Approved January 31, 1991
Date

MINUTES OF THE HOUSE COMMITTEE ON INSURANCE.

The meeting was called to order by Representative Campbell, Vice-Chairman at
Chairperson

3:35 ~~a.m.~~/p.m. on Wednesday, January 30, 1991 in room 531-N of the Capitol.

All members were present except:

Representative Turnquist - Excused
Representative Helgerson - Excused
Representative Cribbs - Excused
Representative Cornfield - Excused

Committee staff present:

Bills Edds, Revisor
Chris Courtwright, Research
Nikki Feuerborn, Committee Secretary

Conferees appearing before the committee:

Gene Johnson
Larry Landwehr
Dave Kettler
Jim Schwartz
Chip Wheelen

Others Attending: See Attached List

Representative Welshimer moved that the minutes for the January 30, 1991, meeting be approved.. Motion seconded by Representative Flower. Motion carried.

Vice-Chairman Campbell requested Chris Courtwright of Research to explain HB 2002 to the Committee and audience. This proposed legislation would reduce the number of days of entitled coverage for alcoholism, drug abuse, and nervous or mental conditions from 30 to 3 for hospitalization in certain health and accident insurance policies. This would be regardless if medical care is indicated or not. This legislation is in response to a mandate issued four years ago which allowed 30 days of mandatory in-patient care for those affected with alcohol and drug addiction. In an attempt to lower insurance rates for the population who have been required to pay through higher premiums for the 30 day entitled coverage even if it was found to be medically unnecessary, this bill would reduce the number of days to 3 for such insurees but not disallow the full 30 days of coverage if medically indicated.

There were no proponents requesting to testify.

Opponents of HB 2002 began testimony with Gene Johnson, who represented the Kansas Community Alcohol Safety Action Project Coordinators Association, Kansas Alcohol and Drug Program Directors Association and the Kansas Alcohol and Drug Counselors Association. Mr. Johnson stated that insurance companies and HMO's may hire firms or individuals to conduct what is classified as utilization review to determine whether that afflicted person in their opinion should be treated in the manner prescribed by the attending physician for their alcohol and drug addiction. A recent Attorney General's opinion stated that even though the insuree does have 30 days coverage under the existing legislation, that under present law the insurance company may deny those benefits as a result of their utilization review activities. Mr. Johnson stated opposition to the proposed legislation due to its lack of solving the problem of insurance companies not following the mandated coverage and could possibly open up some other loopholes in the future for denying the citizens of Kansas adequate alcohol and drug treatment which he said was the third largest disease in the United States. Attachment 1.

Representative Neufeld expressed concern about insurance companies not keeping verbal agreements with treatment centers regarding coverage for the insurees and felt that this legislation might be more easily enforced.

Unless specifically noted, the individual remarks recorded herein have not been transcribed verbatim. Individual remarks as reported herein have not been submitted to the individuals appearing before the committee for editing or corrections.

CONTINUATION SHEET

MINUTES OF THE HOUSE COMMITTEE ON INSURANCE,

room 531-N, Statehouse, at 3:35 ~~a.m.~~/p.m. on Wednesday, January 30, 1991

Mr. Larry Landwehr, speaking for the Teamsters Union of Wichita, said he represented 2,200 people in Kansas. This group has the TAP program in place and feels strongly that the state should keep such policies as now exist intact. In 66 cases reported in his area, the insurance companies have paid out $290,000.

Representative Sprague asked that if all policy holders in this group were required to pay premiums on policies which had 30 day coverage whether they needed it or not, would it not make it more expensive.

Mr. Landwehr testified that some alcoholics need more than 30 days of treatment and that treatment should be decided on-site rather than by a review committee in some other location.

Mr. Dave Ketter of Valley Hope in Atchison stated opposition to the bill due to statistics verifying a lower success rate in treatment of alcoholics who spend less than 30 days in treatment. He said that the three day policy proposed would not allow sufficient time for the insuree to make logical decisions due to the detoxification process. Attachment 2.

Mr. Chip Wheelen, representing the Kansas Medical Society, stated opposition to the bill due to managed care. Often decisions are made by non-medical personnel in these cases. He stated that the Society could tolerate the bill if an amendment could be added that a medically licensed person in the State of Kansas was responsible for making decisions as to medical necessity. Therefore, if a Kansas licensed physician made an irresponsible decision, he could be reported to the Kansas Board of Healing Arts for investigation. He also requested that on Line 7 of Page 2 of the proposed legislation that 1980 be deleted and -R,1987 be added. See Attachment 3. Mr. Wheelen also stated that many insurees in this category suffer from co-morbidity and therefore medical care by a licensed physician would be indicated. Early intervention in many of these cases could begin a pro-active treatment plan which would ultimately save money.

Mr. James Schwartz, Consulting Director of the Kansas Employer Coalition on Health, Inc., presented testimony to the Committee opposing HB 2002 (Attachment 4). He represents 100 employers across Kansas who are concerned about the cost-effectiveness of group health insurance. He stated that he did not think HB 2002 would limit the financial risk from the mandate for inpatient psychiatric care. He said HB 2002 appears to apply a limitation that already exists. On the other hand, the bill could be interpreted as overruling standard medical necessity clauses and creating an exemption for the first three days of treatment. If that is the case, the effect would be to expand the mandate, rather than limit it, as was the original intention.

Representative Wells asked what suggestions he would have in remedying this situation. Mr. Schwartz recommended abolishing state mandates. Representative Sprague asked how legislators could attempt the process of eliminating the mandates if there is such opposition to even limiting them. Representative Sprague reminded the Committee of the abuse of the current mandate by stating that insurees who feel they have mental, alcohol, or drug abuse problems can check into a treatment center for 30 days at a cost of approximately $15,000. The burden of this is at the expense of other policy holders.

Meeting adjourned at 4:10 p.m.

GUEST LIST

COMMITTEE: House Insurance DATE: 1-30-91

NAME (PLEASE PRINT)	ADDRESS	COMPANY/ORGANIZATION
JOSEPH P. NOBLE	TOPEKA 6823 FOUNTAINDALE	ADAMS BUSINESS FORMS
William Black	4921 Cessna Wichita Kansas 67210	Teamsters Local 795
[illegible]	4921 CESSNA ST	TEAMSTERS LOCAL 795
Dick Brock	Topeka	Ins Dept
Steve Johnson	Topeka	Alcohol Program
Roy Miller	Topeka	SRS/ADAS
Diane Ketter	Atchison, Ks	Valley Hope
David Wiebe	Mission, Ks.	Jo. Co. Mental Health Ctr
JOE FURJANIC	TOPEKA	KCA
JAN BUEKER	TOPEKA	K-NASW
JIM OLIVER	TOPEKA	PIAK
PAUL M. KLOTZ	Topeka	Assoc. CMHCs Ks, Inc.
John C. Peterson	Topeka	Charter Hospital Corp
Martha Gabehart	Topeka	Ks Commission on Disability Concerns
[illegible]	Topeka	MHRS
Terry Larson	Topeka	Ks. Alliance for the Mentally Ill
Alan Cobb	WICHITA	WICHITA HOSP.
LISA Getz	WICHITA	WICHITA Hospitals
Nancy Zogleman	Topeka	BC/BS of Ks
LEW JENE SCHNEIDER	TOPEKA	STATE FARM/HIAA
David Hanzlick	Topeka	KDA
Chip Wheelen	Topeka	Ks Medical Soc.
Jim Schwartz	Topeka	KECH

TO: House Insurance Committee

RF: HB 2002

DATE: January 30, 1991

Mr. Chairman and Members of the Committee:

Thank you for the opportunity to address you today on this very important subject. That being coverage of the third most severe health problem in the United States today. I represent the Kansas Community Alcohol Safety Action Project Coordinators Association, Kansas Alcohol and Drug Program Directors Aasociation and the Kansas Alcohol and Drug Counselors Association. Several years ago when mandated health insurance was presented to this Legislature our organizations supported that move. Since that time we have found that even though there are 30 days of mandatory in-patient care for those affected with alcohol and drug addiction, we find it is highly possible that those individuals will not be able to utilize that full 30 days due to limitations to their contract.

In reviewing the proposed legislation before us today HB 2002 we do not feel that this will solve the problems that we are facing in treatment today. Insurance companies and HMO may hire firms or individuals to conduct what is classified as utilization review to determine whether that afflicted person in their opinion should be treated in the manner prescribed by the attending physician for their alcohol and drug addiction. A recent Attorney General's opinion stated that even though the insuree does have 30 days coverage under the existing legislation, that under present law the insurance company may deny those benefits as a result of their utilization review activities.

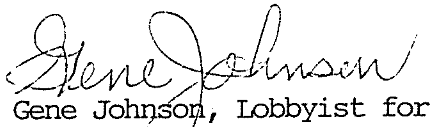
It would appear to us that as a result of the recent Attorney General's opinion even with the suggested language of a minimum of 3 days in the contract that would not legislate the insurance companies to follow that mandated coverage.

Jan 30, 1991 House Insurance
Attachment 1
Page 1

Our organizations oppose this proposed legislation as it does not solve the problem and could possibly open up some other loopholes in the future for denying the citizens of Kansas of adequate alcohol and drug treatment.

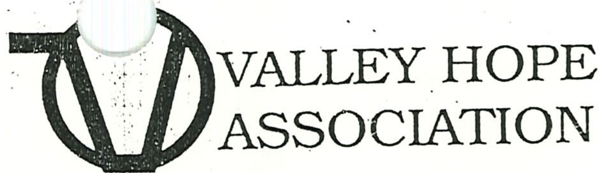
Thank you.

Respectfully,



Gene Johnson, Lobbyist for

Kansas Community Alcohol Safety Action Project Coordinators Association
Kansas Alcohol and Drug Program Directors Association
Kansas Alcohol and Drug Counselors Association



The Valley Hope Association
Successfully Treating Alcohol
& Drug Addiction
Since 1967.

ATCHISON INPATIENT FACILITY
(913) 367-1618
FAX (913) 367-6224

P.O. Box 312 Atchison, KS 66002

January 29, 1991

TREATMENT OUTCOMES FOR ATCHISON VALLEY HOPE FOR SIX MAJOR REFERRING GROUPS IN 1990

Referral Source	# sent to treatment	average # days in treatment	% contacted	% sober	% in AA	% in counseling
A	49	28	75%	70%	73%	38%
B	29	27	72%	86%	76%	67%
C	19	22	95%	78%	67%	83%
D	11	18	82%	67%	78%	44%
E	10	25	90%	100%	89%	22%
F	13	16	58%	29%	43%	29%

The table above shows outcomes for 131 patients who received treatment at Atchison Valley Hope during the calendar year of 1990. At the end of the year we attempted to contact each of those individuals by telephone to discover how they were doing in recovery. We were able to make contact with 101 individuals or their family members. We were not able to contact 30 individuals.

These numbers reflect the potency of inpatient treatment. The data clearly shows that the referral groups with the lowest length of stay in inpatient treatment had the poorest recovery rates and the poorest follow up rates.

Outpatient therapy can only be effective if the patient attends outpatient therapy. In 3 days of detox most alcoholic and drug addicted people are not able to get well enough to make and follow through with a committment to outpatient therapy.

January 30, 1991
House Insurance
Attachment 2

ASSOCIATION BOARD OF DIRECTORS

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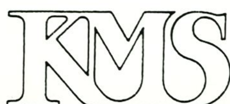


KANSAS MEDICAL SOCIETY
1300 Topeka Avenue • Topeka, Kansas 66612 • (913) 235-2383
Kansas WATS 800-332-0156 FAX 913-235-5114

January 30, 1991

TO: House Insurance Committee

FROM: Kansas Medical Society Chip Wheelen

SUBJECT: House Bill 2002 - Coverage for Mental Illness and Addiction Disorders

Thank you for this opportunity to express our concerns about the provisions of HB 2002. Our opposition to this bill is conditional inasmuch as an amendment would make the bill acceptable to the Kansas Medical Society.

Our concern relates not to the questions surrounding coverage for mental illness or treatment for drug abuse or alcoholism, but instead is related to the question of managed care. The Kansas Medical Society recognizes that managed care and the process of utilization review of services is a fact of life in today's health care industry. We do, however, have serious reservations because all of the review being conducted in the state of Kansas is virtually unregulated. Although there are organizations that conduct utilization review of health care services in a very responsible manner, there are many that do not. Oftentimes the decisions which third parties make regarding their coverage and payment for services interfere with the ability of physicians to provide appropriate quality care to their patients. Much of the review work is not done by a physician or even a person with other health care credentials. Frequently it is a non-provider who makes basic screening decisions and can even determine that a service is not medically necessary. We believe that this lack of accountability is unacceptable.

As some of you know, this subject was a topic of interim study by the 1990 Special Committee on Public Health and Welfare and there is an elaborate record of those proceedings if you should desire to read the information. Instead of inundating you with paper, we have provided one copy of the interim committee report for your minutes. We would encourage you to read Proposal No. 28 in the report of 1990 interim committee studies. Upon reading that report, you will note that the utilization review industry is attempting to develop and implement voluntary standards that are an effort to address the kinds of concerns that we outlined during the interim study. In the meantime, many of the decisions made by review agencies are not accountable to either the patient (insured) nor the health care provider involved. It is for this reason that we respectfully request an amendment to HB 2002 before you take any further action. This amendment would make it clear that any decision as to <u>medical</u> necessity must be made by a person who is actually licensed to practice medicine in Kansas. This would not prohibit screening of claims by non-physician personnel, but would simply mean that any ultimate decision to deny coverage of care must be made by a person who is appropriately credentialed. The other amendment that we offer on page two is nothing more than a technical update of the reference.

Thank you very much for your consideration. We urge you to incorporate these amendments prior to making a recommendation on the bill.

CW:ns

Jan 30, 1991
House Insurance
Attachment 3
1 of 3

Amendments requested by Chip Wheelen
Kansas Medical Society
Jan. 30, 1991

Session of 1991

HOUSE BILL No. 2002

By Special Committee on Insurance

Re Proposal No. 11

12-28

10 AN ACT relating to insurance; concerning coverage for alcoholism,
11 drug abuse and nervous or mental conditions in certain health
12 and accident policies; amending K.S.A. 40-2,105 and repealing
13 the existing section.
14
15 *Be it enacted by the Legislature of the State of Kansas:*
16 Section 1. K.S.A. 40-2,105 is hereby amended to read as follows:
17 40-2,105. (a) *(1)* On or after the effective date of this act, every
18 insurer which issues any individual or group policy of accident and
19 sickness insurance providing medical, surgical or hospital expense
20 coverage for other than specific diseases or accidents only and which
21 provides for reimbursement or indemnity for services rendered to
22 a person covered by such policy in a medical care facility, must
23 provide for reimbursement or indemnity under such individual policy
24 or under such group policy, except as provided in subsection (d),
25 which shall be limited to not less than 30 days per year when such
26 person is confined for treatment of alcoholism, drug abuse or nervous
27 or mental conditions in a medical care facility licensed under the
28 provisions of K.S.A. 65-429 and amendments thereto, a treatment
29 facility for alcoholics licensed under the provisions of K.S.A. 65-4014
30 and amendments thereto, a treatment facility for drug abusers li-
31 censed under the provisions of K.S.A. 65-4605 and amendments
32 thereto, a community mental health center or clinic licensed under
33 the provisions of K.S.A. 75-3307b and amendments thereto or a
34 psychiatric hospital licensed under the provisions of K.S.A. 75-3307b
35 and amendments thereto. *Notwithstanding the foregoing provision,*
36 *no reimbursement or indemnity shall be required with respect to*
37 *any period of confinement exceeding an initial three-day period upon*
38 *a determination* [by a person licensed to practice medicine and surgery in this state] *that the same is medically unnecessary.*
39 *(2)* Such individual policy or such group policy shall also provide
40 for reimbursement or indemnity, except as provided in subsection
41 (d), of the costs of treatment of such person for alcoholism, drug
42 abuse and nervous or mental conditions, limited to not less than
43 100% of the first $100, 80% of the next $100 and 50% of the next

2-3

1 $1,640 in any year and limited to not less than $7,500 in such person's
2 lifetime, in the facilities enumerated when confinement is not nec-
3 essary for the treatment or by a physician licensed or psychologist
4 licensed to practice under the laws of the state of Kansas.
5 (b) For the purposes of this section "nervous or mental condi-
6 tions" means disorders specified in the diagnostic and statistical man-
7 ual of mental disorders, third edition, (DSM-III, ~~1980~~) of the -R, 1987
8 American psychiatric association but shall not include conditions not
9 attributable to a mental disorder that are a focus of attention or
10 treatment (DSM-III, V Codes).
11 (c) The provisions of this section shall be applicable to health
12 maintenance organizations organized under article 32 of chapter 40
13 of the Kansas Statutes Annotated.
14 (d) There shall be no coverage under the provisions of this section
15 for any assessment against any person required by a diversion agree-
16 ment or by order of a court to attend an alcohol and drug safety
17 action program certified pursuant to K.S.A. 8-1008 and amendments
18 thereto.
19 (e) The provisions of this section shall not apply to any medicare
20 supplement policy of insurance, as defined by the commissioner of
21 insurance by rule and regulation.
22 Sec. 2. K.S.A. 40-2,105 is hereby repealed.
23 Sec. 3. This act shall take effect and be in force from and after
24 its publication in the statute book.

3-4-3

RE: PROPOSAL NO. 28 – MEDICAL REVIEW ORGANIZATION REGULATION

Proposal No. 28 directs the Special Committee to:

identify the activities of private agencies and entities that review the necessity for and the appropriateness, quality, and cost of services of health care providers on behalf of nongovernmental third-party payers and employers; determine the role of such utilization review activities in assisting insurers and employers in restraining increases in the cost of health benefits; review American Medical Association model legislation, the legislation enacted in other states, the Health Insurance Association of America survey, and the Institute of Medicine study on the effectiveness of utilization review; study the effect of such review on physician autonomy and current utilization review activities to identify any deficiencies; and consider whether Kansas should create a state regulatory structure to credential and regulate entities that engage in utilization review activities.

Proposal No. 28 was recommended for interim study by the Senate Committee on Public Health and Welfare and by the Kansas Medical Society. During the 1990 Session, the Senate Committee introduced a utilization review regulatory bill (S.B. 760) at the request of the Medical Society, but the bill died in Committee at the end of the 1990 Session.

Background

In the recent past, utilization review -- the method used by purchasers of health care to promote quality in health care, cost effective health care, and to hold down the costs of health care -- has undergone a rapid growth. A decade ago, utilization review was virtually unknown in the private sector, although governmental programs were utilizing health care procedure review in managing programs such as Medicare and Medicaid. During the 1980s, both utilization review and utilization management services came into wider use. A wide range of payers now use some form of utilization review to try to identify inappropriate or unnecessary health care procedures performed by a range of providers, with particular emphasis on the practice of physicians and on hospital services. Utilization review is generally carried out by a third-party agency on behalf of insurers, HMOs, preferred provider organizations, and many large employers who are self-insurers or who are concerned about keeping health benefit costs from escalating at an increasingly rapid rate.

Utilization review has come under fire from some providers who see utilization review procedures as an intrusion into their practice and as a threat to their autonomy in prescribing the care they believe best for their patients. Providers, particularly physicians, are faced with an increasing number of requests to supply information, patient records, and backup data to support the decisions they have made as to the appropriate and necessary treatment for their patients. A source of particular irritation is the lack of standardization among utilization review procedures resulting in physician offices and hospitals being asked to supply data in different formats to entities that reimburse for their services. Complaints about the amount of paperwork involved in reviews, concerns over patient privacy, and questions about the qualifications of persons who conduct utilization review procedures also have been voiced by providers. Questions have been raised as to the value of utilization review procedures as they become increasingly intrusive, particularly in the practice of medicine and surgery. Other issues raised by providers of health care are the lack of standardization of review procedures, failure of review agencies to disclose the criteria they use in making decisions about the appropriateness and necessity of procedures performed, and the lack of clear and uniform procedures for appealing decisions made by reviewers. Several provider groups, but primarily state medical societies, have lobbied in the past two years for state regulation of utilization review, of the agencies carrying out reviews, and of personnel employed to conduct reviews.

Payers of health care, on the other hand, defend utilization review as necessary to control the escalation of health care costs, to protect patients from unnecessary or inappropriate medical interventions, and

as an appropriate role for those who reimburse for health care procedures and who have a responsibility to be sure that scarce health care dollars are wisely spent. In response to questions about the effectiveness of utilization review raised by providers, those who defend the management mechanism point to a survey of health insurance companies conducted by the Health Insurance Association of America in 1988 in which executives of 123 health insurance companies rated various techniques used to hold down costs and to insure that payment is made only for appropriate and necessary medical procedures. Two review procedures were rated as effective in controlling costs by most of those surveyed -- the evaluation of alternate treatment procedures in high-cost cases and concurrent and retrospective reviews in which the reviewers try to change the behavior of physicians whose practice patterns vary from standard practices. In general, payers, whether large employers, insurers, HMOs, or others have opposed state regulation.

In addition to the Health Insurance Association of America survey, the National Institute of Medicine appointed a committee to look into issues raised by providers. The Institute of Medicine committee agreed there were deficiencies in the utilization review system and expressed concern about the quality of review criteria. However, the Institute of Medicine committee also concluded that government regulation is neither desirable nor feasible at the present time, citing a lack of knowledge about what and how to regulate, the potential for harm from ill-conceived regulation, and the lack of any documented evidence of harm to patients arising from utilization review procedures.

The utilization review industry also has begun to address some of the concerns expressed by providers through development of a self-regulation program. In February of 1990, a group of companies joined together to develop a private, voluntary, national credentialing and accreditation program and voluntary utilization review standards and to that end established a nonprofit corporation, the Utilization Review Accreditation Commission. The voluntary effort addresses many of the issues raised by providers, including the role of the utilization review organizations; the scope of inpatient utilization review; the responsibilities of those involved in a review; the utilization review process itself, including notification and appeal procedures; the confidentiality of patient records; and the qualifications of reviewers.

Five major health care groups -- the American Medical Association, the American Hospital Association, the Health Insurance Association of America, Blue Cross and Blue Shield Association, and the American Managed Care and Review Association -- have recently released new voluntary guidelines to monitor utilization review activity. These guidelines focus on standardizing concurrent review activities and general administrative procedures. The Utilization Review Accreditation Commission currently is in the process of developing a single set of standards, which are scheduled for completion at the end of 1990. The organization is expected to be accrediting firms by March, 1991. According to an article from *American Medical News*, the intent of the associations in developing utilization review guidelines is to minimize physician hassles and avert the specter of state regulation of the utilization review industry.

To date, seven states have enacted legislation to regulate private review agents (individuals or agencies) who conduct utilization reviews: Maryland (1988), Arkansas (1989), Maine (1989), South Carolina (1990), Mississippi (1990), Virginia (1990), and Florida (1990).

Of the seven states with legislation, Maryland, Arkansas, South Carolina, Virginia, and Mississippi require private review agents to be certified as a condition for conducting utilization reviews. Florida and Maine require private review agents to be licensed. All states require certain information to be included with applications for certification or licensure, and Florida's and Maine's requirements even exceed the following: a description of review standards or procedures to be used in evaluating proposed or delivered hospital and, in some states, also medical, care; provisions to address appeals of adverse decisions by the private review agent; types and qualifications of individuals performing the reviews; procedures and policies governing the accessibility of agents to patients and providers, with most of the states requiring the equivalent of 40-hour per week accessibility; policies and procedures to protect the confidentiality of patients' medical records; a copy of the materials designed to inform patients and providers of the requirements of the utilization plan; and a list of third-party payers for which the agent is performing utilization reviews.

State legislation in most states excepts from licensure or certification private review agents who perform utilization reviews pursuant to a contract with the federal government under the Social Security Act. Most states also exempt from their legislation in-house utilization reviews. In addition, South Carolina exempts from certification requirements, insurance companies and health maintenance organizations licensed and regulated by the South Carolina Department of Insurance. Other provisions contained, for the most part, in the legislation of the seven states include: revocation of certificates or licenses, renewal procedures and fees for certification or licensure, reporting requirements, and criteria governing proposed decisions for denial or reduction of coverage.

Finally, a model bill was drafted by the American Medical Association in October, 1989. This bill provides for substantial physician involvement in utilization review programs and local control of procedure. It mandates that any denial of reimbursement or preauthorization of a medical procedure be made only if a physician trained in the appropriate specialty or subspecialty concurs with the denial or preauthorization. In addition, it requires that physicians who act as reviewers be considered as being engaged in the practice of medicine in the state and under authority of the state medical licensing act.

Committee Activity

Central to the Committee's study of utilization review regulation was a proposal by a spokesperson for the Kansas Medical Society to impose state regulations on insurance companies and agencies that conduct utilization reviews. Two physicians supported the proposal on behalf of the Association. A representative of Valley Hope Association and a representative of three alcohol and drug-related associations expressed concern about current utilization review practices in Kansas, but did not specifically address the Medical Society proposal. A representative of Asbury-Salina Regional Medical Center likewise raised concerns about utilization review practices but opposed the Society's proposal. The Executive Director of the Board of Healing Arts noted that the Board endorsed regulation of licensees who conduct utilization reviews.

Opponents of the Medical Society proposal or a bill sponsored by the Society, which predated the proposal, included representatives of the Kansas Foundation for Medical Care; Kansas Coalition on Health, Inc.; Blue Cross and Blue Shield of Kansas, Inc.; the American Managed Care and Review Association; Dorth Coombs Insurance, Inc.; Kansas State Nurses' Association; and the Kansas Hospital Association. Written testimony from the Health Insurance Association of America raised objections to 1990 S.B. 760. The Committee also heard a presentation from a representative of the Utilization Review Accreditation Commission who addressed his remarks to a status report of the Association's activities.

The Committee was informed by the Kansas Medical Society spokesperson that enactment of the Society's proposal would address the problem experienced by so many physicians that medical services which have already been rendered are not covered by insurance. According to the spokesperson, the standards established in the proposal would ensure that physicians be given reasons for "medically unnecessary" denials and that they would have recourse available to them in the event of a questionable decision. In addition, the Society had the following concerns about the current practice of utilization review: much of the utilization review is not done by physicians; the review process is often confusing to patients and physicians; and third parties who conduct reviews have little or no accountability for their decisions to pay for or deny health care services.

The Kansas Medical Society proposal included the following major provisions:

1. Beginning May 1, 1992, health services review agencies must be certified to conduct business in Kansas. Exceptions include health services reviews conducted for purposes of credentialing, quality assurance, risk management, or other internal health services review by a health care provider. Also excepted are reviews conducted in relation to litigation or

6 of 3

agents who perform reviews pursuant to a contract with the federal government under the Social Security Act.

2. Standards are set forth to which health services review agencies must adhere. Included in those standards is the requirement that review of services rendered by a health care provider be conducted by another provider who is licensed in Kansas to practice the same profession as the provider being reviewed.

3. Procedures are set forth for obtaining and renewing a certificate of authority to conduct health services review. In addition, a fund is established, to be financed by fees charged for certification of review agencies.

4. The Commissioner of Insurance is authorized to grant, refuse, suspend, or revoke certificates and to assess civil fines.

5. The Healing Arts Act is amended to add review of health care services to the definition of the practice of the healing arts, thus allowing the Board of Healing Arts to take disciplinary action on complaints filed with the Board if a licensee performed substandard review work or if a nonlicensed person performed review of a licensee.

6. Other provisions of the proposed legislation relate to liability, confidentiality and discovery, authority of the Commissioner of Insurance to adopt rules and regulations, establishment of a nine-member advisory Board to assist the Commissioner, and consistency in provisions of accident and health insurance policies with requirements of the Society's proposal.

The Kansas Medical Society proposal noted the following problems concerning current utilization review operations: no mechanism to confirm the identity of persons requesting medical information on the telephone; inability to ensure confidentiality in review deliberations; inability to identify the individual who makes decisions concerning the reimbursement of a patient's care; and decisions which threaten patient safety, privacy, or quality care.

Opponents' arguments against the KMS proposal and earlier proposed legislation included the following: true peer review would not be ensured in the private sector; peer review organizations may be limited in their use of nurses for certain portions of the review; certain utilization reviews are very mechanical and do not require "substantial knowledge in medicine or the practice of the healing arts"; the lack of immunity from liability for those parties, including providers, who conduct reviews, as well as disclosure of their identities, would result in reduced participation in the review process; benefit and payment issues should be separated from necessity and quality of care issues, *e.g.*, payment determinations should not be part of the peer review process; the effectiveness of national voluntary accreditation efforts should be evaluated prior to considering development of statewide regulatory legislation; there is no problem with respect to reviews (Blue Cross and Blue Shield noted that after processing in excess of eight million claims in 1989, it had only one law suit relevant to a subscriber denial of benefits resulting from utilization review); changes to the utilization review procedures currently in effect at Blue Cross and Blue Shield, required by the Medical Society's proposal, could result in restrictions to or elimination of that insurance group's policy of reviewing claims for additional reimbursements due to special circumstances; and it would inflate the costs of the reimbursement system if physicians are compensated for time spent in complying with review agency requirements.

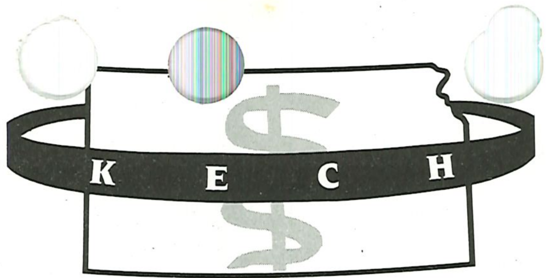
In other arguments against the Medical Society's proposal or 1990 S.B. 760, conferees noted that: certain large insurance groups, such as self-insurers and federal plans (Medicare, Medicaid, and CHAMPUS), would not be affected by the proposal; specific payment guidelines of insurance companies should not become part of the public domain; disclosure of proprietary information, such as the plan criteria and standards of a utilization review agency, will undercut the development of the utilization review industry; provisions in the proposal are aimed more at protecting the status quo in health care delivery and less at assuring quality; the proposal apparently

7-3

assumes that review criteria used by a health services review agency will cover all medical possibilities, which might be an erroneous assumption; the requirement that all adverse decisions on claims be evaluated and concurred with by certified health care providers would be costly; it is questionable whether utilization review, if defined as the practice of medicine, would withstand judicial scrutiny; and reimbursements to regional referral hospitals would not be equitable if the Medical Society's proposal, which requires a review of a health care provider's charges to be based upon charges of similarly situated health care providers providing health care services within the state or within a radius of 100 miles of the principal place of practice or operations of the provider under review were to take effect.

Committee Conclusions and Recommendations

The Special Committee on Public Health and Welfare recommends that no legislation be introduced at this time, but that the standing Public Health and Welfare committees, instead, monitor the progress made by the Utilization Review Accreditation Commission in developing standards to accredit utilization review firms. The Committee notes that, according to a representative of the Commission who spoke to the Committee, a full credentialing and accreditation process should be available for Commission Board approval in the first quarter of 1991. It is recommended that once the process has been approved, the standing Public Health and Welfare committees examine the standards and accreditation mechanism adopted. Finally, the Committee recommends that the standing committees continue to monitor the effectiveness of the standards and accreditation mechanism.



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Testimony to House Insurance Committee on
House Bill 2002
(regulating reimbursement for treatment mental conditions and substance abuse)
by James P. Schwartz Jr.
Consulting Director
January 30, 1991

I am Jim Schwartz, consulting director of the Kansas Employer Coalition on Health. The Coalition is 100 employers across Kansas who are concerned about the cost-effectiveness of group health insurance. Since 1983 we have sought ways to manage the spiraling cost of healthcare benefits for our 350,000 Kansas employees and dependents.

The Kansas Employer Coalition on Health has concerns about the utility and effects of HB 2002. It seems that the bill came out of interim committee discussions about the need for state mandates for health insurance coverage. There was a degree of interest in that committee for repealing mandates — or at least lessening their worst effects. HB 2002 seems, on the surface at least, to limit the financial risk from the mandate for inpatient psychiatric care. On close examination, though, it's unclear that the bill will have that effect. Every insurance policy worth its salt these days has a "medical necessity" clause. That clause says the insurer will not be responsible for payment for care that is determined to be medically unnecessary. So, in a sense, HB 2002 appears to apply a limitation that already exists.

On the other hand, the bill could be interpreted as overruling standard medical necessity clauses and creating an exemption for the first three days of treatment. If that's the case, the effect would be to *expand* the mandate, rather than limit it, as was the original intention.

A worse outcome, from our standpoint, would be that legislators, in passing this bill, might consider that they have dealt adequately with the onerous consequences of state mandates and thus see no need for more effective remedies.

In view of the unclear effects that HB 2002 could have on existing law and potential to achieve meaningful reform, the Kansas Employer Coalition on Health opposes the bill.

House Insurance
Jan 30, 1991

Attachment 4