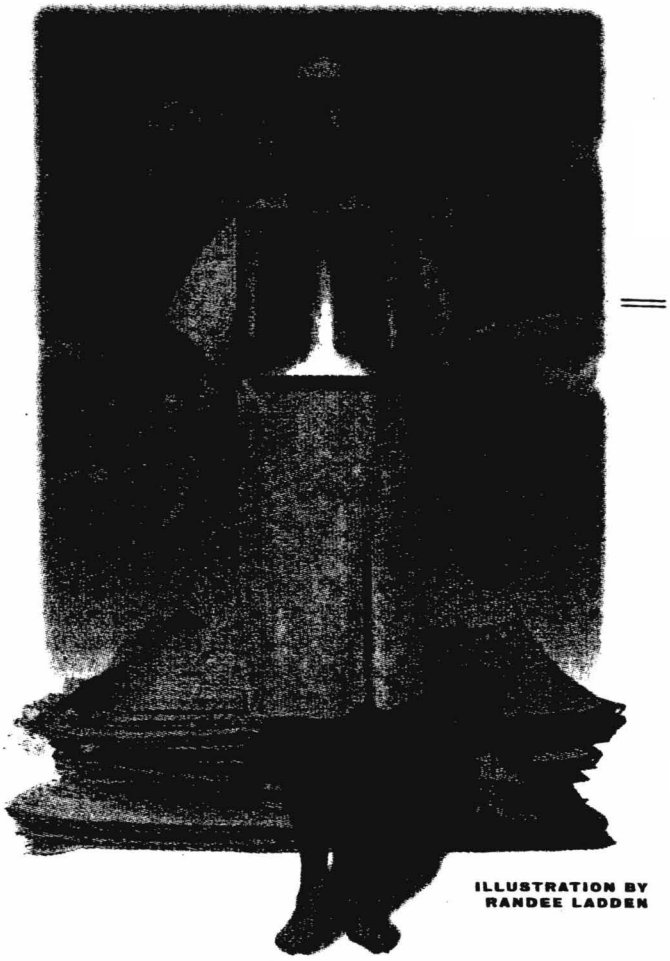

ILLUSTRATION BY RANDEE LADDEN

THE PITFALLS OF privacy

IT TOOK ONLY TWO WEEKS FOR MAINE'S JAN. 1 patient privacy law to go from debut to debacle. As we reported last week, lawmakers there suspended the law Jan. 15 until at least October. They want more time to work out problems that physicians, hospitals and others had with the sweeping and stringent measure.

The law came into being with support of the state's medical and hospital associations. It was properly grounded in the belief that it is the patient who should, except in rare cases, have the right to disclose or withhold personal health information.

However, in practice, physicians steamed over paperwork hassles and hospitals worried about when patients were too ill or injured to sign a release. Clergy members were concerned about how to find out who was in the hospital to visit. Even florists raised their own doomsday scenario — no get-well flowers for Grandma because of hospitals fearing fines (maximum $50,000) for revealing that she's a patient.

Yet for all the high anxiety, Maine's experience is only a taste of just how complicated and contentious privacy and confidentiality issues can be. There is a considerable list of players, with varying degrees of clout and purity of purpose, who would like to take a peek at patient records — insurers, public health agencies, medical researchers, quality assurance programs, employers, police and pharmaceutical firms.

All the while, computer advances continually make that peek all the easier. Research into the human genome brings the level of detail (and potential for discrimination) right down to our individual genes.

The issues of privacy and confidentiality go right to the core of the patient-physician relationship. If patients think that they will be revealing information that can be turned against them, they will be reluctant to seek the care they need.

The AMA has been long and actively involved in protecting patient privacy and professional confidentiality. Its legislative advocacy has been focused on the federal level, where this year the stage is set for a pivotal event in privacy law.

The Health Insurance Portability and Accountability Act of 1996 requires Congress to come up with comprehensive patient privacy rules by this August or the government will, barring a Maine-like breather, default to regulations by the secretary of Health and Human Services. Whichever the source, and even as 30 states consider their own legislation this year, these nationwide rules will have broad impact on privacy issues.

It is unclear if Congress will meet its own self-imposed deadline or what standards it will adopt if it does. Meanwhile, the HHS rules are written and ready to go. However, they have been faulted for not going far enough to protect patient information.

As advocacy in this area has continued, the AMA has worked to keep abreast of the latest developments. Last year, the AMA House of Delegates approved the recommendations of a wide-ranging report that reaffirmed the AMA's commitment to privacy and confidentially and came down strongly on the side of patient rights.

The Association also recently established a task force drawn from its councils to look into new and unresolved issues in this area. One key element of the group's mandate is to make recommendations to physicians about the practical implementation of privacy and confidentiality safeguards. As Maine's experience shows, it's quite a timely subject to study. ◆

SELECTED STATE LAWS ON MANAGED CARE / HMOs

STATE	Comprehensive consumer law (year)	Ban on financial incentives	Ban on gag clauses	Direct Access to ob/gyn	Continuity of Care	HMO Medical Director	Emergency Prudent layperson	Insurer Liability	Independent Review
Alabama	-			■		■			
Alaska	1998	■	■	**					
Arizona	*		■				*		■
Arkansas	1997		■	■ **	■	■	■		
California	1994, '95	■	■	■	■	■	*		exp
Colorado	1997		■	■	■		■		■
Connecticut	1997		■	■**			■	hh	■
Delaware	Regulations	■	■	■	■	■	■		■
Florida	1997	■	■	■**	■	■	*		■
Georgia	1996	■	■	■**			■		
Hawaii	1998		■				■		■
Idaho	1997	■	■	■			■	hh	
Illinois	-			■					
Indiana	1998		■	■	■	■	■		
Iowa	Voluntary		■				■		
Kansas	1997	■	■		■		■		
Kentucky	1998		■	**		■	■		
Louisiana	1997	■	■	■			■	hh	
Maine	1996		■	■**			■	hh	
Maryland	1995	■	■	■	■	■	■	hh	■
Massachusetts	-		■						
Michigan	-		■				■		■
Minnesota	1997	■	■	■	■		■		
Mississippi	1995			■					
Missouri	1997	■	■	■	■	■	■	hh	■
Montana	1997	■	■	■**		■			
Nebraska	1998	■	■	■			■		
Nevada	1997	■	■	■		■	■		
New Hampshire	1997		■	■				hh	
New Jersey	1997	■	■	■	■	■			■
New Mexico	1998	■	■	■			*		■
New York	1996		■	■	■		■	hh	■
North Carolina	Regulations		■	■			■		■
North Dakota	-		■					hh	
Ohio	1997	■	■			■	■		exp
Oklahoma	1997		■			■			
Oregon	1997		■	■			■	hh	
Pennsylvania	1998	■	■	■	■		■		■
Rhode Island	1996	■	■	■		■		hh	■
South Carolina	1998		■	■	■		■	hh	
South Dakota	-								
Tennessee	1998		■	■	■			hh	■
Texas	1997	■	■	■	■	■	■	■hh	■
Utah	-		■	■					
Vermont	1996	■	■	■	■	■	■	hh	■
Virginia	1995, '98		■	■	■		■	hh	■
Washington	1996		■	■			■		
West Virginia	-	■	■	■			■		
Wisconsin	1998		■		■	■	■		
Wyoming	-		■						
Dist. of Columbia	1998		■	■	■		*		■
Puerto Rico	-								
TOTAL	39	22	46	37	20	18	31	1	22

** Alaska and Kentucky have direct access only to chiropractors; Maine covers ob/gyn and chiropractors; Arkansas also covers optometrists; Colorado, Connecticut, and Montana also cover advance practice nurses or midwives and Florida and Georgia also cover dermatologists.

Source: Health Policy Tracking Service, National Conference of State Legislatures.

* State has adopted a variation of the prudent layperson standard
hh = ban on health plan "hold harmless" clauses, which shift all liability to doctor or health facility
exp = applies to experimental treatments
Note: In some cases, state provisions are contained in regulations or administrative code.