Approved: Robert J Tomlinson
Date May 1, 1999

MINUTES OF THE HOUSE COMMITTEE ON INSURANCE.

The meeting was called to order by Chairperson Bob Tomlinson at 12:00 p.m. on April 30, 1999 in Room 526-S of the Capitol.

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| All members were present except: | All members present |
| Committee staff present: | Bob Wolff, Research<br>Ken Wilke, Revisor<br>Mary Best, Secretary |
| Conferees appearing before the committee: | Commissioner Sebelius, Kansas Insurance Department<br>Brad Smoot, Blue Cross/Blue Shield<br>John Federico, Humana Health Care Plans<br>Jerry Slaughter, Kansas Medical Society<br>Larrie Ann Brown, Kansas Association of Health Plans<br>William W. Sneed, Health Insurance Association of America<br>Michael C. Helbert, Kansas Trial Lawyers Association |
| Others attending: | See Attached Guest List |

Upon calling the meeting to order Chairman Tomlinson called for approval of the March Minutes, specifically, March 4, 9, 11, 16, 18 and 23. Rep. Grant moved to approve the minutes and Rep. Dreher. seconded the motion. Motion passed and the Minutes were adopted.

Chairman Tomlinson then proceeded to bring forth the Senate bill before the committee.

**SB 80: Health insurance; external review process**

Insurance Commissioner Kathleen Sebelius gave Proponent Testimony to the committee. A copy of the written testimony is (Attachment #1) attached hereto and incorporated into the Minutes by reference. The Commissioner gave an overview of the bill with its' causes and effects. The bill would allow medical experts to review and hopefully resolve complex medical complaints It was stated that the "risk of independent review makes health plans "more cautious about ensuring that decisions are well supported by clinical standards"... The Commissioner informed the committee that twenty-six states have already passed or have pending legislation that provides some type of independent review. The Commissioner has enclosed copies of the information for the committee to review.

While the Commissioner does not feel the government should micro-manage the marketplace and force areas to adopt one plan, she does feel Congress should provide and external grievance procedure for consumers enrolled in self-funded ERISA plans. She stated the state insurance departments have no jurisdiction over federal plans. Commissioner Sebelius feels the individual states should be given the flexibility to develop solutions to these problems, as the state involved is in the best position to determine what works best for their market place.

The Commissioner went on to explain that this bill would "define an adverse decision as a final decision from the health plan carrier that denies coverage of a service on the grounds that it is not medically necessary, or is experimental or investigational. It defines health insurance plan to include all health insurance carriers, not just HMO'S."

The amendment proposed by the Insurance Department would strike lines 27-33 on page 4, and insert new language which would read, "The decision of the external review organization may be reviewed by the District Court at the request of either the insured, insurer or health insurance plan. The review by the District Court shall be *de novo.* The decision of the external review organization shall not preclude the insured, insurer or health insurance plan from exercising other available remedies applicable under state or federal law. Seeking a review by the District Court or any other available remedies exercised by the insured, insurer or health insurance plan after the decision of the external review organization will not stay the external review organization's decision as to the payment or provision of services to be rendered during the pendency of the review by the insurer or health insurance plan. All material used in an external review and the decision of the external review organization as a result of the external review shall be deemed admissible in any subsequent litigation." The appeal and filing time was recommended to be changed from 180 days to 90 days.

The Commissioner then took questions from Rep. Boston

Mr. Brad Smoot, Blue Cross/Blue Shield, gave Proponent Testimony to the committee. A copy of the written testimony is (Attachment #2) attached hereto and incorporated into the Minutes by reference. Mr. Smoot stated his organization was in favor of the bill with language change to Page 2, line 41, deleting 180 day and inserting 90 days. They feel this is in the best interest of the patient and the insurer. They also request the "scope of review" language in Section 3(c) be modified. They offered an amendment which would rely on the terms of the insurance contract as those terms defined in the policy. "Without this change, insurers would conduct their internal reviews based on the terms of the insurance contract only to have the matter considered under a different standard spelled out in the statute." With this amendment reviewers would decide coverage based on the language of the policy agreed on by the parties in the insurance contract. Mr. Smoot stood for questions by the committee.

Questions were asked by Boston, Vining, Cox.

Mr. John Federico, Humana Health Care Plan, gave Testimony to the committee. A copy of the testimony is (Attachment #3) attached hereto and incorporated into the Minutes by reference. Mr. Federico stated his organization was in favor of the External Review concept.. They did, however, have concerns about the bill. They expressed their concern about the section of the bill which "requires all authorized External Review Organizations, approved by the Insurance Commissioner, to contract only with Kansas doctors.' They were also concerned about the "language allowing for *de novo* review of the ERO decisions." His organization will withhold an official position on the bill until after they review the changes being recommended. Mr. Federico stood for questions from the committee.

Questions were asked by Rep. Phelps, Kirk, Showalter, Cox.

Mr. Jerry Slaughter, Kansas Medical Society, gave Proponent Testimony to the committee. A copy of the written testimony is (Attachment #4) attached hereto and incorporated into the Minutes by reference. Mr. Slaughter. Mr. Slaughter felt the process should be "user-friendly." meaning "the process should be accessible, timely and not unnecessarily bureaucratic." They also felt it should be structured so the participation of physicians and other providers is encouraged and facilitated. It was stated it is quite possible that if the states enact their programs before the federal law is in place it may not preempt the local efforts. His organization supported the bill. Mr. slaughter stood for questions from the committee.

Questions were asked by Rep. Boston, McCreary.

Dr. Charles Wheelen, Kansas Psychiatric Society, offered oral Proponent Testimony only. He had offered written testimony to the Senate committee and wanted to reaffirm the necessity of the bill. There were no questions.

Ms. Larrie Ann Brown, Kansas Association of Health Plans, gave Proponent Testimony to the committee. A copy of the testimony is (Attachment #5) attached hereto and incorporated into the Minutes by reference. Ms. Brown supported the bill. There were no questions.

Mr. Bill Sneed, Health Insurance Associations of America gave Testimony to the committee. A copy of the written testimony is (Attachment #6) attached hereto and incorporated into the Minutes by reference. Mr. Sneed stated his organization was in support of the bill, but "opposed on general principle to state mandates within the highly competitive marketplace." They agreed with the proposed amendments to page 2, line 41 and page 4, ll.3-14, as proposed by the insurance department but were opposed to the language on page 1, ll. 34-36, and requested the language be deleted. They also addressed the amendment regarding the type of review by the external review organization which require payment of services even pending appeal, and respectfully requested the language be deleted. Mr. Sneed then stood for questions from the committee. There were no questions.

Mr. Michael Helbert, Kansas Trial Lawyers, gave Proponent Testimony to the committee. A copy of the testimony is (Attachment #7) attached hereto and incorporated into the Minutes by reference. They were in support of the bill and its language, which clearly states the consumers are not "bound" by the decisions of the ERO. The KTLA believes "that establishing HMO liability is the only way to insure that consumers are afforded a meaningful remedy when denied health care benefits." He quoted Dr. Ratcliffe Anderson, Jr., of the AMA who has stated "Patients' rights legislation should take the essential step of making health plans accountable for their negligent medical decision-making....." There were no questions from the committee.

Public hearings and discussions on the bill were closed.

Chairman Tomlinson addressed the committee in regard to the bill and that it could be placed on the consent calendar, when the question arose. **Rep Cox moved to adopt the amendment and the balloons offered by Commissioner Sebelius and Brad Smoot. The motion was seconded by Rep. Kirk. There was no discussion. Vote was taken and motion passed. Rep. Kirk moved to pass the bill out marked favorable as amended. Rep. Toelkes seconded the motion. There was no discussion. Vote taken and the motion passed.**

Meeting was adjourned 1:45 p.m.

# HOUSE INSURANCE COMMITTEE GUEST LIST

DATE: April 30, 1999

| NAME | REPRESENTING |
|---|---|
| David Hanson | Ks Insur Assns |
| Paul Davis | Kansas Insurance Dept |
| Maggie Keating | " " |
| Steve Montgomery | United HealthCare |
| Linda DeCoursey | Kansas Insurance Dept. |
| Kathleen Sebelius | " " |
| Anna Hardt | " " |
| Rick Tuetken | KALU |
| Pat Morris | KMA |
| Chip Wheelen | Ks Psychiatric Society |
| Bill Sneed | HCAA |
| Brad Smoot | BCBSKS |
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**Kathleen Sebelius**
Commissioner of Insurance
**Kansas Insurance Department**

TO: House Committee on Insurance

FROM: Kathleen Sebelius, Insurance Commissioner

RE: SB 80 – External Grievance Review Procedures

DATE: April 30, 1999

Mr. Chairman and members of the Committee:

Two years ago, a young man called my office with a health insurance complaint. He was a 21-year old college football player, who was gravely ill and his insurance company refused to pay for the treatment prescribed by his doctor.

The treatment was a unique type of chemotherapy and the insurance company ruled the procedure was experimental. This kind of chemotherapy is also very expensive. Fortunately, after a week of negotiating, we were able to convince the insurer to cover the costs of the treatment.

While we were successful in getting the insurance company to pay, this experience clearly demonstrated to me the need for a new process that would allow medical experts to resolve complex medical complaints very quickly.

I am not alone in my call for a better consumer protection process to deal with medical grievance complaints. The National Association of Insurance Commissioners has recommended that the original grievance model be amended to include external, independent level of review.

The Henry J. Kaiser Family Foundation conducted a study in November, 1998 of these independent review panels. Their finding was that external review procedures improved medical

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Consumer Assistance Hotline
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House Comm on Ins
Attachment #1
April 30, 1999 1-1

decision-making. The risk of an independent review makes health plans "more cautious about ensuring that decisions are well supported by clinical standards" and they are widely regarded as valuable and fair. The fact that the disposition of external review equally favored consumers and plans was cited as both an indication of the need for the process as well as evidence of its objectivity and credibility."

Twenty-six states have either passed legislation or have legislation pending that provides some type of independent review process. While each state's law varies, we are seeing that a mechanism to review disputes does add protection for the consumer. I've attached information on several states.

FEDERAL GOVERNMENT

Recently I testified before the U. S. Senate Labor Committee and urged members of Congress to support such consumer protections. I do believe Congress should provide external grievance procedures for consumers enrolled in self-funded ERISA plans. State insurance departments lack jurisdiction over these federal plans. I believe consumers within ERISA plans deserve the same type of protections available under state law.

I do not believe the federal government should micromanage the marketplace and force diverse regions and localities into a "one size fits all" approach. Rather, states should be given the flexibility to continue to develop innovative solutions to complex problems, including the development of independent external grievance procedures for health plans. The delivery of health care is a local activity and the State is in the best position to determine what works best in our marketplace.

HOW THE KANSAS PLAN WORKS

It is important to note that one of the most valuable services that state insurance departments perform is the handling of consumer complaints. The Kansas Insurance Department is dedicated to



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the fair resolution of questions and complaints from consumers about insurance. In 1998, we had a record year in that we obtained $10.3 million for consumers who couldn't resolve claims with their insurance companies. However, in some cases resolution may not happen, and may require expertise beyond the insurance department. I'm asking you to pass Sub. for SB 80, which establishes a process for providing medical experts to evaluate and resolve these tough issues.

Sub. for SB 80 defines an adverse decision as a final decision from the health plan carrier that denies coverage of a service on the grounds that it is not medically necessary, or is experimental or investigational. It defines health insurance plan to include all health insurance carriers, not just HMOs.

To access the external review process: (1) the insured must exhaust all the internal appeal levels provided by the health benefit plan, unless it is an emergency; or (2) the insured has not received a final decision from the insured within 60 days of their appeal.

When the health plan makes a final adverse decision, they must notify the insured of the opportunity to request an external review within a certain time period from the Kansas Insurance Department. The insured, or someone acting on the behalf of the insured, provides a written request for an external review, and a preliminary determination is made for appropriateness of the external review. The Commissioner then notifies the insured, or someone acting on behalf of the insured, and the insurer or health insurance plan that an external review will or will not be granted. The review process does not change the terms of the coverage in the contract.

The Commissioner contracts with external review organizations that have no interest in either party to perform the reviews. Qualified and credentialed health care providers, with specific expertise in the medical in the area to be reviewed, will conduct reviews. If an emergency condition exists, an expedited process is activated and a determination is rendered in less than seven days.



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3-11

The decision of the independent review organization must be completed in 30 days, and written notice provided to the insured and the Commissioner with the basis and rationale for its decision. Current language of the bill states that the plan is binding on the insurer for payment or provision of service, and that all parties have other remedies under state or federal law.

Sub. for SB 80 also provides for other areas such as: 1) data reporting to the Commissioner of the external review organization; 2) confidentiality of medical information to be maintained applicable to state and federal laws; and 3) protection in case of damages for individuals on the review organization or working on behalf of such organization in case..

AMENDMENT

Various groups interested in Sub. for SB 80 have worked very diligently in determining the appropriate language to include in this bill, and I certainly appreciate their efforts to make this bill work best for Kansas. In the spirit of compromise, I agreed to reduce the 180 days an insured has to request an external review to 90 days. I also support the changes being suggested on page four, lines 1 through 14, regarding the standard of review for the external review organization.

The amendment I am proposing strikes lines 27-33 on page 4, and the new language is contained in the attached balloon. It would make the insurance company or health insurance provide payment or provision of the services, if the decision is in favor of the insured. However, the decision of the external review organization may be reviewed directly by the District Court at the request of the insured, insurer or health insurance plan. The decision of the external review organization does not preclude all parties from exercising other available remedies applicable under state or federal law. And, all material used in the review and the decision is admissible in any subsequent litigation.



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I could not support any amendment that would add language to denote that nothing in this act shall be construed to create a new cause of action. I feel that language is not needed, and would create ambiguity.

CONCLUSION

I'm convinced that no issue is of greater concern to consumers or state regulators than the appropriate resolution of consumer complaints. It is critical to return decisions about medical treatment to medical professionals. An external grievance process provides an important safety net for health care consumers. I encourage you to pass this important consumer protection initiative and adopt Sub. for SB 80 with stated amendments to establish an independent external grievance procedure for Kansas.



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3-11

external review conducted pursuant to this act.
(g) The external review organization shall maintain confidentiality of the medical records of the insured in accordance to state and federal law.
Sec. 4. (a) ~~The decision of the external review organization shall be binding as to payment or provision of services on the health insurance plan or insurer, except to the extent the insured, insurer or health insurance plan has other remedies applicable under state or federal law. All material used in an external review and the decision of the external review organization as a result of the external review shall be deemed admissible in any subsequent litigation.~~
(b) In no event shall more than one external review be available during the same year for any request arising out of the same set of facts. An insured may not pursue, either concurrently or sequentially, an external review process under both a federal and state law. In the event external review processes are available pursuant to federal law and this act, the insured shall have the option of designating which external review process will be utilized.
(c) The commissioner of insurance is hereby authorized to negotiate and enter into contracts necessary to perform the duties required by this act.

"The decision of the external review organization may be reviewed directly by the District Court at the request of either the insured, insurer or health insurance plan. The review by the District Court shall be *de novo*. The decision of the external review organization shall not preclude the insured, insurer or health insurance plan from exercising other available remedies applicable under state or federal law. Seeking a review by the District Court or any other available remedies exercised by the insured, insurer or health insurance plan after the decision of the external review organization will not stay the external review organization's decision as to the payment or provision of services to be rendered during the pendency of the review by the insurer or health insurance plan. All material used in an external review and the decision of the external review organization as a result of the external review shall be deemed admissible in any subsequent litigation."



(d) The commissioner of insurance shall adopt rules and regulations necessary to carry out the purposes of this act. The rules and regulations shall ensure that the commissioner is able to provide for an effective and efficient external review of health care services.
Sec. 5. This act shall take effect and be in force from and after January 1, 2000, and its publication in the statute book.

# EXTERNAL REVIEW OF HEALTH PLAN DECISIONS: AN OVERVIEW OF KEY PROGRAM FEATURES IN THE STATES AND MEDICARE

**Prepared for the Henry J. Kaiser Family Foundation by:**

**Karen Pollitz, M.P.P.**

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**Institute for Health Care Research and Policy**

**Georgetown University**

**NOVEMBER 1998**

## TABLE 1. SUMMARY HIGHLIGHTS OF STATE AND MEDICARE EXTERNAL REVIEW PROGRAMS

| Program | Scope of External Review | Who Performs Reviews? | Review Binding? | Review Cost | Who Pays for Review? | Number of Covered Enrollees | Number and Disposition of Cases * | Program Effective Date |
|---|---|---|---|---|---|---|---|---|
| **AZ** | Medical necessity determinations | Insurance Department-approved IRO or individual physicians | Yes | Negotiated between health plans and reviewers | health plan | not available | not applicable | July 1998 |
| **CA** | Experimental and investigational therapies for terminally ill persons | Accredited IROs, which may also be academic health centers | Yes | Negotiated between health plans and reviewers | health plan | not available | not applicable | July 1998 (postponed) |
| **CT** | Medical necessity determinations | One of 3 contracting IROs | Yes | $ 285-$410 depending on contractor | state (with plan licensing fees)<br><br>consumer pays $25 filing fee | not available | 18 cases January - July 1998 (6 dismissed at preliminary. review, 12 to full review)<br><br>66% decided for consumer (of 9 cases decided; 3 reviews pending) | January 1998 |
| **FL** | Any consumer grievance not resolved by the plan | State employee panel, advised by outside physicians | Yes | $65/hour | state (with plan licensing fees) | 4.4 million (include 400,000 Medicaid enrollees) | 403 cases from 1993 through April 98 (100 cases settled prior to full review; 303 cases to full review)<br><br>60% decided for consumer (cases going to full review) | 1985 |

## TABLE 1. (continued) SUMMARY HIGHLIGHTS OF STATE AND MEDICARE EXTERNAL REVIEW PROGRAMS

| Program | Scope of External Review | Who Performs Reviews? | Review Binding? | Review Cost | Who Pays for Review? | Number of Covered Enrollees | Number and Disposition of Cases | Program Effective Date |
|---|---|---|---|---|---|---|---|---|
| **MI** | Any consumer grievance not resolved by the plan | Health Department-appointed task force | Yes | Nominal (volunteer reviewers paid expenses) | state | 1.8 million commercial and Medicaid HMO enrollees | 49 cases from 1995 through June 1998<br><br>39% of cases decided for consumer | 1978 |
| **MO**** | Medical necessity determinations (statutory process)<br><br>Informal regulatory process still applies to coverage issues and preexisting condition determinations | IRO contracting with state | Yes | $76/hour | state | 1.6 million managed care enrollees | 60 cases from 1994 through June 1998<br><br>50% of cases decided for consumer | 1994 |
| **NJ** | Medical necessity determinations | One of 2 IROs contracting with state | No | $330-$350 (depending on contractor) | health plan<br><br>consumer pays $25 filing fee, reduced to $2 for hardship | 3.5 million managed care enrollees | 69 cases from March 1997 through July 1998<br><br>42% of cases decided for consumer | March 1997 |
| **NM** | Medical necessity determinations | Insurance Department-appointed Independent Review Board | Yes | nominal (volunteer reviewers) | state | not available | 10 cases March 1997-March 1998 (8 dismissed after preliminary review; 2 to full review)<br><br>50 % of cases decided for consumer | March 1997 |

## TABLE 1. (continued) SUMMARY HIGHLIGHTS OF STATE AND MEDICARE EXTERNAL REVIEW PROGRAMS

| Program | Scope of External Review | Who Performs Reviews? | Review Binding? | Review Cost | Who Pays for Review | Number of Covered Enrollees | Number and Disposition of Cases | Program Effective Date |
|---|---|---|---|---|---|---|---|---|
| **OH** | Experimental and investigational therapies for terminally ill persons | Insurance Department-approved IROs, which may be academic health centers | Yes | negotiated between health plans and reviewers | health plan | 2.6 million HMO enrollees | Not applicable | October 1998 |
| **PA*** ** | Any consumer grievance not resolved by the plan | Committee of state regulatory staff, advised by outside physicians | No | $300 or less | state | 5 million | 729 cases from 1991 through June 1998; 185 cases in 1997<br><br>37% of cases decided for consumer | 1991 |
| **RI** | Emergency cases (prospective and retrospective) and prospective non-emergency medical necessity determinations | One of 2 IROs contracting with state | Yes | $250-$475 (depending on contractor) | plan pays half, consumer pays half | not available | 59 cases in 1997<br><br>68% of cases decided for consumer | 1997 |

## TABLE 1. (continued) SUMMARY HIGHLIGHTS OF STATE AND MEDICARE EXTERNAL REVIEW PROGRAMS

| Program | Scope of External Review | Who Performs Reviews? | Review Binding? | Review Cost | Who Pays for Review | Number of Covered Enrollees | Number and Disposition of Cases | Program Effective Date |
|---|---|---|---|---|---|---|---|---|
| **TX** | Medical necessity determinations | IRO contracting with state | Yes | $460-650 (depending on type of case) | health plan | 2.7 million enrollees | 218 cases from November 1997 to September 4,1998 (194 cases decided and 24 pending)<br><br>48% of cases decided for consumer (includes 11 partially overturned cases) | November 1997 |
| **VT****** | Medical necessity determinations in mental health and substance abuse claims | Insurance Department-appointed panel of providers | Yes | volunteer reviewers paid honoraria and expenses | State (with licensing fees) | 275,000 | 15 cases sent to independent panel (3 completed formal review; remainder were dismissed at preliminary review or plan paid for care prior to full review)<br><br>33% of cases decided for consumer | November 1996 |
| **Medicare** | Any disputed HMO denial not resolved by the plan | IRO contracting with Medicare | Yes | less than $300 per case | Medicare | 5.2 million | approximately 40,000 cases since 1989, 9025 cases in 1997<br><br>31.5% of cases decided for consumer | 1989 |

* Percentage applies to number of cases reaching full external review.

**Table includes information about both Missouri's current external review program, mandated by law, and prior program established by regulatory authority.

***Information in table pertains to Pennsylvania's existing external review program established by regulatory authority. A modified program with different features was enacted in 1998 and will take effect in 1999.

****Information in table pertains to program for Vermont's mental health and substance abuse claims. The state recently enacted a law expanding a somewhat different external review program for other types of health claims. It will take effect in 1999.

# BRAD SMOOT

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Statement of Brad Smoot, Legislative Counsel
Blue Cross Blue Shield of Kansas
To
House Insurance Committee
Regarding 1999 SB 80
April 30, 1999

Blue Cross Blue Shield of Kansas is a not for profit mutual life insurance company providing insurance benefits to 700,000 Kansans in 103 counties. We are pleased to endorse the concept of "external review" of health plan coverage decisions and 1999 Senate Bill 80, with some clarifying amendments.

As you know, a health plan or insurer has a written contract with each insured which describes in elaborate detail what medical products or services will be paid for under the contract. It is this promise by the insurer to pay which causes the insured to pay premiums each month. And both parties, the insurer and the insured, are equally entitled to rely on the terms of the written contract. It is important to remember that the contract does not direct how or when the insured will seek medical treatment nor how that care will be delivered. Those matters are between the provider and patient. The insurance contract concerns only when and how much will be paid for by the insurer or health plan.

And as with any written document, there may be some disagreement about the meaning of the terms. This potential for dispute arises whether the contract is an indemnity style health insurance policy or a managed care arrangement. For years federal law and industry practice has allowed for "internal reviews" of insurer decisions regarding payment for products or services. At BCBS our internal procedures allow for appeal to our CEO and even our Board of Directors, which is composed exclusively of our policyholders. Even with 700,000 policyholders, we have only a handful of appeals that reach the Board of Director level.

However, there appears to be considerable interest in having some independent party review the insurer's coverage decisions. An independent review would give insureds and insurers confidence that the correct decision has been made in each case and that they have been treated fairly. These are the true benefits of "external review."

We would urge the Legislature to make two changes in SB 80 as passed by the Senate. First, we would urge a reduction in the time to request external review from 180 days to 90 days. (Page 2, line 41, delete 180; insert 90.) While this is not a huge issue, it is in the best interests of the patient and the insurer to get the payment issue resolved as soon as possible. Delay certainly does not benefit the patient seeking treatment and

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insurers would be forced to reserve funds for an extended period for a procedure which may never be delivered. Contracts are renewed ever year. Policies sometimes change. Insureds change carriers. Over time, the situation gets more complicated; not less. Federal law requires internal reviews to be completed with 60 days. As now drafted, SB 80 could make the entire process last 9 months or more. Speeding the process only improves the result for all concerned.

In addition, we would urge that the "scope of review" language contained in Section 3(c) be modified. During Senate hearings and numerous discussions, all interested parties attempted to come up with language defining "medical necessity" and "experimental treatment." There was no consensus, in part because each insurer uses slightly different wording in defining these terms in their respective contracts. Our proposed amendment, attached, simply relies on the terms of the insurance contract as those terms are defined in the policy. Without this change, insurers would conduct their internal reviews based on the terms of the insurance contract only to have the matter considered under a different standard spelled out in the statute. In some instances, the terms of the policy would be more favorable to the insured than the language chosen by the Senate. With the amendment, the external reviewers would determine the coverage based on the language of the policy agreed to by the parties in the insurance contract. This amendment has met with approval from all interested parties including the Kansas Insurance Department and the Kansas Association of Health Plans.

We urge the Committee to amend the bill as proposed and recommend it for passage. Thank you for consideration of our views.

the insured and concurrently send a copy of such decision to the commissioner including the basis and rationale for its decision within 30 business days. ~~Each external review shall be based on clinical criteria which~~ are generally accepted, recognized and reasonable standards of practice by prudent physicians or other providers. The standard of review shall be whether the health care service denied by the insurer or health insurance plan was, under the insured's contract, medically necessary and clinically appropriate as to the type, frequency, extent, site and duration. In any external review regarding experimental or investigational treatment, the standard of review shall be whether the health care service denied by the insurer or health insurance plan is approved by the food and drug administration, is reimbursed by medicare and such experimental or investigational treatment has at least entered phase III trials of the national ~~institute of health.~~

(d) The external review organization shall provide expedited resolution when an emergency medical condition exists, and shall resolve all issues within seven business days.

(e) The external review organization shall maintain and report such data as may be required by the commissioner in order to assess the effectiveness of the external review process.

(f) No external review organization nor any individual working on behalf of such organization shall be liable in damages to any insured, health insurance plan or insurer for any opinion rendered as part of an external review conducted pursuant to this act.

(g) The external review organization shall maintain confidentiality of the medical records of the insured in accordance to state and federal law.

Sec. 4. (a) The decision of the external review organization shall be binding as to payment or provision of services on the health insurance plan or insurer, except to the extent the insured, insurer or health insurance plan has other remedies applicable under state or federal law. All material used in an external review and the decision of the external review organization as a result of the external review shall be deemed admissible in any subsequent litigation.

(b) In no event shall more than one external review be available during the same year for any request arising out of the same set of facts. An insured may not pursue, either concurrently or sequentially, an external review process under both a federal and state law. In the event external review processes are available pursuant to federal law and this act, the insured shall have the option of designating which external review process will be utilized.

(c) The commissioner of insurance is hereby authorized to negotiate and enter into contracts necessary to perform the duties required by this act.

The standard of review shall be whether the health care service denied by the insurer or health insurance plan was medically necessary under the terms of the insured's contract. In reviews regarding experimental or investigational treatment, the standard of review shall be whether the health care service denied by the insurer or health insurance plan was covered or excluded from coverage under the terms of the insured's contract.

KANSAS MEDICAL SOCIETY

April 30, 1999

***To:*** House Insurance Committee

***From:*** Jerry Slaughter
Executive Director

***Subject:*** **Substitute for SB 80; relating to the establishment of an external review process for health insurance coverage determinations**

The Kansas Medical Society appreciates the opportunity to appear today in support of Substitute for SB 80, which establishes a process whereby consumers can access independent reviews of the decisions made by insurers regarding their care.

One of the most contentious aspects of the current health insurance environment is the potential for an insurance company to make a care or coverage decision that appears to adversely affect an insured individual. Whether it has to do with experimental treatment options or a dispute over what is medically necessary care, the intersection of patient expectations and company care management decisions is difficult for all involved. The opportunity for both sides to submit such questions to an objective, qualified review process is good for patient care, and fair for all parties.

If enacted, the bill would create an independent, external review process available to patients who make a written request to the Insurance Commissioner for the external review after having exhausted the internal appeals procedures of their health plan. Medical necessity determinations, and questions of experimental or investigational therapies would be the kinds of issues that would qualify for external review. The Insurance Commissioner would contract with one or more external review organizations to do the reviews. A process for expedited reviews would be established for the consideration of emergencies.

From our standpoint, there are a couple of key considerations that are essential elements for the external review concept to work. First, the process must be user-friendly. In other words, the process should be accessible, timely and not unnecessarily bureaucratic. Second, it should be structured in such a way that the participation of physicians and other providers on the external review panels is encouraged and facilitated. Anything that subjects panel members to additional liability exposure, hassles or expense will discourage their participation, and make it very difficult for EROs to recruit qualified reviewers.

House Comm on Ins.
Attachment #4
April 30, 1999

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As you may know, Congress is currently considering several patient protection bills, most of which include a federally mandated and run external review process. It is quite possible that if states enact their own systems, the federal law may not preempt the local efforts. I think we all would prefer a state approach over a federally mandated and controlled review system.

We do support the bill as approved by the Senate. We believe this bill has the potential of providing a fair and expeditious mediation process that will benefit patients, and we hope improve relationships between health plans and those they insure. We urge your favorable consideration of the bill. Thank you.

# Kansas Association of Health Plans

**Testimony before the**
**House Insurance Committee**
**The Honorable Bob Tomlinson, Chairman**
**Hearings on Substitute for SB 80**
**April 30, 1999**

Good morning Chairman Tomlinson and members of the committee. Thank you for allowing me to appear before you today. I am Larrie Ann Brown, Executive Director of the Kansas Association of Health Plans (KAHP).

The KAHP is a nonprofit association dedicated to providing the public information on managed care health plans. Members of the KAHP are Kansas licensed health maintenance organizations, preferred provider organizations and others who support managed care. Members of the KAHP serve many of the Kansans who are insured by an HMO.

The KAHP appears here today in support of the concept of external grievance review for health plan members. An effective external review will increase consumer confidence in their health care and in the managed care industry.

The KAHP has been actively involved in efforts to craft effective legislation on this important issue. We have appreciated the opportunity to work with the Insurance Commissioner, the Kansas Medical Society and legislative leaders and have been pleased to give them the health plans' perspective.

Again, thank you for allowing the KAHP to appear here today. I will be happy to try to answer any questions that you have concerning this issue.

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April 30, 1999

# MEMORANDUM

TO: Representative Bob Tomlinson, Chairman
House Insurance Committee

FROM: William W. Sneed, Legislative Counsel
Health Insurance Association of America

DATE: April 30, 1999

RE: S.B. 80

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Mr. Chairman, Members of the Committee: I am Bill Sneed and I represent the Health Insurance Association of America ("HIAA"), which constitutes the majority of the commercial insurers writing health insurance in today's marketplace. We are pleased to offer these comments regarding S.B. 80.

Notwithstanding the fact that our Association is opposed on general principle to state mandates within the highly competitive insurance marketplace, we do rise in support of S.B. 80. After reviewing the bill that was passed by the Senate and the proposed amendments that were worked on by the interested parties, please accept the following comments.

We would agree with the proposed amendment that would reduce the time to request an external review from 180 to 90 days. This is found on page 2, line 41.

We would agree to the proposed amendment by Blue Cross/Blue Shield which reinstitutes the original language of S.B. 80 relative to the standard of review that the external review organizations will utilize. This is found on page 4, ll. 3-14.

We would argue that the language found on page 1, ll. 34-36, which in essence requires the external review entity to utilize Kansas doctors (unless none are available) greatly

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curtails the ability of external review organizations to effectively and efficiently process these reviews. Of the various external review statutes (at present time, well over 20 states), we are aware of only one state which utilizes such a narrow focus. We believe that consumers in the state would be more effectively served by deleting this language.

Finally, the amendment regarding the type of review on order by the external review organization requires payment of the services even pending appeal. We would argue that this may create confusion and could in essence negate any right of appeal from a practical point of view. We would argue that the Courts have the necessary tools to make a swift decision if an appeal is taken, and this would not be overly burdensome to the appealing party. Thus, we would respectfully request that that language be deleted from the proposed amendment.

Thank you very much for allowing us to present these comments, and if you have any questions, please feel free to contact me.

Respectfully submitted,

William W. Sneed

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**Senate Bill 80**
**Testimony Before the House Insurance Committee**

Good morning, my name is Michael C. Helbert and I am an attorney practicing in Emporia, Kansas. I appear here today on behalf of the Kansas Trial Lawyers Association in support of Senate Bill 80.

Senate Bill 80 was originally introduced by Commissioner Sebelius to create a "consumer friendly" process for health care consumers who are denied health care services from their HMO. We support the proposed legislation in its current form. Our major concern is to insure that the consumer will have the right to a meaningful judicial review. A goal of the HMO industry is to restrict the health care consumer's right to judicial review of decisions by HMO's or other health care insurers that deny them necessary health care services. KTLA supports current language in the bill which clearly states that consumers are not "bound" by the decisions of the external review organization and retain their individual right to judicial review. KTLA also wants to protect the integrity of the expedited process for consumers who have been denied coverage for treatment of life-threatening conditions.

We believe that the HMO industry may offer an amendment as follows:

"Nothing in this bill shall be construed to create a new cause of action.".

KTLA is opposed to such an amendment for the following reasons:

1. This industry language creates ambiguity and confusion in the bill and would

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likely foster litigation. Does it limit the consumer's right to use the external review process created by the act itself or to exercise their right to judicial remedies? We don't know. The impact of the industry language is unknown.

2. Consumers should not be penalized for using the external review process. If the legislation creating that process limits consumer's legal rights in any way they would, in fact, be penalized.

3. There is no hidden agenda in this bill. The stated purpose of the bill is to create a new consumer friendly process to resolve disputes between health care consumers and their HMO or health insurance carrier.

4. The industry language appear to be in direct conflict with the existing language in the bill which clearly states consumers and health insurance companies have the right to exercise their available remedies under state and federal law.

5. What new cause of action is the industry worried about?

6. Is the industry trying to prevent Kansas consumers from taking advantage of any HMO liability remedy that might be passed by the federal government or created in case law?

After lengthy discussions and debate, it appears that Senate Bill 80 in its present form is a bill that will provide an avenue to consumers who have been denied health benefits by an HMO. KTLA fervently believes that establishing HMO liability is the only way to insure that consumers are afforded a meaningful remedy when denied health care benefits.

As Dr. Ratcliffe Anderson, Jr., M.D. on behalf of the AMA has stated "Patients' rights legislation should take the essential step of making health plans accountable for their negligent

medical decision-making. Current interpretation of ERISA law immunize employer-sponsored health plans from state-based liability claims by injured patients. Any proposed legislation should remove that insulation, and make those health plans that make medical decisions accountable for those decisions. This remains an issue of fundamental fairness. Americans covered by ERISA plans should have the same right of redress as those who are covered by non-ERISA plans. Permitting plans to escape liability for negligence due to legal loopholes places patients in serious jeopardy. The AMA does not intend to increase employer liability, as it is generally health plans, not employers, that are making unfair "medical necessity" decisions.

In addition, it is critical that any new legislation affecting ERISA fully preserve the application of positive case law precedent that has included holding health plans accountable under state law for the quality of benefits and the adequacy of the health plant network.[1]

We hope that this committee remembers that external grievance procedures are not a substitute for HMO liability. We also hope that this bill is just the first step in providing a comprehensive plan for the protection of medical consumers in this state.