Approved: 3-1-06
Date

MINUTES OF THE SENATE FINANCIAL INSTITUTIONS AND INSURANCE COMMITTEE

The meeting was called to order by Chairman Ruth Teichman at 9:30 A.M. on February 16, 2006 in Room 234-N of the Capitol.

All members were present.

Committee staff present:
Melissa Calderwood, Kansas Legislative Research Department
Terri Weber, Kansas Legislative Research Department
Ken Wilke, Office of Revisor of Statutes
Bev Beam, Committee Secretary

Conferees appearing before the committee:
Commissioner Sandy Praeger
Gary Sherrer
Matt All, Governor's Office
Senator Barbara Allen
Terri Roberts, Kansas State Nurses Assn.
Sky Westerlund, Kansas Chapter Nat'l. Assn. Of Social Workers
Larrie Ann Lower, Kansas Assn. Of Health Plans
Bill Sneed, America's Health Insurance Plan
Jerry Slaughter, Kansas Medical Society

Others attending:
See attached list.

The Chair welcomed everyone to the meeting and asked Melissa Calderwood for an overview of **(SB 522) concerning health insurance; providing the insured certain appeal rights regarding adverse health care decisions.**

Ms. Calderwood said (**SB 522**) would enact new law to provide the insured with certain appeal rights for adverse health care decisions made through a utilization review process. Specifically, the bill would require an insurer, as part of its insurance plan, to provide to each insured a copy of the insurer's process for utilization review. If the health insurer uses the utilization review organization, its insured is to be notified of the name of that organization. If the health insurance plan or process for utilization review contains a provision for two levels of appeal or internal review for the adverse health care decision, that plan would be required to provide written notice to the insured that the insured may voluntarily waive the insured's right to second appeal or internal review.

Additionally, if an insured waives the right to the second appeal or internal review, the insurer's health insurance plan will waive its right to assert that the insured has failed to exhaust administrative remedies because the insured did not elect to submit review of a health care decision which is adverse to the insured to the second appeal or internal review provided by the insurer's health insurance plan and give notice to the insured of the insured's right to external review.

She said the bill also states that if an insured elects to request the second appeal or internal review of a health care decision which is adverse to the insured, the insured shall have the right to appear in person before designated representatives of the insurer's health insurance plan or utilization review organization at the second appeal or internal review meeting. The designated representatives who will be deciding the appeal or internal review shall be present and participate in person, by telephone or by other electronic means.

She continued that upon receipt of a request from the insured for the second appeal or internal review meeting, the insurer's health insurance plan or utilization review organization shall send notice to the insured of the insured's right to request, within five working days, the opportunity to appear in person before an appeal or internal review panel of the insurer's health insurance plan's or utilization review organization's designated representatives.

Finally, the insurer's health insurance plan or utilization review organization shall provide the insured in writing a decision setting forth the relevant facts and conclusions supporting its decision.

The Chair called on Commissioner Sandy Praeger for her testimony in support of (**SB 522**). Commissioner Praeger said it is important for insureds to receive coverage for the medical care they need when they need it so long as the care is within the scope of their health insurance contract. She said this bill can expedite the appeal process for the insured when they challenge an insurance company's original ruling. In addition, she said it is important to allow the consumer to have legal representation present throughout the appeal process, if they so desire. She added that it is important to note that this bill does not say that health insurance companies cannot have a secondary internal appeal process. It provides the consumer yet another opportunity for their case to be heard and prevail, she said. This bill does say if a consumer voluntarily wants to forego their right to a secondary appeal, they can. (Attachment 1)

The Chair called on Gary Sherrer for his testimony. Mr. Sherrer gave testimony from a personal experience he had with his insurance carrier. He said that while the issue is personal to him because of his wife's health issues, he feels strongly that this bill is needed public policy. The issue is, he said, should Kansans have protection by statute of some fundamental rights in the health insurance appeal process. Mr. Sherrer said every Kansan, regardless of the company they do business with, should be protected with a guarantee of these basic rights. The health insurance industry does not operate in a pure free market environment, he said. Government regulation is appropriate and necessary.

Mr. Sherrer said he was asking the committee to ensure that if their constituents are ever part of an appeal process, they will have the right to waive it; the right to be given a reasonable amount of time to make their case; the right to ask and receive answers to relevant questions; the right to have those who are going to vote hear their appeal; the right to see all the records relevant to the appeal; the right to be represented by an attorney or person of their choosing; an the right at their own expense to record the proceeding. (Attachment 2)

The Chair called on Matt All, Chief Counsel to the Governor. Mr. All testified that of all the things Commissioner Sebelius accomplished when she was Insurance Commissioner, perhaps the most important was her work to enhance the rights and protections of Kansas consumers, particularly in health insurance. Mr. All said (**SB 522**) is another important step in protecting Kansas consumers. It would provide important safeguards for consumers facing a denial of health coverage. It would require health insurers to provide information about their internal review and appeal process, and would make the procedures for these appeals more fair and more sensible for consumers. (Attachment 3)

The Chair called on Senator Barbara Allen for her testimony. Senator Allen relinquished her time to hear other testimony. (Attachment 4)

Next to testify was Sky Westerlund, Executive Director of the Kansas Chapter, National Association of Social Workers. Ms. Westerlund said SB 522 is for the consumer of health and mental health care. It outlines, by statute, what the insurance industry must do when they reject a need for benefits and the insured person requests to appeal the decision. Persons who pay premiums and believe that their health and mental health care needs will be paid for through their insurance coverage can experience an unsettling situation when the insurance company rejects their request for a benefit. She said this is anguishing for all consumers.

Ms. Westerlund said KNASW supports (**SB522**) because it offers a specific process to help the consumer when that person must appeal a decision made by the insurance carrier to reject a benefit. It assures a streamlined and clear appeals process when fighting for benefits. It creates a uniform appeals process for all insurance carriers to follow and it will create necessary oversight of this aspect of insurance industry service to consumers. (Attachment 5)

The Chair called on Larrie Ann Lower, Executive Director of the Kansas Association of Health Plans. Ms. Lower testified that the Kansas Association of Health Plans is supportive of granting an insured the ability to waive a second level of review within the health insurance companies internal review process of claims decisions. However, from an insured's standpoint, many times that second level of internal review is decided to the benefit of the insured, she said.

Ms. Lower stated that it is the opinion of the Kansas Association of Health Plans that six of the sections need to be clarified. She said her association asks that the committee allow them the opportunity to continue to working to determine language that can be agreed to. (Attachment 6)

The Chair called on Bill Sneed, Legislative Counsel to America's Health Insurance Plans. Mr. Sneed said America's Health Insurance Plans supports passage of (**SB 522**) but requests the Committee consider some amendments to the bill. Mr. Sneed said he looks forward to working with the proponents of this bill in an effort to craft a well-balanced piece of legislation that will protect the rights of individuals, and at the same time, allow for a process that will work effectively and inexpensively, as compared to direct external review and/or litigation. Mr. Sneed requested that the Committee consider the amendments as mentioned in his testimony. (Attachment 7)

Jerry Slaughter, Executive Director, Kansas Medical Society, also testified in support of (**SB 522**). Mr. Slaughter said (**SB 522**) would establish certain appeal rights for individuals when contesting adverse decisions made by health insurers. He said under current law, an individual who contests an adverse decision made by a health plan on whether a certain service should be covered must first exhaust all the internal review procedures of the health plan before appealing the decision to the external review process afforded them. Health insurers must have an internal review process in place, but Kansas law does not prescribe what that process must entail. Because the law isn't specific about requirements for internal review, it can vary considerably from insurer to insurer. It can be simple and straight forward, to quite complex for individuals to navigate. (**SB 522**) provides that when a health insurer has a two-level review or appeal process, an individual may waive the right to a second appeal, and go directly to external review.

Mr. Slaughter stated further that the bill provides in the event an individual elects to request a second-level appeal, the individual has the right to appear in person, the right to be represented by counsel, the right to receive and review all relevant documents, and the right to record the proceedings of the second-level appeal. He said the Kansas Medical Society supports these changes in law. He continued that without question, appeals of health insurers' adverse coverage decisions have immense implications for individuals and families. Because so much is at stake in these matters, it makes sense to do everything we can to make sure the process is fair, timely and transparent, he said. The changes contained in (**SB 522**) will not prevent an insurer from making coverage decisions based on their own medical necessity guidelines. It will, however, allow an individual the right to access the external review process earlier in certain cases. It also provides individuals with a greater opportunity to participate in and understand an insurer's internal review process, which has such a key role in coverage determinations. We believe the proposed changes are reasonable, and we urge support of this bill, he said. (Attachment 8)

The meeting adjourned at 10:30 a.m. The next meeting of this Committee is scheduled for February 20, 2006.

FINANCIAL INSTITUTIONS & INSURANCE COMMITTEE GUEST LIST
DATE: February 16, 2006

NAME	REPRESENTING
Jeannie Goodwin	City of Wichita
Steve Westerlund	KNASW
Bill Sneed	AHIP
Doug Wareham	Kansas Bankers Assn.
Andrew Couch	Federico Consulting
Steve Montgomery	United Healthcare
Alex Kotoyantz	PIA
Brad Smoot	FCBS
[illegible]	KWA
Gary Sherrer	Self
Lindsey Douglas	Hein Law Firm
Beth Jones	Hatfield Govt Relations
[illegible]	KAHP
[illegible]	KID
Sandy Praeger	KS Ins Commissioner

Kansas Insurance Department

Sandy Praeger COMMISSIONER OF INSURANCE

COMMENTS
ON

SB 522—PROVIDING AN INSURED CERTAIN APPEAL RIGHTS

SENATE FINANCIAL INSTITUTIONS AND INSURANCE
February 16, 2006

Madam Chair and Members of the Committee:

Thank you for the opportunity to speak with you on behalf of the Kansas Insurance Department. I am here today to support SB 522. I believe it is important for insureds to receive coverage for the medical care they need when they need it, so long as the care is within the scope of their health insurance contract.

This bill can expedite the appeal process for the insured when they challenge an insurance company's original ruling. In addition I believe it is important to allow the consumer to have legal representation present throughout the appeal process if they so desire.

However, it is important to note that this bill does not say that health insurance companies cannot have a secondary internal appeal process. In fact I believe it is important for the secondary appeal process to continue to be offered. It provides the consumer yet another opportunity for their case to be heard and prevail. What this bill does say, is if a consumer voluntarily wants to forego their right to a secondary appeal, they can.

Madam Chair, I support SB 522 and I urge this committee to recommend it favorable for passage. Thank you again for the opportunity to address the committee today and I would be happy to stand for any questions.

Sandy Praeger
Commissioner of Insurance

Senate FI&I Committee
Attachment 1-1
February 16, 2006

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Senate Committee on Financial Institutions and Insurance

Testimony of Gary Sherrer

Senate Bill 522

February 16, 2006

Senate FI&I Committee
Attachment 2-1
February 16, 2006

Thank you for the opportunity to speak in support of Senate Bill 522. I appear here today as a private citizen representing no group or organization but supporting legislation that will touch the lives of thousands of Kansans. Senate Bill 522 is nothing less than a "Bill of Rights" for Kansans who are subjected to the appeals process of health insurance companies.

First let me provide you some background on how I discovered there is no protection of basic consumer rights in the health insurance appeals process. In July of last year my wife Judy was diagnosed with a rare and very aggressive form of lymphoma. Only one to two percent of lymphoma patients develop this form of the disease. Long term prognosis is not good and the treatment is aggressive chemotherapy followed by a stem cell transplant. The transplant procedure is one in which a persons stem cells are "harvested" from their blood, stored, then following high dose chemotherapy are replaced. This can only be done when the cancer is in remission and thus timing is critical. One of the Doctors Coventry Health Insurance of Kansa, Inc. used in the appeals evaluation noted that a stem cell transplant can double the survival chances of a patient with my wife's diagnosis.

In August of 2005 our health insurance company, Coventry Health Insurance of Kansas, Inc., authorized Evaluation Procedures for an "Autologous Peripheral Stem Cell Transplant" and in their letter of August 15 noted "Autologous Peripheral Stem Cell Transplants are covered when prior-authorized and obtained at a facility as determined by us." My wife met the requirements of the evaluation procedures and her Doctors requested coverage for the transplant itself. Coventry denied the coverage. Our Doctors appealed and the first level appeal was denied. We were told we could have a second level appeal at which time we could appear before the review group. Because time was important we asked to waive the second appeal and go directly to the state process of appeal. We knew that the Coventry staff were not going to vote in our favor. They had not at level one (two independent Doctors

said yes, two said no and Coventry broke the tie.) and we were confident they would protect the company's money on round two. As you can see in the letter dated October 4, 2005 they denied our right to waive the second appeal. At one point they even wrote to deny an expedited appeal, but after many phone calls they relented on this issue.

What was most troubling was the hearing itself. Note in the letter of November 8, 2005 setting the "rules" for the hearing that they decided I could have 15 minutes to advocate a life saving procedure for my wife of 40 years. No recording of the hearing would be made. I could not have an attorney unless they and the Committee said so. (Yet their attorney was on the conference call during the entire appeal hearing.) At the hearing when I asked a question I was told that there were to be no questions from me and that I was just to make my presentation. In the letter to their Medical Director I asked questions so I could prepare for the hearing. He refused to answer them. Then at the hearing when I asked questions I was told I could not. To this day my questions have never been answered. There were to be five people voting on this appeal. Three Doctors, none of whom were at the meeting or on the conference call, a medical director from the Coventry of Tennessee who was on a conference call, and a gentleman who was identified as a Coventry policy holder who was present in the room. After my 15 minute presentation no questions were asked of me and the appeal hearing concluded. We finally were able to utilize the state appeal process which was handled extremely well by the Kansas Insurance Department We did receive an adverse ruling. While we disagree with it, as do our Doctors, we accept it and are prepared to pay for the treatment which will cost between $75,000 and $100,000. Unfortunately during the delays my wife had to go through additional chemotherapy which I believe has contributed to her inability to produce enough stem cells for harvesting. She has been accepted into a clinical trial for a new drug that may help.

While this issue is personal to me because of Judy I am here today as someone who has spent time in the development of public policy and strongly believes this bill is needed public policy. The issue is should Kansans have protection by statue of some fundamental rights in the health insurance appeal process. Let me make it clear that I am not making a judgment on other health insurance companies and how they handle the appeal process. I am sure it varies from company to company. That is just the point—it should not vary. Every Kansan, regardless of the company they do business with should be protected with a guarantee of these basic rights. The health insurance industry does not operate in a pure free market environment. I doubt there are many in this room that had a say in what plan they would be covered by. Government regulation is appropriate and necessary.

I am asking you to ensure that if your constituents are ever part of an appeal process they will have the right to waive it; the right to be given a reasonable amount of time to make their case; the right to ask and receive answers to relevant questions; the right to have those who are going to vote hear their appeal; the right to see all the records relevant to the appeal; the right to be represented by an attorney or person of their choosing; the and the right at their own expense to record the proceeding.

There is nothing unreasonable about the granting of these rights. Members of the committee we are not talking about protection of insurance companies. We are talking about protecting Kansans who are dealing in life and death matters. Kansas who will find themselves unable to pay for treatment their Doctor prescribes for them or their loved ones. Catastrophic illness has an impact on the patient and their family that cannot be put into words. To compound that by putting them at the mercy of the health insurance companies during the appeals process is inexcusable. Please support a consumer "Bill of Rights", please support Senate Bill 522.

THANK YOU

COVENTRY
Health Care of Kansas, Inc.
With you when it matters.™

October 4, 2005

Kansas City Cancer Center
Attn: Sunil Abhyankar, M.D.
4320 Wornall Road, Suite 220
Kansas City, MO 64111

Member: Judith Sherrer
Member #: 901130885*02
Issue: Autologous Stem Cell Transplant

Dear Dr. Abhyankar:

This letter is in response to your first level appeal requesting authorization for an autologous stem cell transplant for the above listed member.

After careful review of all available information and the member's plan benefits, the First Level Appeal Committee, including independent review by three (3) physicians board-certified in Hematology and Oncology has made the determination to uphold the Plan's original denial. The Committee's decision was based on the following:

According to the member's Coventry Health Care of Kansas, Inc. POS Evidence of Coverage as purchased the employer, Bank of Blue Valley, Section 6, states the following items are excluded from Coverage:

"Procedures and treatments that the Plan determines and defines to be Experimental or Investigational;"

Section 1.44 of the member's POS Evidence of Coverage states:

"A health product or service is deemed Experimental or Investigational if one or more of the following conditions are met:

• Any drug not approved for use by the Federal Food and Drug Administration ("FDA"); any drug that is classified as an Investigational New Drug ("IND") by the FDA; any drug that is proposed for off-label prescribing. As used herein, off-label prescribing means prescribing prescription drugs for treatments other than those stated in the labeling approved by the FDA.

• For Kansas-based Employer Groups, off-label prescribing for the treatment of cancer is not considered Experimental or Investigational.

• Any health product or service that is subject to Investigational Review Board (IRB) review or approval.

Any health product or service that is the subject of a clinical trial that meets criteria for Phase I, II or III as set forth by FDA regulations, except as specifically covered

• Any health product or service whose effectiveness is unproven or is not considered standard treatment by the medical community, based on clinical evidence reported by Peer-Reviewed Medical Literature and by generally recognized academic experts."

An autologous stem cell transplant has been requested for this member. It is not considered standard treatment by the medical community, based on clinical evidence reported by Peer-Reviewed Medical Literature and by generally recognized academic experts.

The member has the right to a second level appeal (Grievance Committee). Coventry Health Care of Kansas, Inc. received a request from Ms. Sherrer on November 1, 2005 to have the second level of appeal waived. This request has been denied, as we would like the member to have the benefit of all levels of appeal at the plan level. Although this is an internal review, we would like to give the member every opportunity to present the issues relevant to this case.

The Second Level Committee will include independent review by three (3) board-certified oncologist/hematologists. Please see the attached page for further information on the member's appeal rights. Furthermore, if the member requests a second level appeal, we will be happy to process it on an expedited basis.

Thank you for contacting Coventry regarding this matter, and allowing us the opportunity to respond. If you should have any questions regarding other issues, please contact our Customer Service Department at 1-800-969-3343, available Monday through Friday, 8 a.m. to 5 p.m.

Sincerely,

Karen L. Emerick
Appeals Coordinator
Coventry Health Care of Kansas, Inc.

cc: Judith K. Sherrer
2217 W. 124th Street
Leawood, KS 66209

Enclosures: Member Appeal Rights

COVENTRY
Health Care of Kansas, Inc.

With you when it matters.™

November 8, 2005

Gary L. Sherrer
2217 W. 124th Street
Leawood, KS 66209

RE: Member: Judith K. Sherrer
ID#: 901130885*02

Dear Ms. Sherrer:

The Appeals Unit of Coventry Health Care of Kansas, Inc. (Coventry) is in receipt of your letter requesting a Second Level Appeal regarding authorization or your wife, Judith to receive benefits for an autologous stem cell transplant. Your letter was received in our office on November 7, 2005.

The Second Level Grievance Committee is scheduled to meet on November 9, 2005 at 3:00 p.m. You have the right to attend this meeting, either in person or by telephone.

Please fax to me at fax number: 1-866-769-2408 any additional documentation that you wish to present to the committee as soon as possible. This information will be included in the informational packet sent to the Committee Members. We must receive your information in a timely manner. The Grievance Committee is composed of:

- Coventry Members who are not employees;
- Employees of Coventry who are not involved in the incident that caused the grievance or have reviewed the case at a prior stage of the appeal process; and
- Clinical Peers if applicable.

You will be allowed fifteen (15) minutes to present your issues to the Committee. The hearing will be an informal proceeding intended to allow both parties to explain their position. The hearing will not be electronically recorded and neither party may be represented by an attorney without the approval of the other party and the members of the Grievance Committee.

The Committee members will arrive at a final decision by majority hand vote. You will be mailed a letter advising you of the Committee's determination. If you have any questions regarding this matter, please feel free to contact me at (816) 460-4382. Thank you for bringing these concerns to our attention. We appreciate your patience during the review process.

Sincerely,

Karen L. Emerick
Appeals Department
Coventry Health Care of Kansas, Inc.

October 31, 2005

James Utley, M.D.
Medical Director
Coventry Health Care of Kansas, Inc.
8320 Ward Parkway
Kansas City, Missouri 64114

Dear Dr. Utley;

In a letter dated October 21, 2005, you denied the request for coverage of an Autologous Peripheral Stem Cell Transplant. My intent is appeal this decision to the Insurance Commission of Kansas. To prepare my appeal I would like the following questions answered in writing. As time is of the essence I request your response as soon as possible.

Question #1

Is it the policy of Coventry to deny this treatment to all lymphoma patients? If not what are the exceptions and what is the basis for the exception?

Question #2

Has Coventry Health Care of Kansas ever provided coverage for Autologous Peripheral Stem Cell Transplant for any of its policy holders for any type of lymphoma ?

Question #3

If it is the policy of Coventry Health Care of Kansas to not allow this procedure why then , in a letter dated August 15th, 2005 did Coventry (Dr. Elizabeth Peterson) authorize "evaluation for possible Autologous Peripheral Stem Cell Transplant"—authorization #905920?

Question #4

Your reason for denial was that items excluded from coverage include "6)Procedures and treatments that the Plan determines to be Experimental or Investigational;". Sub Section 1862 (a) (1) (A) of the Medicare Manual states: Autologous Stem Cell Transplantation is considered reasonable and necessary for the following conditions and is covered under Medicare for patients with: "Resistant non-Hodgkins or those presenting with poor prognostic features following an initial response.". It seems unlikely that the Medicare program is involved in "experimental or investigational" programs. This procedure is used for lymphoma patients all over the United States and has been for years. It would appear that the Federal Government recognizes that, but a for profit insurance company does not. Can you explain the difference is approaches?

Coventry Health Care of Kansas has as its slogan "With you when it matters." This transplant really matters and you are clearly not with me.

Judith K. Sherrer
ID# 901130885-02

KANSAS
OFFICE OF THE GOVERNOR KATHLEEN SEBELIUS, GOVERNOR

TESTIMONY ON SENATE BILL NO. 522

MATTHEW D. ALL

CHIEF COUNSEL TO THE GOVERNOR

BEFORE THE SENATE COMMITTEE ON FINANCIAL INSTITUTIONS AND INSURANCE

Thursday, February 16, 2006

Madame Chairman and Members of the Committee:

Thank you for allowing me to testify on Senate Bill 522. My name is Matthew D. All, and I am the Chief Counsel to the Governor. Before I took my current job, I had the honor of serving as the Assistant Insurance Commissioner under then-Commissioner Kathleen Sebelius.

Of all the things Commissioner Sebelius accomplished in that office, perhaps the most important was her work to enhance the rights and protections of Kansas consumers, particularly in health insurance. In 1999, for example, she worked with many of you to give consumers whose health insurers denied them treatment the right to an external, independent review of that denial.

Senate Bill 522 is another important step in protecting Kansas consumers. It would provide important safeguards for consumers facing a denial of health coverage. It would require health insurers to provide information about their internal review and appeal process, and would make the procedures for these appeals fairer and more sensible for consumers.

Few things in life are more difficult than having a serious illness, or caring for a loved one with a serious illness. Having to wade through a confusing and opaque review process is the last thing Kansans in that situation need. Senate Bill 522 will help those Kansans. We applaud Senator Allen for proposing this bill, and we urge you to support it.

Senate FI & I Com.
Attachment 3-1
February 16, 2006

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STATE OF KANSAS

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TOPEKA

SENATE CHAMBER

COMMITTEE ASSIGNMENTS
CHAIR: ASSESSMENT AND TAXATION
MEMBER: EDUCATION
JUDICIARY

February 16, 2006

Madame Chair, Members of the Committee:

Thank you for the opportunity to testify in support of SB 522, providing the insured certain appeal rights regarding adverse health care decisions. This bill is a "Consumer Bill of Rights", providing people like you and me certain appeal rights in the internal review process in health insurance appeals.

Under current law, Kansas does require health insurance companies to have an internal review process, but we do not stipulate what that process must be. The NAIC has a Health Carrier Grievance Procedure Model Act, parts of which are the basis of this bill. According to information provided by the NAIC, 39 states have enacted either model/similar legislation, or related legislation/regulations. Kansas is one of 11 states that has taken no legislative action in this area.

One of the arguments you might hear in opposition to certain provisions of this bill is the particular situation that was the genesis for this legislation was one incident, involving one consumer and one insurance company. Certainly not the normal occurrence. But the fact is, the story you will hear is a real story, and it could happen to you or me, just like it happened to Gary and Judy Sherrer, because there are no consumer protections in place during the internal review process.

Another argument you might hear is Kansas should not implement some of these consumer rights, because they will raise costs for the insurance companies. Gary Sherrer is the best spokesman I know, and you will hear from him shortly. As you listen to his story, put on your consumer hat for a moment. I submit that sometime in your lifetime, you or your loved one will be faced with a similar situation.

Ask yourself if you would want the following basic rights to be afforded to you in an appeal hearing, when you or your loved one has been denied health insurance benefits for a critical, expensive, potentially life-saving procedure, such as a stem-cell transplant.

1. The right to appear in person before the appeal panel.

Senate FI&I Committee
Attachment 4-1
February 16, 2006

2. The right to have all members of the appeal panel who will be deciding your case present and participating, either in person or by electronic means.

3. The right to receive copies of all records and documents relevant to your request for coverage.

4. The right to have a reasonable and adequate amount of time to present your case to the appeal panel.

5. The right to ask questions at the hearing to members of the appeal panel relevant to the subject matter of the appeal.

6. The right to be represented by an attorney at the hearing.

7. The right to record the proceedings of the appeal, at your own expense, in case you need a record of the appeal hearing for future litigation.

8. The right, after being informed of what you are giving up, to waive your second appeal, because time is literally of the essence, and you want to move on to the external review process in hopes of obtaining a favorable outcome.

Today, NONE of these basic rights are afforded the insured. All of the control lies with the insurance companies. This morning, I was pleasantly surprised to learn that the Kansas Association of Health Plans and American Health Insurance Plans were listed as proponents of the bill. While I am extremely appreciative of their support, I recognize they lend it along with significant proposed amendments to the bill. Please carefully consider whether each of their amendments are offered for the benefit of the insurance industry, or for the benefit of the Kansas consumer.

I am proud that Governor Sebelius, and Insurance Commissioner Praeger, and the Kansas Medical Society and representatives of the insurance industry are here today testifying in support of SB 522. A Consumer Bill of Rights in the internal review process for insurance appeals is the fair and right thing to do. I respectfully ask for your support.

Barbara P. Allen

Barbara P. Allen
Senator, District 8

February 16, 2006

Financial Institutions and Insurance

Good morning. My name is Sky Westerlund. I serve as the Executive Director of the Kansas Chapter, National Association of Social Workers (KNASW). KNASW is a membership organization working on behalf of the profession and practice of social work in Kansas.

Social workers have been licensed at three levels of practice in Kansas since 1976. These are the baccalaureate (LBSW), the master (LMSW) and the clinical social worker, (LSCSW). Social workers are the major provider of mental health services in the state and in the nation. Mental health services are offered in the public sector, such as community mental health centers and state institutions and in the private sector through small business private practices.

SB 522 is for the consumer of health and mental health care. It outlines, by statute, what the insurance industry must do when they reject a need for benefits and the insured person requests to appeal the decision. **Persons who pay premiums and believe that their health and mental health care needs will be paid for through their insurance coverage can experience an unsettling situation when the insurance company rejects their request for a benefit.** This is anguishing for all consumers. And then, consider the individual who is dealing with mental health issues. Working through depression or anxiety or post traumatic stress disorder or a multitude of other such mental health problems is a time of great vulnerability in the client's life. Fighting for benefits usually compounds the very mental health distress that the individual is working to address.

To illustrate, Kansas law related to mental health benefits provides for up to 45 days of outpatient care [KSA 40-2,105a (2)]. However, through aggressive utilization review (UR), it is typical that insurance carriers will require extensive justification for continued mental health care after only six or eight appointments. If the benefits are not approved, then the individual faces the decision of whether to go without proper mental health care or fight the insurance company for their benefits.

Senate FI & I Committee
Attachment 5-1
February 16, 2006

KNASW favors SB 522 because:

- It offers a specific process to help the client (consumer) when that person must appeal a decision made by the insurance carrier to reject a benefit.
- It assures a streamlined and clear appeals process when fighting for benefits.
- It creates a uniform appeals process for all insurance carriers to follow.
- It will create necessary oversight of this aspect of insurance industry service to consumers.

Thank you for your consideration of this important consumer focused legislation.

Kansas Association
of Health Plans

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kahp@kansasstatehouse.com

Testimony before the
Senate Financial Institutions and Insurance Committee
SB 522
February 16, 2006

Madam Chair and members of the Committee. Thank you for allowing me to appear before you today. I am Larrie Ann Lower, 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 other entities that are connected to managed care. KAHP members serve most all of the Kansans enrolled in a Kansas licensed HMO. KAHP members also serve the Kansans enrolled in HealthWave and medicaid managed care and also many of the Kansans enrolled in PPO's and self insured plans. We appreciate the opportunity to provide comment on SB 522.

The Kansas Association of Health Plans is supportive of granting an insured the ability to waive a second level of review within the health insurance companies internal review process of claims decisions. However, from an insureds standpoint many times that second level of internal review is decided to the benefit of the insured. In one member plan five of six second level reviews overturned the first review thus avoiding the need for external review in those cases. In addition, at times the second internal review provides a more thorough review of the issues than the external review provided through the KID. An example is that most plans utilize three providers at the second level where only one provider may be utilized at the external review level.

Yesterday morning some of us participated in a conference call with Lt. Gov. Sherrer and Sen. Allen. We agreed to work on language for amendments and to continue discussing the bill.

The following are sections we have agreed need to be clarified:

Section 1(a): Requires a copy of the utilization review process and the name of the utilization review organization used, to be sent to all policyholders and the plan must notify policyholders of any changes to the process. Some plans use several organizations from all over the country, depending on the procedure or treatment proposed. Frequently these organizations and the providers serving on these panels change. In addition, review processes differ from condition to condition.

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Section 1(e)(1) is unclear and should be clarified to state that the insured has five working days from receipt of the notice of the right to a appeal to a second review to request the opportunity to appear before a panel. The time period along with Section 1(f) will be checked for conflicts with DOL standards for ERISA groups.

Section 1(e)(2) requires copies of all relevant documents, records and other information that are not confidential or privileged be provided to the insured. This language is very broad and will be clarified with DOL language currently used by ERISA groups.

Section 1(e)(5) indicates the member has the right to ask questions of any representatives serving on the review panel. This language will be clarified to assure that insureds will have the right to ask questions during the review meeting.

The sections which require further discussion include:

Section 1(e)(7) which allows the second appeal to be recorded at the expense of the insured. This raises concerns by the plans because it could lead members of the review panel to be reluctant to speak for fear of potential court proceedings and even being reluctant to serve as members of the panel at all.

Section 1(d) requires that all members of the review panel be present at the second review either in person, by telephone or by other electronic means. As mentioned, several plans utilize three providers to perform second level of reviews. As with the above section, plans are concerned that their ability to obtain providers willing to participate in the reviews will be severely hampered with this requirement.

As mentioned earlier several of us have met with Sen. Allen and Lt. Gov. Sherrer and plan to continue conversations. We ask that the committee allow us the opportunity to continue to work with them to determine language that can be agreed to. Thank you and I will be happy to answer any questions you may have.

Polsinelli | Shalton
Welte | Suelthaus PC

Memorandum

TO: THE HONORABLE RUTH TEICHMAN, CHAIR
SENATE FINANCIAL INSTITUTIONS AND INSURANCE COMMITTEE

FROM: WILLIAM W. SNEED, LEGISLATIVE COUNSEL
AMERICA'S HEALTH INSURANCE PLANS

RE: S.B. 522

DATE: FEBRUARY 16, 2006

Madam Chair, Members of the Committee: My name is Bill Sneed and I represent America's Health Insurance Plans ("AHIP"). AHIP is the national trade association representing nearly 1300 member companies providing health insurance coverage to more than two hundred million Americans. We appreciate the opportunity to testify regarding S.B. 522. Please be advised that after reviewing S.B. 522, we wish to lend our support to its passage. However, there are a few items that we would respectfully request the Committee considering changing.

Internal review of claims provides an additional opportunity for review of an internal health insurance plan decision to before moving to potentially costly external review and/or litigation. This process provides a mechanism for insureds and insurers to review situations on claims that generally fall outside the normal day-to-day claims activities. My member companies indicate to me that although second tier internal reviews only happen occasionally, and a significant number of reviews result in favor of the insured. . Thus, when analyzing S.B. 522 we must keep in mind the balance between the protection of the insured and his or her rights under the policy versus a process that works best on an informal, less judicial level.

First, on a technical note, we are uncertain as to why when the phrase "health insurance plan" is utilized in the bill, it is prefaced with the term "insurer" or "insurers." Since "health insurance plan" is defined by referenced in Section 1(h), it appears to us that utilizing "insurer" or "insurers" is redundant. Thus, page 1, lines 18, 20, 25, 29 and 35, and page 2, lines 1, 4, 15, 26 and 29, we would suggest deleting the word "insurers," and if necessary, change to the appropriate pronoun.

Next, we respectfully suggest amending Section 1 to make it clear that if the applicable procedures are included in the insurer's initial policy, no additional mailings need to be made

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unless there is an adverse decision. With that change, we have eliminated some of the language in subsection (b) and (c) to conform with the changes in subsection (a). Further, this eliminates the notice requirement in subsection (e) and simply states that it is a listing of the insured's rights.

Finally, we suggest placing the notice requirement on the insured only in subsection (f) and reference back to the time starting under notice found in subsection (a).

Next, subsection (d) attempts to require all participating representatives who will be deciding on the appeal or internal review to be present and participate in person, by telephone or other electronic means. As we have explained to the proponents of the bill, such a requirement is impracticable as many members of these boards are practicing physicians, and inserting such a requirement would, in our opinion, cause such a burden that it might well eliminate internal review processes altogether and simply require people to go immediately to external review.

As stated earlier, internal review processes are valuable tools to that allow individuals review of health insurance plan determinations. We believe that our proposal, i.e., at least one non-employee participant will take part in person or by telephone or electronic means, will allow the insured the ability to have dialogue with someone within the process, and at the same time not create such a burden as to destroy the internal review process.

In that same vein, we would request that subsection (e)(7) be eliminated. Although in a perfect world it might sound reasonable to record the process so as to memorialize what occurred in the event of future dealings, I believe we all recognize we don't live in a perfect world. Because of the litigious nature of our society, such a requirement would most likely force all companies utilizing internal review to direct the individuals involved in the internal review to simply not say anything. Such a chilling effect would ruin what should be a give-and-take exchange between the insurer and the insured.

Also, for clarification, we have added the phrase "during the meeting" in subsection (e)(5). This will make it clear that the questions will be asked at the meeting.

Finally, inasmuch as we discussed the term "adverse decision," we believe it is appropriate to include by reference the definition of "adverse decision" as found in K.S.A. 40-22a13. We believe this is consistent with the other definitions found in subsection (h).

As stated earlier, we look forward to working with the proponents of this bill in an effort to craft a well-balanced piece of legislation that will protect the rights of the individuals, and at the same time, allow for a process that will work effectively and inexpensively, as compared to direct external review and/or litigation. Thus, we respectfully request that the Committee consider these amendments, and we look forward to working with the Committee in the future.

Respectfully submitted,

William W. Sneed

WWS:kjb

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To: Senate Committee on Financial Institutions and Insurance

From: Jerry Slaughter
Executive Director

Subject: SB 522; Concerning appeal rights of adverse decisions by health insurers

Date: February 16, 2006

The Kansas Medical Society appreciates the opportunity to appear in support of SB 522, which would establish certain appeal rights for individuals when contesting adverse decisions made by health insurers.

Under current law, an individual who contests an adverse decision made by a health plan on whether a certain service should be covered must first exhaust all the internal review procedures of the health plan before appealing the decision to the external review process afforded them under K.S.A. 40-22a14, *et seq*. Health insurers must have an internal review process in place, but Kansas law does not proscribe what that process must entail. Because the law isn't specific about requirements for internal review, it can vary considerably from insurer to insurer. It can be simple and straightforward, to quite complex for individuals to navigate. SB 522 provides that when a health insurer has a two-level review or appeal process, an individual may waive the right to a second appeal, and go directly to external review, notwithstanding the provisions of K.S.A. 40-22a14(d).

The bill provides further that in the event an individual elects to request a second-level appeal, the individual has the right to appear in person, the right to be represented by counsel, the right to receive and review all relevant documents, and the right to record the proceedings of the second-level appeal.

We support these changes in law. Without question, appeals of health insurers' adverse coverage decisions have immense implications for individuals and families. Because so much is at stake in these matters, it makes sense to do everything we can to make sure the process is fair, timely and transparent. The changes contained in SB 522 will not prevent an insurer from making coverage decisions based on their own medical necessity guidelines. It will, however, allow an individual the right to access the external review process earlier in certain cases. It also provides individuals with a greater opportunity to participate in and understand an insurer's internal review process, which has such a key role in coverage determinations. We believe the proposed changes are reasonable, and we urge your support of this bill. Thank you for considering our comments.

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