SENATE BILL 269/ASSEMBLY BILL 518
(INDEPENDENT EXTERNAL REVIEW OF CERTAIN HEALTH PLAN DECISIONS)

PROPOSED AMENDMENTS TO SIMPLIFY PROCESS FOR ENROLLEES IN INDEMNITY PLANS

1. Under current law, managed care plans (HMOs and other health insurance plans that require enrollees, or give enrollees financial incentives, to use only providers that are managed, employed, owned, or under contract with the health insurer) are required to have an internal grievance procedure.

- SB 269/AB 518 would create a mechanism for independent external review of certain decisions after the enrollee has gone through the internal grievance procedure. The enrollee could bypass the internal grievance procedure and go directly to the independent review only if (a) the insurer and the enrollee agreed to skip the grievance procedure, or (b) requiring the enrollee to go through the internal grievance procedure first would jeopardize the enrollee's life, health, or ability to regain maximum function.

  The independent external review applies only to an insurer's denial of coverage on the grounds that the proposed treatment is experimental, or that the treatment sought does not meet the insurer's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness. The internal grievance procedure which HMOs and other managed care plans are currently required to have in place are much broader, covering "any dissatisfaction with the administration or claims practices of or provision of services by" the plan (e.g., waiting times for routine appointments, prior authorization procedures). Wis. Admin. Code INS 3.50.

- SB 269/AB 518, 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 do the following:

  (A) For managed care plans, retain the bills' provision that requires enrollees to go through the plan's internal grievance procedures (except in the special situations noted above) before being allowed to obtain the external independent review.

  (B) 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 HMOs/managed care plans, then the plan may require enrollees to go through the internal grievance procedure before proceeding to external independent review, just as the bill provides for managed care plans. If the plan chooses not to create an internal grievance procedure, then enrollees would have the right to proceed directly to independent external review for the adverse determinations covered by the bill.

NOTE: This expands consumers' ability to directly obtain a binding independent review of an insurer's adverse determination, while maintaining the bills' provisions allowing HMOs to require that consumers go through the HMO's internal grievance procedure before going to outside independent review.

(C) For non-managed care plans that document to OCI that they made no adverse determinations during the previous 12 months that would qualify for independent external review (i.e., no denials of care on grounds that the treatment was experimental or not medically necessary), the plan could receive a waiver from the regulatory requirements imposed by the bill. The waiver would be valid for one year (and renewable upon a showing, again, of no adverse determinations during the previous year). OCI could override the waiver and order an independent external review upon appeal of an enrollee to OCI in the event of a serious 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 (which may thus have one set of grievance procedures and one set of arrangements for independent external reviews, even though the network contracts with multiple insurers).

Amendment to SB 269 to accomplish the above:

1. Do not renumber/modify current section 609.15, Stats. (basically deletes current Sections 8 to 17 of SB 269).

2. Modify Section 19 of the bill to provide that a health benefit plan, other than a health benefit plan covered by Chapter 609 (managed care plans), may, but is not required to, establish an internal grievance procedure meeting the requirements of sec. 609.15, Stats.

3. Modify Section 20 of the bill (or add separate section preceding Section 20) to provide that an insured must exhaust the internal grievance procedure of a managed care plan under current sec. 609.15, Stats., before requesting an independent review; or, if a health benefit plan not covered by Chapter 609 has established an internal grievance procedure meeting the requirements of sec. 609.15, Stats., the insured must exhaust that internal grievance procedure before requesting an independent review; but if the health benefit plan has not established an internal grievance procedure meeting the requirements of sec. 609.15, Stats., then the insured need not exhaust any internal grievance procedures and may proceed directly to independent review. (Retain the exceptions already in the bill for bypassing the internal grievance procedure, at page 9, lines 1-11.)

4. Add clarifying language to both sec. 609.15, Stats. (current law) and the new provisions on independent review, to provide that in the case of preferred provider plans, responsibility for complying with the internal grievance procedures and with the external independent review requirements may be specifically assigned, by contract between a preferred provider network and an insurer using that preferred provider network, to the preferred provider network or to the sponsoring insurer. In the absence of any specific assignment, responsibility for complying with these requirements will be deemed to rest with the preferred provider network.

WHYTE
HIRSCHBOECK
DUDEK S.C.

DESCRIPTION OF IMPROVEMENTS TO SB 269 MADE BY THE SENATE SUBSTITUTE AMENDMENT

Senate Bill 269 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 Substitute 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.

46377.2

TO: Senator Rod Moen – Chair
Senate Committee on Health, Utilities, Veterans and Military Affairs

FROM: Ron Hermes –Retained Council
Health Insurance Assoc. of America (HIAA)

DATE: January 14, 2000

RE: SB 269/AB 518 amendment

Senate Bill 269 is designed to require health insurers to provide an internal grievance mechanism and to provide an independent review of the insurer's decision in cases where the insured is not satisfied with a coverage decision made by an insurer. This bill is designed to address situations where the insurer and the insured disagree about whether a particular medical service is "medically necessary," or whether the service is "experimental." Supplemental insurers are included in SB 269 even though questions of medical necessity and experimental/investigational treatment are not at issue under hospital indemnity or supplemental policies.

Although policies will vary from company to company, **specified disease insurance** typically pays a lump sum to someone who suffers a specified critical illness or injury and survives. The payment, generally made to you in a lump sum 30 days after the onset of your illness (depending on the policy), can be used for any purpose — on bills, for medical expenses not covered under an individual's other insurance policies, such as seeing out-of-network doctors, to pay for home health care, or to make up for a spouse's lost income if he or she takes time off work to care for the sick individual. Other possible uses: retrofitting a car or home for a wheelchair or keeping a business afloat while out of commission due to illness. The payout is also nontaxable.

Hospital Indemnity plans are intended to pay a certain amount of money per day if you are hospitalized. Hospital Indemnity plans generally pay a fixed daily benefit between $50 and $100 per day in the event of hospitalization. The policy pays the benefit directly to the insured and not to the hospital or health care provider. These plans are generally sold with the idea that "you may need extra income if you are hospitalized."

These types of supplemental coverage are designed to supplement, and not replace, traditional health insurance.

Requiring hospital indemnity and specified disease plan carriers to implement external review procedures is unnecessary. Why?

Medical necessity determinations – specified disease and hospital indemnity plans *do not cover specified treatments and procedures*, therefore there are no medical necessity determinations to be made. Hospital indemnity insurance provides a stipulated daily, weekly, or monthly payment to an insured person during hospital confinement, without regard to the actual confinement expense. Specified disease plans provide an unallocated benefit, subject to a maximum amount, for *expenses* in connection with the treatment of specified diseases, such as cancer, poliomyelitis, encephalitis, and spinal meningitis. These policies are designed to supplement major medical policies. In essence, these policies reimburse individuals for being sick.

We are asking for your support on amending SB 269 as follows:

On page 6, line 22, delete "includes the coverage specified in s. 632.745 (11) (b) 10".

On page 8, lines 3-4, delete the words, ", except that 'health benefit plan' includes the coverage specified in s. 632.745 (11) (b) 10".

PEGGY
ROSENZWEIG

State Senator, 5th Senate District

TO: Members of the Committee on Health, Utilities, Veterans and Military Affairs

FROM: Senator Peggy Rosenzweig

DATE: November 3, 1999

RE: Senate Bill 246 and Senate Bill 269

I would like to thank Senator Moen for holding a hearing today on Senate Bill 246, which I authored, and Senate Bill 269, which is co-authored by Senator Breske and Representative Underheim. These bills are similar and very important, because they provide for the independent, external review of health care decisions made by health insurers.

As you are all aware, I have always had an interest in expanding access to good, quality health insurance for the citizens of Wisconsin. In addition, I am interested in making sure that when people have access, they actually receive the care they are entitled to under their insurance. I introduced Senate Bill 246 as a way to improve the health insurance system in Wisconsin by allowing independent panels comprised of health care providers to review medical decisions made by health insurers. Numerous groups, including the State Medical Society, AARP and the Center for Public Representation warmly received the bill. It was my hope that Senate Bill 246 would jump start a discussion on this issue in the state and bring us closer to a system that other states have adopted and that is being considered on the federal level as well.

Soon after my bill was introduced, Representative Underheim introduced Assembly Bill 518, and invited parties interested in the issue of external review to meet and hammer out a compromise that everyone could support. The fruit of that labor is embodied in Senate Bill 269, which you have here before you today. While I am here today to speak in support of Senate Bill 269, which I believe represents a fair compromise that all parties, from advocate to insurers can support, I would be remiss if I did not point out several provisions from my bill that were included in SB 269, which I believe makes the bill better.

For instance:

- SB 269 does not allow a contractual relationship between the independent review organizations (IROs), which establish the review panels, and insurers.

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- When determining if treatment meets the $500 threshold limit established in the bill, you must look at the entire course of treatment, not just one procedure or pill.

- Notice of the right to pursue external review must be given to the enrollee as soon as the internal insurance review is concluded.

- IROs must meet certain specific criteria and standards before being certified by OCI.

- Reviewers must meet certain, specific criteria before being approved.

- In cases of emergency, an expedited review is provided, and in all cases the parties must adhere to strict timelines.

- Standards for what constitutes experimental treatment are codified.

- Provides for immunity for good faith actions of IROs.

Those provisions and others included in Senate Bill 269 make it, along with Senate Bill 246, worthy of the Committee's support. I would hope the members of the Committee would support the bill, which I believe provides the best opportunity for passage in the Legislature. While it may not have everything that everybody wants, it is a good compromise that will allow for grievances to be heard and possibly resolved before real problems occur. I want to thank Senator Moen for the opportunity to speak and would be happy to answer any questions.

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David B. Slautterback
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I am David Slautterback, an AARP volunteer. I am here to testify on behalf of our Wisconsin State Legislative Committee. I am Chairman of the Subcommittee on Health and Long Term Care and Coordinator of the Capital City Task Force.

Thank you for the opportunity to testify in favor of Senate Bill 269. It is now over two years since we began an earnest effort to urge legislation that would give consumers the right to an independent external review when they believe that their insurer has unfairly denied a medical service or refused payment for a service received. Until now, the internal grievance process, however well designed, has ended with the company against which grievance was made being the judge of the quality of the grievance. Our members have told us this issue is of great concern to them, as it must be for all consumers who have had reason to grieve a denial of care by their insurer.

AARP is secure in the belief that both insurer and insured are best served when an independent panel of experts, current in knowledge of the issue in dispute, will make a binding decision as to the justification of the denial. This is the fundamental issue addressed by SB 269. The content of the bill is the result of extensive and vigorous negotiations among concerned parties who worked hard to find common ground that all could support enthusiastically. The Committee will recognize that successful negotiation means the parties have to yield on some things they wanted and this was true for AARP. But I emphasize that this is excellent legislation that is strongly endorsed by AARP.

At least 19 other states have adopted legislation of this sort. The experiences of these states shows how well the system can work, how heavily it is used, and what cost we can expect. The evidence that the national office of AARP has gathered indicates that independent, external review is not heavily used. Further, the national office of AARP authorized an accounting by two national organizations who concluded that the cost, if covered by a premium increase would amount to 4 or 5 cents per premium, in other word, about 50 or 60 cents a year.

So far, all states report that the system is working well and that an unintended consequence is that it makes the internal grievance procedure work better than before. Note that the integration of the two procedures is important for maximum benefit to both insured and insurer. Breaking the interlocking of internal and external procedures diminishes the effectiveness of each of them. Equally, if not more, important is the fact that this bill covers all insurers and this feature is crucial. To treat some consumers

and/or some insurers differently than others would be unfair and, of course, lead to antagonism, competitive advantages, and disadvantages that could cause a well designed system to fail. The principle losers then would be the consumers whom we represent.

I want to call your attention to a very important and innovative part of this legislation. It is in the way an Independent Review Organization (IRO) is assigned. The Insurance Commissioner prepares a list of certified IRO's and may refuse to certify an IRO that does not have a quality assurance program in place and/or charges excessive fees. From this list, the insured chooses one.

In urging you to pass this legislation I am representing our Wisconsin members (about 700,000 of them) and other consumers. Also, we have worked in the Collaboration on Healthcare Consumer Protection (CHCP) whose members in addition to AARP are, The Center for Public Representation, The State Medical Society, The Milwaukee County Medical Society, The Society for Podiatric Medicine, The Nurses Association, and WEA Insurance Group. Further, we are supported by Wisconsin Citizen Action whose Health Care Task Force includes several other advocacy groups as well as AARP. Each of us and all of us strongly support Senate Bill 269.

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

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

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

RE: **Support for Senate Bill 269 related to Independent External Review**

DATE: **November 3, 1999**

The State Medical Society of Wisconsin appreciates the opportunity to express its support for making an independent external review process available to all patients with health care coverage in Wisconsin. We are grateful for the efforts of Senators Breske, Clausing and Rosenzweig to introduce legislation that gives patients a source for independent, impartial decisions about their grievances with their health care plans. SB 269 represents a positive step forward in the fight for patients' rights.

Senate Bill 269 addresses the priorities of the State Medical Society with regard to independent external review:

* The process developed in the bill eliminates the need for any contractual relationship between an independent review organization and a health care plan (whose decision is the reason for the review). Instead, the Office of the Commissioner of Insurance will present patients seeking independent review with a list of those organizations qualified to do independent reviews, and the patient will select the organization he or she wants to conduct the review. This eliminates concerns that a health plan would select only those review organizations that have acted in the interest of the health plan.

* The Medical Society appreciates the careful consideration the bill gives to the qualifications of the health care professionals who are to conduct the review. Physicians firmly believe that the reviewers must be an expert in treating the medical condition that is the subject of the review, be knowledgeable about the treatment that is the subject of the review through current and actual clinical experience, be licensed and board certified in the area appropriate to the subject of the review, and have a good disciplinary history. We are pleased that these criterion are included in SB 269.

* Physicians also support a broad trigger device delineating those issues that can be reviewed externally. The language in the bill is sufficiently broad to include adverse determinations regarding medical issues, but not so broad as to include complaints policy holders have with regard to administrative issues. We also are pleased that the requirement for independent external review extends to all health plans, not just those defined as managed care plans.

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* While physicians would prefer no filing fee for patients seeking independent external review, and a lower monetary threshold to access the review process, they understand the need to minimize the number of frivolous requests for independent external review. The Medical Society believes that not requiring patients to meet copayment and deductible requirements as part of the $500 threshold goes a long way toward making the external review process more accessible.

Again, the State Medical Society of Wisconsin is pleased to support the substitute amendment to AB 518. We look forward to working for passage of this patient rights legislation, and again thank Senators Breske, Clausing and Rosenzweig for their leadership on this issue.

Greater La Crosse
Health Plans, Inc.
Managed care that works.

External Review Bill
LRB 3798
November 3, 1999

Good Afternoon. My name is Steven M. Kunes. I am the Executive Director of Greater La Crosse Health Plans, Inc. Greater La Crosse Health Plans is a provider owned and managed HMO founded in 1986 by Skemp Clinic, Ltd. and the Franciscan Health System. Mayo Group Practice in Rochester, Minnesota currently wholly owns the Plan.

Greater La Crosse Health Plans supports the Wisconsin Association of Health Plans' position of support for LRB 3798. Over the past several months, the Association along with other interested parties have worked diligently to design an external review bill that meets patient needs without redirecting health plan resources away from patient care.

Greater La Crosse Health Plans is a physician-led HMO. The patient's primary care practitioner directs patient care. Over the past three years, Greater La Crosse Health Plans recorded only eight grievances. Of those eight only one denial of payment was upheld. In the 13 years that Greater La Crosse Health Plan has been in existence, this grievance was the only one that needed an independent external review. This review was not requested by the grievant, but by the Grievance Committee, in order to make sure the denial was justifiable. Overall, HMO patients are highly satisfied with their health plans. HMOs support the external review as the right thing to do for the patient's peace of mind.

Greater La Crosse Health Plans developed its own Patients Bill of Rights. We call it Rights and Responsibilities of Wisconsin HMO Members. One of the key rights is the right to present a complaint or grievance. We are continually developing innovative ways to streamline internal grievance processes. Such innovations have led to an overall decline in the rate of HMO grievances. With 1.6 million Wisconsin residents insured and 27 million health care services provided, only 5,000 grievances were recorded in 1998. That equates to only .01 percent of HMO patients that had concerns about their care. I submit that Greater La Crosse Health Plan's rate was not even measurable.

Greater La Crosse Health Plans applauds the protections in LRB 3798 to all health care consumers in Wisconsin. The external review is one more means to quickly and fairly address patient concerns without substantially increasing the cost of health care.

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Provisions of LRB 3798 that Greater La Crosse Health Plans agree with are the following:

- Must apply to all insurers, including indemnity coverage
- Decisions subject to review include adverse and experimental treatment decisions
- Value of service must exceed $500
- Patient must pay a $50 filing fee, refundable if patient prevails
- Insurers pay the cost of the external review
- OCI certifies the IROs and maintains a list of those approved. From that list the patient may select the IRO of choice to conduct the review.
- External review requires exhaustion of the internal grievance process.

Thank you for your time and allowing me to speak on behalf of Greater La Crosse Health Plans, Inc., and their support of LRB 3798. If you have any questions, I would be happy to answer them.

Submitted by,

Steven M.Kunes, Executive Director
Greater La Crosse Health Plans, Inc.

If there's anything we can do for you, just give us a call at Member Services at (608) 791-9853 ext. 6201, or 1-800-362-5454 ext. 6201 (outside La Crosse area)

Greater La Crosse
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COMMUNICATING RIGHTS & RESPONSIBILITIES OF WISCONSIN HMO MEMBERS

Wisconsin Health Maintenance Organizations (HMOs) are committed to maintaining a mutually respectful relationship with their members that promotes high quality, cost effective health care. This document provides key information on the rights and responsibilities of HMO members and sets the framework for cooperation among members, providers and the health plan.

Greater La Crosse
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Your Rights . . .

To **choose.**

You have the right to choose a personal physician from among the health plan's network of primary care physicians.

To **information.**

You have the right to information on your health plan relating to: • covered and excluded health care benefits; • available primary and specialty care providers; • preventive care; • your illness and its care; • the process to make known a complaint or request; and • policies/procedures relevant to your care.

To **privacy and confidentiality.**

You have the right to privacy and confidentiality of all communications and records on your care.

To **participate in your care.**

You have the right to be active in decisions about your treatment. You have the right to a candid discussion of appropriate or medically necessary treatment options for your condition, regardless of cost or benefit coverage. You have the right to be informed about the risks and benefits of treatment and to refuse care.

To **present a complaint/grievance.**

You have the right to voice concerns about your care and to receive a prompt and fair review of your complaints.

To be treated with **respect and dignity.**

You have the right to be treated with respect and dignity regardless of your race, age, sex or creed.

Your Responsibilities . . .

To **choose a personal physician.**

You have a responsibility to choose a personal physician from among the health plan's network of primary care physicians and to establish a relationship with that physician.

To know your **benefits and requirements.**

You have a responsibility to: • understand your health plan benefits; • follow the required procedures; • know how to use the plan's provider network; and • ask questions about things you don't understand.

To provide **accurate information.**

You have a responsibility to provide accurate and complete information about your health history and your eligibility/enrollment. You have a responsibility to show your ID card each time you receive services and to fullfill any financial obligations you may incur.

To **participate in your care.**

You have a responsibility to participate in your care by: • asking questions to understand your illness; • following the recommended/agreed upon treatment plan for your illness; and • making healthy lifestyle choices to try to maintain your health and prevent illness.

To **keep your appointments.**

You have a responsibility to keep your appointments or to give early notice if you must cancel.

To show **consideration and respect.**

You have a responsibility to show consideration and respect to health care providers and staff.

Association of
Wisconsin **HMOs**

William L. Carr
President

Nancy J. Wenzel
Executive Director

2 East Mifflin Street • Suite 701 • Madison, Wisconsin 53703 • 608-255-8599 • Fax 608-255-8627

November 3, 1999

To: Members, Senate Health, Utilities, Veterans & Military Affairs Committee

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

Support for SB 269, External Review

Wisconsin HMOs urge you to support independent, external review as proposed in SB 269, the Senate companion to ASA 1 to AB 518. Over the past several months, members of the Wisconsin Association of Health Plans have worked diligently with other interested parties to craft an external review bill that meets patients' needs without diverting limited resources away from patient care toward unnecessary administrative tasks.

SB 269 represents a consensus bill among key lawmakers, consumer advocates, the State Medical Society (SMS), the Office of the Commissioner of Insurance (OCI), HMOs and other insurers as a meaningful way to provide Wisconsin patients with an independent opinion on health insurance coverage decisions. **Wisconsin HMOs urge you to support SB 269 in lieu of SB 246,** because key elements of SB 246 are incorporated in the consensus bill, SB 269.

Why do HMOs support the external review plan in SB 269?

- Even though Wisconsin HMO patients are highly satisfied with their health plans, HMOs support SB 269 as the right thing to do for patients' peace of mind.
- External review is an effective way to respond to patient concerns, without dramatically increasing the cost of health care.
- Wisconsin already has the best patient protections in the country. By passing SB 269, the Wisconsin Legislature will make the best state law even better.
- Because Wisconsin HMOs have confidence in the quality of care they provide, 19 Wisconsin HMOs already voluntarily use an external or independent review process.
- Wisconsin HMOs annually provide more than 27 million health care services for more than 1.6 million residents. With approximately 5,000 grievances in 1998, that represents concerns with only .01 percent of patient services.

As the only currently accountable health care delivery system, HMOs applaud providing to Wisconsin health care consumers the protections in SB 269. Please support SB 269 and reject any efforts to amend the bill in a way that destroys the important balance and patient protections embodied in SB 269.

Opposition to SB 258, Suing Managed Care Plans

Wisconsin HMOs urge you to reject SB 258, suing managed care plans and other regulations. The external review proposal in SB 269 is a patient friendly, truly independent process that is better than the one proposed in SB 258. Wisconsin HMOs also oppose the right to sue and direct access to specialists provisions.

- **The proposal to sue HMOs isn't a "Patients' Bill of Rights"—it's a "Lawyers' Right to Bill."** Expanded health plan liability will increase health care costs and increase the number of uninsured. The Barents Group estimates that liability legislation could increase premiums between 2.7 percent and 8.6 percent. For each 1 percent increase in premiums, 400,000 people lose their health insurance.

  SB 258 does not simply "codify case law." The language of SB 258 is much broader than the Court's ruling referenced in the bill and would dramatically increase the rate of litigation. Disputes over coverage decisions are best handled through the health plan's grievance process and independent review rather than by a judge and jury with no medical training.

- **The real winners with direct access legislation are specialists.** Direct access will increase health care costs without clinical benefits and lead to inappropriate use of specialty services. A study by the Wyatt Company showed that direct access in a managed care setting could increase health plan costs by 4 percent to 14 percent. A study of patients treated for acute low back pain found that patients had similar outcomes regardless of whether they were treated by a primary care physician, an orthopedic surgeon or a chiropractor. Average outpatient charges were highest for patients of orthopedic surgeons and chiropractors, with no better results.

  Health plans are rapidly responding to patients by developing a variety of streamlined referral initiatives without a direct access mandate. And, 1997 Wisconsin Act 237, the "Managed Care Consumer Protection Act," allows patients to request a standing referral to a specialist. Act 237 also allows specialists to provide primary care services. Access to specialty care is already widely available to managed care plan patients. In fact, a recent study of over 2,000 U.S. physicians practicing in managed care environments found that the final coverage denial rate for referrals to specialists of choice was only 2.6 percent.

True patient protection preserves access to affordable health care. SB 258 will dramatically increase costs without any real benefits for patients. Please reject SB 258.

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: Independent External Review

DATE: November 3, 1999

The physicians of the State Medical Society of Wisconsin are appreciative of legislators from both parties in both houses who have recognized the need for patients to access an independent external review process. Following are the priorities of the State Medical Society of Wisconsin with regard to independent external review.

SMS Independent External Review Priorities

***No contractual relationship between the independent review organization and the health plan**

***Reviewer Qualifications:**

-physician serves as the reviewer of cases where a physician is the grievant's health care provider

-the physician reviewer is of the same specialty as the physician involved in the case subject to review

-the physician is in active practice

-the physician is Wisconsin licensed and board certified in the area or areas appropriate to the subject of the review

-in good standing with the medical examining board

***All health plans (not just managed care) must offer independent external review**

***A broad trigger device related to the kinds of medical issues that can be reviewed externally**

***Plan pays for the costs of the external review**

***Reasonable monetary threshold that the proposed treatment must meet to qualify for independent review**

***No filing fee for the policy holder**

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MEMBER:
Joint Committee on Finance

ROBERT L. COWLES

Wisconsin State Senator • 2nd Senate District

November 22, 1999

To: Senator Moen, Chairman of the Senate Health Committee

From: Senator Cowles

Re: Assembly Bill 518

I have received several letters from Chiropractic patients who oppose the $500.00 limit provision included in Assembly Bill 518.

I told these individuals that I would provide you with a copy of their letters since the bill is now in the Senate Health Committee. I should also mention that these letters reference Senate Bill 258 as the companion bill to Assembly Bill 518. This is not correct, however, Assembly Bill 518 is the bill at the center of their concern.

Please contact me if you have any questions regarding these letters.

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Hoffman Chiropractic Office

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FAX TRANSMISSION COVER SHEET

Date: 11-9-99

To: Senator Robert Cowles

Fax: (608) 267-0304

Re: SB 258

Sender: Kim Helmila, CA

YOU SHOULD RECEIVE 2 PAGE(S), INCLUDING THIS COVER SHEET. IF YOU DO NOT RECEIVE ALL THE PAGES, PLEASE CALL 920 498-3611.

GLENN J. HOFFMAN, D.C.
2101 S. Oneida Street
Green Bay, WI 54304

Telephone: (920) 498-3611

Senator Robert L. Cowles
2nd Senate District
PO Box 7882
Madison, WI 53707

Dear Senator Cowles:

I respectfully request 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 to 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 makes this a "surgeon and hospital protection bill", as they are the primary providers whose services cost more than $500.

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

Sincerely,

Glenn J. Hoffman DC

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I greatly appreciate your help to insure that my rights, as a chiropractic patient, are not treated unfairly.

Sincerely a concerned NE Wisconsin chiropractic patient,

Carrie L. Norton

Carrie L. Norton
1686 Shawano Ave Apt #24
Green Bay WI 54303-3249

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Madison, WI 53707-7882

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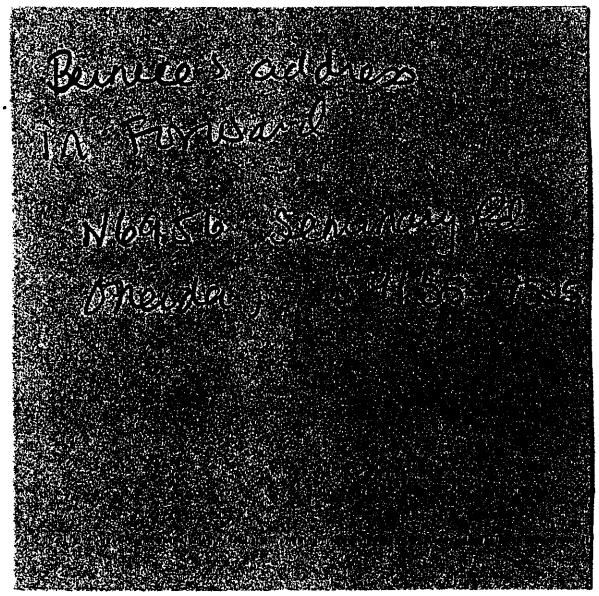
Sincerely a concerned NE Wisconsin chiropractic patient,

Bernice Moore

Bernice Moore
222 S. Wisconsin St
De Pere Wi 54115



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Sincerely a concerned NE Wisconsin chiropractic patient,

1553 Conner Rd
Green Bay, WI 54313

* Can't decipher name

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Belinda Brennan

Belinda Brennan
[redacted] Vliet St.
Kewaunee, WI [redacted] 54216

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Sincerely a concerned NE Wisconsin chiropractic patient,

Jeanette Pieper

Jeanette Pieper
1125 Arnold Dr.
Green Bay, WI
54304

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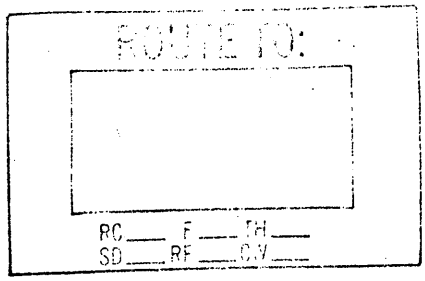
Jan Steinhorst

JAN STEINHORST
1993 ARGONNE ST.
GREEN BAY, WI 54304



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Jon M. Albert

726 Bond St.
Green Bay, WI 54303

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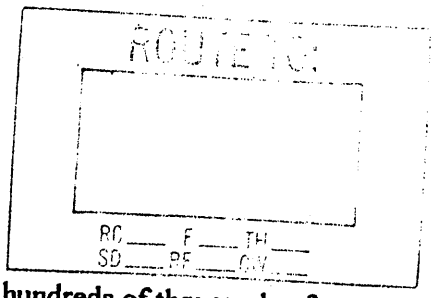
PO Box 7882
Madison, WI 53707-7882



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Lori Mc Guire
3791 Mill Rd.
Greenleaf Wis. 54126

Lori McGuire

SB 269/AB 518
Golden Rule Insurance Company

One of the major problems facing the health insurance industry is the false perception that all insurers have significant control over the decisions made by health care providers in treating their patients. While it is true that some HMOs do exercise a great deal of control, many insurers exercise little or no control. In fact, it is erroneous to treat all health insurance carriers the same with respect to their product line or nature of operation. In response to this misconception and the reported public outcry of policy makers "to do something," lawmakers attempt through legislation to remedy perceived problems by directing insurers to take remedial actions.

This year's Wisconsin legislative response has taken the form of a Patient Protection Act SB 269 and AB 518. These bills include requirements for grievance and external review procedures. While heath maintenance organizations (HMOs) may exercise a great deal of control over the health care treatment of their policy holders, other types of health insurance, whether delivered through a preferred provider organization (PPO) or a traditional indemnity plan, do not control the medical treatment of policy holders. PPO and indemnity carriers simply make decisions concerning reimbursement of health care expenses of policy holders based upon the insurance contract. Additionally, PPO and indemnity plans do not use a gatekeeper to steer a patient through the organization. Placing typical patient protection restrictions on an entity which only finances health care services creates additional financial burdens without benefit to the average consumer.

PPO plans typically do not restrict a policy holder's access to medical treatment by making determinations of appropriateness of care or conducting utilization review before treatment is received. In other words, PPO plans do not second guess a physician's recommended treatment. Policy holders are free to pick whatever providers they want for their treatment. What PPOs do is make a determination on whether the course of treatment recommended by a provider is medically necessary. If the treatment is deemed medically necessary in order to treat the policy holder's conditions and the treatment is covered under the health insurance contract, then the health insurance carrier will pay for the treatment. PPO plans typically do not require prior approval for access to treatment or specialists, nor do they use a gatekeeper.

Smaller carriers like Golden Rule lease established networks of providers through agreements referred to as "access contracts." Insurers that lease networks have no control whatsoever over the providers delivering health care through the network. They do not control whether a provider is removed from the network, nor do they control whether a provider is included in the network. Additionally, because they lack any control over the network they are not in the position to satisfy many of the requirements of SB 269 and AB 518. Unfortunately, the language contained in SB 269 and AB 518 requires carriers that lease PPOs to be responsible for activities that are outside of their control.

However, HMOs often use *primary care physicians* otherwise known as "PCPs" or "gatekeepers" to restrict enrollees' access to specialists, health care treatments and procedures. To qualify for coverage under the insurance plan, all care and treatment must first originate through, and be approved by, the PCP. HMOs engage in *extensive utilization review*. This review is done before care is received, concurrent with treatment, and even after the patient has completed treatment. Most HMOs require their enrollees to have medical services authorized before treatment. Under such a scenario, the pre-authorization results in the assurance that the treatment sought is customary for the diagnosis and is most cost-effective. In other words, the pre-authorization procedure weighs the existence of other, less costly, and potentially less effective, treatments. Only after such a cost/effective analysis is complete, will the HMO authorize treatment.

For Golden Rule's PPO plan to comply with SB 269 and AB 518 which are intended to regulate managed health care delivery systems is an almost insurmountable task. A PPO plan, unlike the managed care entity, does not manage the medical care provided to the consumer. This means that carriers like Golden Rule with a PPO that lease our provider network falls into regulation not designed for our type of operation because we offer a PPO plan even though we have little, if any, control of the network. A more efficient approach would be for SB 269 and AB 518 to limit their applicability to the managed care operations of "health insurance issuers."

The proper place to regulate a PPO network is at the level of control. The legislature might look to who controls the network, who is responsible for its design and maintenance. Additionally, policy makers should look to see who profits from the creation of the network, to determine what entity is creating the network in order to either use it itself or lease access to it to other carriers. These are the organizations that have both access to the information needed to satisfy patient protection laws and the ability to exercise control over providers who participate in the network.

SB 269 and AB 518 while well-intentioned, may have serious, negative consequences to the ability of other types of products to continue providing health care coverage to Wisconsin families. It is extremely important that Wisconsin policy makers craft laws that are narrowly tailored to the types of plans they are attempting to address. Broad legislation which forces all health plans to operate in a similar manner will ultimately take away any meaningful consumer choice. The PPO health insurance product offers consumers a responsive alternative to HMOs.

MEMORANDUM

TO: Members of the Wisconsin Senate

FROM: Pete Christianson, for AFLAC

RE: Amendment Needed to Senate Bill 269

DATE: November 9, 1999

Senate Bill 269 is scheduled for an executive session in the Senate Committee on Health, Utilities, Veterans and Military Affairs. I write on behalf of AFLAC to seek a simple amendment to the bill. AFLAC is an insurance company which offers hospital indemnity insurance as well as coverage for specified diseases.

Such supplemental coverage is designed to supplement, and not replace, traditional health insurance. Individuals buy such supplemental coverage to provide money to cover expenses which are incidental to their health care coverage. For example, a hospital indemnity policy provides a fixed daily benefit for every day of hospitalization – perhaps $100 per day. The policy pays the benefit directly to the insured and not to the hospital or health care provider. There is no coordination of benefits between an indemnity policy and an individual's traditional health insurance coverage.

Senate Bill 269 is designed to require insurers to provide an internal grievance mechanism and to provide an independent review of the insurer's decision in cases where the insured is not satisfied with a coverage decision made by the insurer. According to the LRB analysis, "the [insurer's] decision must relate to the insurer's denial of treatment or payment for treatment that the insurer determined was experimental or to the insurer's denial, reduction or termination of a health care service or payment for a health care service, including admission to or continued stay in a health care facility, on the basis that the health care service did not meet the plan's requirements for medical necessity or appropriateness, health care setting or level of care or effectiveness". [Emphasis added]

The bill is designed to address situations where the insurer and patient disagree about whether a particular medical service should be covered, whether the service is experimental, or whether there is "medical necessity" for a particular treatment. None of these matters are ever at issue with respect to supplemental indemnity insurance. With a hospital indemnity policy, the covered individual is entitled to receive a flat dollar amount per day of hospitalization, whether the traditional health insurance plan covers the hospitalization or not.

Accordingly, the bill should be amended in the following manner:

*On page 6, line 22, delete "includes the coverage specified in s. 632.745 (11) (b) 10. and".

*On page 8, lines 3-4, delete the words ", except that 'health benefit plan' includes the coverage specified in s. 632.745 (11) (b) 10".

State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Tommy G. Thompson
Governor
Connie L. O'Connell
Commissioner

121 East Wilson Street • P.O. Box 7873
Madison, Wisconsin 53707-7873
Phone: (608) 266-3585 • Fax: (608) 266-9935
E-Mail: information@oci.state.wi.us
http://badger.state.wi.us/agencies/oci/oci_home.htm

Testimony to
Senate Health, Utilities, Veterans and Military Affairs Committee
November 3, 1999

by Connie L. O'Connell
Commissioner of Insurance

Thank you, Senator Moen and members of the Committee for providing the opportunity to testify in support of SB 269 creating a process for independent review of heath plan decisions in Wisconsin.

There has been considerable discussion regarding patient protections on a national level. Wisconsin consumers are fortunate that their state elected officials have not waited for federal action and instead have been enacting a comprehensive framework of consumer protections for enrollees of managed care plans. However, a gap has been identified in our existing protections. Consumers have expressed concern that when they disagree with the denial of medical services by their health plan, they have limited avenues to appeal that denial. Their first option is to access the internal grievance process of their plan. While this has proven to be an effective process for many consumers, some enrollees express concern that the plan cannot take a truly independent look at their complaints.

A second alternative for the consumer is to file a complaint with our office. Our complaint process has yielded positive results for many consumers. Last year we were able to return $3.5 million on behalf of insurance consumers. However, we do not have either the statutory authority or medical expertise to overturn a medical decision by a plan.

SB 269 provides consumers with a review structure that is independent from the health plan and has the expertise necessary to review medical decisions. Therefore, this legislation fills a regulatory gap in Wisconsin and provides an important consumer protection that will help restore confidence in our health insurance system.

Independent review is becoming a widely accepted method of providing balance to health plan decision making. At its October national meeting, the National Association of Insurance Commissioners (NAIC) adopted a model act on independent review. Many states have enacted or implemented independent review programs in recent years. The federal Medicare program mandates an independent review process for Medicare HMO enrollees. And recent Congressional action is also moving towards mandating independent review of health plan decisions.

Since early this year Representative Underheim, in coordination with Senator Breske, has been working on this legislation with affected parties including consumers, insurers and health care providers. OCI was pleased to participate in this process. The draft before you today represents the input of these affected parties and the compromises negotiated by the parties including what issues are appealable, the cost to

be born by the consumers for the appeals, characteristics of reviewers, and the role of OCI supervising the independent review process.

Highlights of the Independent Review Bill

I would like to share with you what I consider to be some of the most important features of this proposal:

Adverse Determination

The bill provides broad access to the independent review process by establishing "adverse determination" as the basis for an appeal to the Independent Review Organization (IRO). An adverse determination is any significant limitation of a benefit by the health plan. This definition does not require review of noncare related complaints such as "The receptionist was rude to me," while preserving an enrollees right to challenge coverage decisions.

For example, limiting the number of days of hospitalization authorized for coverage by the health plan would be considered an adverse determination and could be the basis for an appeal. This definition would also include decisions about whether a procedure was experimental treatment, cosmetic or medically necessary.

Qualifications for IROs.

We believe it is critical that there be no question about the independence of the IRO. This legislation contains clear standards for evaluating what is independent. The standards for independence in this bill provide strong consumer assurance that the IRO is making a determination separate from the health plan.

At the same time, OCI does not want the establishment of a large bureaucracy to administer the IRO program. To that end, we support the creation in the bill of a system to allocate independent review requests to the IROs. Under this system, OCI will certify IRO's that meet the standards in the statute and rule. Consumers would then be permitted to select from among any of the certified and qualified IROs to hear their case. OCI would also approve, in advance, a fee schedule for each IRO to eliminate any concern that reimbursement to the IRO was somehow reflective of the determination on cases it decided.

Timely Relief

One of the primary advantages of independent review programs is that they provide timely relief to enrollees. While the right to sue may eventually provide resolution to enrollees, the legal process is not timely. By the time the cases have wound their way through the courts, it is often too late to help the enrollee. Independent review gives the enrollees almost immediate decisions on the medical necessity of their care. There is a process to expedite most cases if warranted by the individual's medical circumstances. The least we can do for people who are facing difficult medical situations is to provide them with timely answers to their questions about insurance coverage for their treatment.

Let me close by saying that OCI believes that adoption of independent review legislation is very important for our health insurance consumers in Wisconsin. An IRO process will close a gap in the regulatory fabric that protects consumers. It will also help restore consumer confidence in their health insurance system.

WHYTE
HIRSCHBOECK
DUDEK S.C.

MEMORANDUM

W
HD
LAW

To: Senate Committee on Health, Utitlities, Veterans and Military Affairs

From: Laura Leitch for the Wisconsin Academy of Family Physicians

Subject: External Review for Health Benefit Plans (SB-269, SB-246, SB-258)

Date: November 3, 1999

The Wisconsin Academy of Family Physicians (WAFP), the largest specialty organization of physicians in the state, strongly supports providing patients with an independent external review of adverse decisions by their health benefit plan.

An independent external review is an important piece of comprehensive patient rights. Currently, patients believe they are powerless when their health care plan refuses to pay for treatment recommended by their physician or other health care provider. Powerlessness leads to anxiety and patients are increasingly anxious about the care provided and not provided by their health care plans. This anxiety can be reduced through the availability of an independent external review. Even if the independent review supports the decision of the health care plan, the patient will feel less anxious about the decision, knowing that the decision was made by independent physicians who would not be influenced by financial considerations.

There are certainly issues that will be considered as the Senate debates these bills. WAFP requests that the Senate ensure that an independent external review for patients becomes the law in Wisconsin.

Center for Public
Representation, Inc.

P.O. Box 260049 Madison, WI 53726-0049 608/251-4008 FAX: 608/251-1263 CPR@vms2.macc.wisc.edu

Testimony by Collaboration for Healthcare Consumer Protection
Before the Committee on Health, Utilities, Veterans and Military Affairs

November 3, 1999

The Collaboration for Consumer Healthcare Protection (CHCP) includes the Milwaukee Medical Society, American Association of Retired Persons (AARP), the Center for Public Representation (CPR), Wisconsin Nurses Association, Wisconsin Society for Podiatric Medicine, and the State Medical Society of Wisconsin.

We support Senate Bill 269 companion to Assembly Bill 518.

Independent External Review (IER) protects both the insured and the quality of health insurance coverage. IER allows experts in the medical treatment to decide what treatments are required. Therefore, IER protects the insured from being denied medical treatment without a review.

All Health Care Plans Are Covered

CHCP supports the application of this bill to all health benefit plans to provide the insured an opportunity to request an independent external review. This breadth of coverage sets a standard of high-quality care no matter which health plan the consumer chooses.

Peer Clinical Reviewers

CHCP supports independent review panels constituted from currently and actively practicing healthcare providers who are experts in the medical condition that is subject to review. For example, if an insured is denied treatment for cancer, an oncologist must sit on the review panel. Additionally, CHCP supports the specialized review of experimental procedures. This specialization standard will ensure the insured the most complete, credible and up-to-date review possible.

Requires All Plans Have Internal Grievance Procedures

CHCP supports the application of this bill to require all health benefit plans to set up an internal grievance procedure. This broad application will set a standard of high-quality care no matter which health plan the consumer chooses. Additionally, CHCP supports the provisions that allow for the insured and insurer to bypass the internal grievance procedure.

Expedited Review

CHCP supports the expedited independent external review procedure. Once the insured has exhausted the internal grievance procedure the expedited review protects the insured from any undue delay in the initiation of independent external review process.

Consumers Chooses IRO Directly

CHCP supports OCI certification of IROs to effectively provide the independent review required under the bill. The consumer chooses an IRO from the certified list. Allowing the consumer independent choice of the certified IROs avoids the appearance of a conflict of interest.