WISCONSIN ASSOCIATION OF
WALHI
LIFE AND HEALTH INSURERS

TO: Members
Wisconsin State Senate

FROM: Wisconsin Association of Life and Health Insurers

DATE: January 25, 2000

SUBJECT: Senate Bill 258: External Review

The Wisconsin Association of Life and Health Insurers (WALHI) supports legislation establishing a method for independent review of denied health care services. Interested groups, including WALHI, AARP, Center for Public Representation, the State Medical Society and the Wisconsin Association of Health Care Plans worked together to develop a comprehensive and fair external review proposal.

Senate Bill 258 as amended by the Senate Committee on Health, Utilities, Veterans and Military Affairs closely reflects the groups compromise. However, the substitute removes two important components.

- A $50 filing fee to be paid by the insured or their representative to the independent review organization was deleted. The $50 fee was designed to prevent abuse of the independent review process and was set low enough to address affordability concerns. It should be noted that if the reviewer finds in favor of the insured, the fee is refunded in full.

- To be eligible for external review, the amount of the denied service was changed from $500 to $200. Establishing a higher threshold is necessary in order to balance the cost of conducting the review and the cost of the denied service. We estimate the average cost of an external review to be $500. Keep in mind that the threshold does not apply to a single service or item, but rather to a course of treatment.

We respectfully request that you amend SSA 1 to SB 258 to restore the $50 filing fee for external review and set the cost of eligible services for review at $500.

Thank you for your serious consideration of our request.

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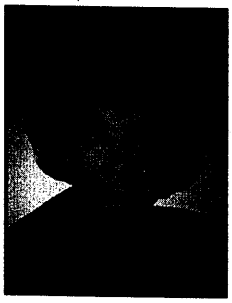

Alice Clausing

WISCONSIN STATE SENATOR

Testimony on the Patients' Bill of Rights – SB 258
Senator Alice Clausing
November 3, 1999

Thank you Mr. Chairman for the opportunity to testify today on behalf of SB 258. Managed care has rewritten the book on health care. In 1987 13% of all Americans receiving health insurance through an employer were enrolled in an HMO. By 1996, that number had grown to 75%. Today, 80% of all Americans believe that H.M.O.'s compromise on quality to save money.

The balance of power between patient and provider shifted towards providers as the lines between the medical practitioner, the organization as medical practice and the organization as insurance company blurred. HMO's blend aspects from many service models with the hope of providing more coverage at less cost. Unfortunately the tools to protect consumers and punish those who act in bad faith have not evolved as rapidly as HMO's have grown. We hear about the result from our constituents and we see it on the cover of Newsweek.

Representative Wasserman and I restore the balance between the patient and his health care provider by creating a Patients' Bill of Rights.

Our proposal is based on three basic beliefs:

1) **Patients have the right to see any physician specialist within the group without a referral from their primary care physician.**

When an individual becomes a member of an HMO they have the expectation of seeing the specialists listed in the promotional literature if the need arises. This bill cuts the red tape. It does not effect restrictions on physicians who are outside of the group; it simply guarantees each patient access to the full range of expertise that is available within the group.

2) **Patients' have the right to appeal denials to a physician unaffiliated with the group that made the denial.**

Currently, managed care plans must have written grievance procedures permitting review by an internal panel. The practical result is the left hand reviewing the action of the right hand.

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We extend current law to allow patients to appeal the panel's decision to seek a binding decision from an outside physician in the same field of specialization.

3) Patients have the right to sue their managed care provider for substandard care.

This proposal embraces the belief that patients have the right to sue an HMO for bad faith. This bill reflects the finding of the Wisconsin Supreme Court in McEvoy vs. Group Health Cooperative. Medical treatment denied administratively is an insurance decision, not a medical decision. Patients deserve clear statutory language outlining who is responsible when their HMO fails to provide either health or insurance.

Justice Bradley in her decision called tort action important to "leveling the playing field" between powerful insurance companies and subscribers at a very vulnerable moment in their lives. I couldn't agree more. We must acknowledge that HMOs are both providers involved making medical judgments and insurers making non-medical judgment with very medical ramifications. Consumers must be provided with a clear path for recourse.

The Wasserman-Clausing proposal differs from other similar proposals in three very significant areas

First, we do not assess an appeal or filing fee. Only 7 states currently have a filing fee. In one state it is permissive and two other states allow the fee to be waived in case of financial hardship. That leaves only 4 of 30 states with independent review having a filing fee.

In testimony before the Assembly Insurance Committee senior citizen groups, organized labor and others representing consumers agreed that no filing fee was far superior to even a small filing fee. AARP has been outspoken in its support for fee-free appeals.

The solution to nuisance claims is not a nuisance fee. Filing fees discourage the sick and the tired from appealing – regardless of the merits of their appeal.

Second, this bill does not establish a cost threshold that must be crossed before a denial may be appealed, a provision only 6 states accept.

I am uncomfortable establishing a dollar threshold that must be crossed to trigger appeal rights. My fear is that we simply create a silent deductible for those who are able to cover the cost of treatment and yet another barrier for those without financial resources.

The treatment cost threshold and the filing fee create a financial hurdle with the sole purpose of discouraging appeals.

Third and most importantly, this proposal includes a patient's right to sue their HMO for bad faith as I outlined earlier.

As you know, I am co-sponsoring a similar proposal that does not include language assuring patients the right to sue their HMO. I respect the effort and spirit of my colleagues who have worked long and hard on this issue. But it is, at best, a partial solution. It provides a process, but not access and it fails to provide a clear path for patient's seeking legal redress. HMOs make potentially life and death decisions. How they are held accountable for their decisions needs to be laid out in the statutes. It's that simple.

I encourage you to support the Patients' Bill of Rights, and send it to the Senate floor for consideration by the full Senate.

I would be happy to answer any questions. Thank you.

State Medical Society of Wisconsin
Advancing the health of the people of Wisconsin

TO: **State Senator Rodney Moen, Chair**
Members, Senate Committee on Health, Utilities, Veterans and Military Affairs

FROM: **M. Colleen Wilson, Legislative Counsel**
Government Relations

RE: **Senate Bill 258**

DATE: **November 3, 1999**

The State Medical Society of Wisconsin appreciates the opportunity to comment on SB 258, authored by Senator Clausing and Representative Wasserman. The State Medical Society supports the availability of an opportunity for a patient to seek an independent review of a decision of a managed care plan. The SMS believes that this opportunity should be available for all patients, however, not just those in managed care, and would be more comfortable if the review process was detailed in state statute. We look forward to working with Senator Clausing, Representative Wasserman and all legislators committed to making independent external review a reality for Wisconsin patients.

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MEMORANDUM

TO: Members of the Wisconsin Senate

FROM: Pete Christianson, for AFLAC

RE: Suggested Amendment to Senate Bill 258

DATE: January 25, 2000

Senate Bill 258, as amended by Senate Substitute Amendment 1, would create internal grievance procedures and independent review of certain coverage decisions made by health benefit plans. Pulled into the definition of "health benefit plan" are hospital indemnity and specified disease plans. This is accomplished via the inclusion of the phrase "except that 'health benefit plan' includes the coverage specified in s. 632.745 (11) (b) 10." on page 4, lines 23-24, and page 6, lines 6-7. For the reasons stated below, that language should be stricken from the Substitute Amendment.

Wis. Stats. s. 632.745 (11) (b) 10. deletes from the definition of "health benefit plan" hospital indemnity or other fixed indemnity insurance or coverage only for a specified disease or illness. Under such coverage, a person who is hospitalized or who undergoes treatment for the indicated disease or illness is entitled to receive a flat amount per day of hospitalization or treatment. With such policies, the insurer makes no determination concerning the appropriateness of care or even the need for care, hence there is no insurer decision to review.

A quick glance at the independent review procedure created in the Substitute Amendment proves the point. See SECTION 20, which begins on page 5 of the Substitute Amendment. When an "adverse determination" has been made, the patient is entitled to independent review of the insurer's decision. Four enumerated conditions are set forth:

A. "An admission to a health care facility, the availability of care, the continued stay or other treatment that is a covered benefit has been reviewed". With a hospital indemnity or specified disease policy, the insurer makes no decision concerning hospital admission, continued stay, or the nature of the treatment (if any) rendered.

B "Based on the information provided, the treatment ... does not meet the health plan's requirements for medical necessity, appropriateness, health care setting, level of care of effectiveness". With a hospital indemnity or specified disease policy, the insurer makes no decision concerning medical

necessity, appropriateness of care, the level of care, or the effectiveness of care.

C. "Based on the information provided, the insurer that issued the health benefit plan reduced, denied or terminated the treatment ... or payment for the treatment...". Again, with a hospital indemnity or specified disease plan, the insurer makes no determination concerning what treatments are appropriate or the duration of any treatment rendered. You qualify for a payment under the policy if you are hospitalized (in the case of a hospital indemnity plan) or undergo any treatment for the specified illness (in the case of a specified disease policy). It is the patient's health care provider who determines whether a covered act occurs and <u>not</u> the insurer!

D. "...the amount of the reduction or the cost or expected cost of the denied or terminated treatment or payment exceeds, or will exceed during the course of the treatment, $200". Again, it is the patient's health care provider who determines what care is appropriate and the policy pays depending on that decision. In the case of a hospital indemnity plan, the patient is paid if the he or she has been hospitalized. In the case of a specified disease policy, the patient is paid if he or she has been treated for the disease!

For the reasons stated above, the phrase "except that 'health benefit plan' includes the coverage specified in s. 632.745 (11) (b) 10." should be stricken from lines 23-24 on page 4 and lines 6-7 on page 6 of Senate Substitute Amendment 1 to Senate Bill 258.

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DESCRIPTION OF PROPOSED IMPROVEMENTS TO THE SUBSTITUTE AMENDMENT TO SB 258 (INDEPENDENT EXTERNAL REVIEW)

The Senate Substitute Amendment to Senate Bill 258 as drafted, would not only apply the new independent external review requirement to virtually all health plans (not just managed care plans) it would also require that all other health plans create the internal grievance procedures now required of HMOs and would require that consumers go through these internal grievance procedures before being entitled to the independent external review.

This added administrative layer for consumers not in managed care plans is unnecessary. It would be simpler, less costly, and fairer to both consumers and insurers to adopt this Simple Amendment which does the following:

1) For other health plans (primarily indemnity plans that do not require the use of particular providers or impose other managed care requirements on enrollees), allow but do not mandate that the plans create an internal grievance procedure. If the plan creates an internal grievance procedure that meets the requirements now applicable to managed care plans, then the plan must require enrollees to go through the internal grievance procedure before proceeding to external independent review. If the plan chooses not to create an internal grievance procedure, then the enrollees would have the right to proceed directly to independent external review for the adverse determinations covered by the bill. **This expands consumers' ability to directly obtain a binding independent review of an insurer's adverse determination.**

2) For preferred provider plans, where frequently an insurer contracts with or leases a separately-organized and managed, preferred provider network, clarify that responsibility for complying with the internal grievance procedures and the external independent review requirements may be assigned by contract to either the preferred provider network or the insurer. In the absence of contractual provisions assigning the responsibility to the insurer, compliance will be assumed to rest with the preferred provider network.

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William L. Carr
President

Wisconsin Association of Health Plans

Nancy J. Wenzel
Executive Director

JAN 2 4 2000

January 24, 2000

To: Members, Wisconsin Senate

From: Nancy J. Wenzel, Executive Director
Julie A. Daggett, Director of Government Affairs

RE: SB 258, External Review

Wisconsin HMOs urge you to adopt external review requirements as passed by the Assembly in AB 518. AB 518 represents a consensus proposal among consumer and health care groups that meets patients' needs without diverting limited resources away from patient care toward unnecessary administrative tasks. Wisconsin HMOs urge you to take the following action on SB 258, the external review bill before the Senate.

- **Oppose exempting certain insurers or groups of insurers from the provisions of external review.** All Wisconsin patients, not just HMO patients, deserve protections. Exempting certain insurers or groups of insurers from the provisions of the external review bill represents repealing protections for patients not in HMOs. Wisconsin HMO patients have had the benefit of an internal grievance process for years and many Wisconsin HMOs already voluntarily provide external review rights.

- **Support including a $50 filing fee in SB 258.** A reasonable filing fee is a necessary deterrent to the filing of less serious requests for external review. Such a deterrent is necessary to ensure that the external review process does not become overloaded and remains available for those patients who need it most. A $50 fee is not excessive considering that patients have access to the entire internal review process at no cost. When patients prevail in an external review, the entire $50 fee is returned.

- **Support including a $500 dollar threshold in SB 258.** An appropriate dollar threshold for services eligible for external review is necessary to strike a balance with the cost to insurers of conducting an external review. Five hundred dollars is estimated to be an average cost of an external review. It is important to remember that the threshold does not apply to a single service or item, but rather to a course of treatment. As such, and with the cost of medical services today, few claims would not meet the threshold requirement.

- **Oppose adding health plan liability to SB 258.** Controversial amendments like the right to sue HMOs in state court could kill an external review bill. Wisconsin patients should not lose external review over an issue that should be debated separately.

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November 6, 1999

Senator Rod Moen
PO Box 7882
Madison, WI 53707

Dear Senator Moen:

The Wisconsin Chiropractic Association respectfully requests that SB 258 be amended so that the hundreds of thousands of chiropractic patients in Wisconsin may also participate in the benefits of this legislation.

The HMO industry and the Assembly companion bill AB 518 propose limiting the right to an independent review by setting a threshold of $500. If the Senate were to accept this amount, it would severely limit the number of chiropractic patients that would have the right to an independent review of their denied services.

Tens of thousands of times each year the HMO and insurance industry deny chiropractic care as not being "medically necessary". Instead of an independent review by qualified chiropractors, these insurers hide behind the personal opinions of largely unqualified anonymous reviewers. Because the amount charged for chiropractic services are relatively small a significant amount of care can be denied while the insurer stays under the $500 threshold. Lowering the threshold would allow chiropractic patients the same rights as medical patients to an independent review.

Since the consumer has the obligation to pay $50 if they wish an independent review of the denied services, $100 would be a more appropriate threshold. A threshold set higher than this amount threatens to make this a "surgeon and hospital protection bill", as they are the primary providers whose services cost more than $500.

We very much appreciate your help to insure that chiropractic patients are not treated unfairly.

Sincerely,

Russell A. Leonard
Executive Director

Wisconsin Academy of Trial Lawyers

Keeping Wisconsin Families Safe

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MEMORANDUM

To: Rep. Gregg Underheim

From: ~~Paul Sicula~~

Re: Senate Bill 258

Date: ~~January 27, 2000~~

SB 350 - SenOrs
Rod Moen

We have two concerns with SB 258 and AB 518. First, the decision of the independent review organization is "binding" on the insured and the insurer. (SSA 1, page 9, lines 10-11) What does the word "binding" mean? Does it mean there is no right to appeal an unfavorable ruling? Under one interpretation a "binding" decision arguably takes away the right to hold an HMO liable for a bad faith claim as announced by the Supreme Court in *McEvoy v. Group Health Cooperative of Eau Claire,* 213 Wis. 2d 507, 570 N.W.2d 397 (1997). Coupled with a grant of immunity to the health plan subject to the independent review, (SSA 1, page 15, lines 5-8) it appears SB 258 and AB 518 give consumers far fewer rights than they have now under the *McEvoy* decision.

In *McEvoy* the Wisconsin Supreme Court held the tort of bad faith applies to HMOs making out of network decisions. In the case, a 13-year-old girl, Angela McEvoy, who was a member of Group Health Cooperative of Eau Claire (GHC), was being treated for anorexia nervosa. GHC referred her to an out-of-network provider at the University of Minnesota Hospital (UMH). Angela was treated for 6 weeks of in-patient care. (42 days). The GHC policy authorized in-patient psychological care for up to 70 days. After 6 weeks, the GHC Medical Director decided to discontinue coverage at UMH. Both Angela's treating physician and her psychiatrist at UMH opposed the decision because she hadn't met her treatment goals. Angela was discharged, but relapsed immediately and had to be readmitted to treatment at UMH.

Angela and her mother commenced action in the circuit court of Eau Claire alleging GHC breached the insurance policy in bad faith, "denied and threatened to deny Angela McEvoy coverage for her treatment and failed to authorize appropriate treatment." GHC moved to dismiss the complaint on the grounds this was a malpractice action and governed by Wisconsin Statutes Chapter 655. The trial court agreed and dismissed the complaint. The McEvoys appealed and the court of appeals reversed. The Supreme Court reviewed the decision and also reversed the trial court finding bad faith claims may properly be maintained against HMOs.

Under SB 258, would the tort action for bad faith be disallowed if the McEvoys had followed the independent review procedures outlined in the bill? If the McEvoys had availed themselves of the right to an independent review under SB 258, the decision is "binding." Does that mean the McEvoys couldn't sue the HMO for bad faith? Does that mean if the independent reviewer had ruled against the McEvoys and denied additional treatment, the health care plan would be immune from damages for Angela's injuries?

Because the independent review process is voluntary, if the injured patient doesn't use the independent review process, would he or she still be able to sue the health plan for bad faith? This may confuse consumers and create a trap for the unwary. For example, if the consumer believes the HMO is wrong in denying treatment, what should he or she do? Should he or she use the independent review system to resolve disputes with HMOs in a timely manner or forego treatment to retain possible legal remedies? Most consumers won't know they have to make this choice. In fact, many HMOs may promote resolution of claims through the internal review process. Most people will be unaware they may be giving up their right to damages if they use the process and there is a bad outcome — death or serious injury.

We recommend the following amendment to preserve the *McEvoy* decision.

Assembly Amendment to Senate Substitute Amendment 1 to Senate Bill 258

At the locations indicated, amend the substitute amendment as follows:

Page 9, line 11, insert after "insurer." "This decision does not prohibit an insured from bringing an action in tort against the insurer health benefit plan for a bad faith denial of coverage."

Page 15, delete lines 5-8.

Wisconsin Academy of Trial Lawyers