Approved: _____
Date

MINUTES OF THE SENATE COMMITTEE ON FINANCIAL INSTITUTIONS AND INSURANCE .

The meeting was called to order by Chairperson Senator Don Steffes at 9:00 a.m. on April 7, 1999, in Room 529 S of the Capitol.

All members were present except: Senator Paul Feleciano, Excused

Committee staff present: Dr. Bill Wolff, Research
Ken Wilke, Office of Revisor
Nikki Feuerborn, Committee Secretary

Conferees appearing before the committee: Kathleen Sebelius, Insurance Commissioner

Others attending: See Attached

Discussion and Action on SB 80 - External Review

Commissioner Sebelius presented the Committee with a substitute bill which contains the language agreed to thus far by the Department and the industry, as well as several balloon amendments prepared by the Department (Attachment 1). She stated the goal of the bill was to establish the final step in the process of consumers negotiating with their health plan. Although the Department is not particularly in favor of setting a timetable for notifying the Commissioner of adverse decisions, a 180 day time frame would be acceptable. The 180 day time period would begin 30 days after medical records are received. This will be detailed through Rules and Regulations rather than statutorily. The Insurance Department is viewed as a pass-through agency and would screen criteria for requesting external review only. They neither make any recommendations nor decisions in the external review process. Although the bill contains language which prohibits the insured from using both state and federal external review processes simultaneously, external review does not yet exist on the federal level. It is anticipated that such a process will be put in place within the year. There will probably be fewer than ten requests per year for external review in Kansas.

Suggested amendments by the Committee were:

1. Change from 90 to 180 the number of days an insured, treating physician or health care provider acting on behalf of the insured, or a legally authorized designee has to notify the Insurance Commissioner of an adverse decision by a health insurance plan or an insurer to request an external review.

2. Add the insured to those persons receiving a written decision from the external review organization.

3. Delete the language regarding liability for damages "unless the opinion was rendered in bad faith or involved gross negligence."

Senator Biggs moved to report the bill favorably as amended. Motion was seconded by Senator Corbin. Motion carried.

Senator Biggs moved that the minutes of March 24 and 31, 1999, be approved. Motion was seconded by Senator Becker. Motion carried.

The meeting was adjourned at 10:00 a.m.

SENATE FINANCIAL INSTITUTIONS AND INSURANCE COMMITTEE
GUEST LIST

DATE: 4/7/99

NAME	REPRESENTING
Bill Sneed	HIAA
Lee WRIGHT	Farmers Ins.
PAT MORRIS	K.A.I.A.
[illegible]	KMS
Brad Smoot	BCBS
Lisa Manley	KFMC
Stacey Soldan	Columbia / HCA
[illegible]	KCA
Maggie Keating	KS Ins. Dept.
Paul Davis	" "
Linda De Coursey	" "
Kathleen Sebelius	" "
John Peterson	Kaiser Permanente

Application (WordPerfect; "WordPerfect"; Default!; "EN")
FontSize (FontSize: 13.98p)
AttributeAppearanceToggle (Attrib: Bold!)
Justification (Justification: Center!)
HardReturn ()

Session of 1999

Sub for SENATE BILL No. 80
By Committee on Financial Institutions and Insurance
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AN ACT relating to accident and health insurance; concerning an external review process; providing certain requirements.

Be it enacted by the Legislature of the State of Kansas:

Section 1. (a) For purposes of this act:

(1) ``Adverse decision'' means a utilization review determination by a third-party administrator, a health insurance plan, an insurer, or a health care provider acting on behalf of an insured that a proposed or delivered health care service which would otherwise be covered under an insured's contract is not or was not medically necessary or the health care treatment has been determined to be experimental or investigational and, (a) if the requested service is provided in a manner that leaves the insured with a financial obligation to the provider or providers of such services,

22 or (b) the adverse decision is the reason for the insured not receiving the requested services.

23 (2) ``Health insurance plan'' means any hospital or medical expense

24 policy, health, hospital or medical service corporation contract, and a plan

25 provided by a municipal group-funded pool, or a health maintenance

26 organization contract offered by an employer or any certificate issued

27 under any such policies, contracts or plans. ~~Health insurance plan does~~

~~28 not include policies or certificates covering any specified disease, specified~~

~~29 accident or accident only coverage, credit, dental, disability income,~~

~~30 hospital indemnity, long-term care insurance as defined by K.S.A. 40-2227~~

~~31 and amendments thereto, vision care or any other limited supplemental~~

~~32 benefit nor to any medicare supplement policy of insurance as defined by~~

~~33 the commissioner of insurance by rule and regulation, any coverage issued~~

~~34 as a supplement to liability insurance, workers' compensation or similar~~

~~35 insurance, automobile medical-payment insurance or any insurance under~~

~~36 which benefits are payable with or without regard to fault, whether written~~

~~37 on a group, blanket, or individual basis.~~

38 (3) "Insurer" means any health insurance company, fraternal benefit society,

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39 health maintenance organization, nonprofit hospital and medical service

40 corporation, provider sponsored organizations, municipal group funded pool,

41 and the self-funded coverage established by the state of Kansas for its employees.

42 (4) "Insured" means the beneficiary of any health insurance company, fraternal

43 benefit society, health maintenance organization, nonprofit hospital

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1 and medical service corporation, municipal group funded pool, and the

2 self-funded coverage established by the state of Kansas, or any hospital or medical expense,

3 health, hospital or medical service corporation contract, or a plan

4 provided by a municipal group-funded pool.

5 (5) "External review organization" means an entity that conducts

6 independent external reviews of adverse decisions pursuant to a

7 contract with the commissioner. Such entity shall have experience

8 serving as the external quality review organization in health programs

9 administered by the state of Kansas, or be a nationally accredited

10 external review organization which utilizes health care providers

11 actively engaged in the practice of their profession in the state of Kansas

who are qualified and credentialed with respect to the health care service review. In the event no Kansas providers are qualified and credentialed with respect to the review of any case, the external review organization shall have the discretion to employ health care providers who actively engage in their practice outside the state of Kansas.

(6) "Emergency medical condition" means the sudden, and at the time, unexpected onset of a health condition that requires immediate medical attention, where failure to provide medical attention would result in a serious impairment to bodily functions, or serious dysfunction of a bodily organ or part, or would place a person's health in serious jeopardy.

Sec. 2

~~(a)~~ *(b)* The right to review under this act shall not be construed to change the terms of coverage under a health insurance plan or insurance policy.

~~(b)~~ *(c)* The insurer or health insurance plan shall provide written notice to the insured of a final adverse decision and the opportunity for requesting an external review.

~~(c)~~ *(d)* The insured has the right to request an independent external review of

(a) The provisions of this act shall not apply to any policy or certificate which provides coverage for any specified disease, specified accident or accident only coverage, credit, dental, disability income, hospital indemnity, long-term care insurance as defined by K.S.A. 40-227 and amendments thereto, vision care or any other limited supplemental benefit nor to any medicare supplement policy of insurance as defined by the commissioner of insurance by rule and regulation, ***coverage under a plan through Medicare, Medicaid, or the federal employees health benefits program,*** *any coverage issued as a supplement to liability insurance, workers' compensation or similar insurance, automobile medical-payment insurance or any insurance under which benefits are payable with or without regard to fault, whether written on a group, blanket, or individual basis.*

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an adverse decision by a health insurance plan or insurer when: (1) The insured has exhausted all available internal review procedures provided by the health insurance plan or insurer, unless the insured has a emergency medical condition, in which case an ~~expedited~~ procedure is used; or (2) The the insured has not received a final decision from the insurer within 60 days of seeking the internal review, except to the extent that the delay was requested by the insured.

~~(d)~~ *(e)* ~~The external review shall be requested~~ in writing to the commissioner from the following persons: (i) the insured, or (ii) the treating physician or health care provider acting on behalf of the insured with written authorization from the insured, or (iii) legally authorized designee.

Within 90 days of receipt of an adverse decision by a health insurance plan or an insurer, any request for external review shall be made

~~(e)~~ *(f)* The insured shall provide all information in the possession of the insured pertaining to the adverse decision in order for the commissioner to make a preliminary determination for an external review. The insured shall also provide the commissioner with an appeal form, and a fully executed release for the commissioner and the external review organization to obtain any necessary medical records ~~form~~ *from* the insurer or health insurance plan and

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any other relevant provider.

~~(f)~~ *(g)* In responding to the commissioner, the insurer or health insurance plan shall provide a copy of the adverse decision given to the insured and all medical and other records pertaining to the insured's claim within 5 business days of the request of the commissioner.

~~(g)~~ *(h)* The confidentiality of any medical information submitted by insured, on behalf of the insured, insurer, or health insurance plan, shall be maintained pursuant to applicable state and federal laws.

Sec. 3. (a) The commissioner shall:

(1) Negotiate contracts with external review organizations which are eligible to conduct independent review of the adverse decision by a health insurance plan or insurer.

(a) The external review organization as defined in Section 1(a) (5) of this act shall provide that all reviews completed pursuant to this act are conducted by qualified and credentialed health care providers with respect to the health care service under review and who have no conflict of interest relating to the

performance of their duties in this act.

~~(b) The reviews shall be completed in accordance with standards of decision-making based on clinical review criteria and shall resolve all issues within 30 business days. The external review organization shall issue a written decision to the commissioner including the basis and rationale for the decision. The standard of review shall be whether the health care service denied by the insurer or health insurance plan was medically necessary and appropriate under the insured's contract. In reviews regarding experimental or investigational treatment, the external review organization shall state reasons that the requested treatment should or should not be provided by the health insurance plan or insurer, based on the insured's medical condition.~~

The external review organization shall issue a written decision to the commissioner including the basis and rationale for its decision within 30 business days. The reviews shall be based on clinical criteria which are generally accepted and recognized 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 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 approved by the Food and Drug Administration, is reimbursed by Medicare, and it has at least entered phase III trials of the National Institute of Health.

(c) The external review organization shall provide expedited resolution when an emergency medical condition exists, and shall resolve all issues within 7 business days.

(d) 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.

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(e) No external review organization nor any individual working on behalf of such organization shall be liable in damages to any insured for any opinion rendered as part of ~~the~~ an external review conducted pursuant to this act.

, health insurance plan, or insurer

, unless the opinion was rendered in bad faith or involved gross negligence

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

(2) Allow the insurer or the health insurance plan, an insured or treating physician or health care provider acting on behalf of the insured, or legally authorized designee filing a request for external review to provide additional written information as may be relevant for the commissioner to make a final decision on whether the request qualifies for external review.

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(3) Make a decision on a request for external review within 10 business days after receiving all necessary information.

(4) Notify the insured and treating physician or health care provider acting on behalf of the insured, or legally authorized designee, and insurer or health insurance plan in writing that a request for external review will or will not be granted.

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(5) Design and implement an expedited procedure for use in an emergency medical condition for purposes of the external review organization rendering a decision.

Sec. 4. (a) The decision of the external review organization shall be:

~~(1)~~ binding as to payment or provision of services on the health insurance plan or insurer, ~~and (2) except as to (1), the external review organization decision is binding~~ *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 external review shall be deemed admissible in any subsequent litigation.

(b) 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.

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.

(c) The commissioner of insurance is hereby authorized to negotiate and enter into contracts necessary to perform the duties required by this act. The rules and regulation shall ensure that the commissioner is able to provide for an effective and efficient external review of health care services.

(d) The commissioner of insurance shall adopt rules and regulations necessary to carry out the purposes of this act.

Sec. 5. This act shall take effect and be in force from and after January 1, 2000, and its publication in the statute book.