00-169

WCA | Wisconsin Chiropractic Association
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MW
what is your opinion of these changes?
RM

December 15, 2000

Julie E. Walsh
Office of the Commissioner of Insurance
P.O. Box 7873
Madison, WI 53707

Dear Julie:

Pat Essie and I met with Representative Gregg Underheim this week to discuss the IRO rule draft. He suggested that we share our recommendations with you in advance of the public hearing on January 10th and we are pleased to do so.

IRO Rule Change Recommendations

1. **Medical license requirement** (Draft language – Page 13)

> 18.10 (5) The independent review organization shall have a medical director or clinical director with professional post-residency experience in direct patient care who holds a current license to practice medicine, has a clinical specialty appropriate to the type of reviews conducted and oversees the medical aspects of the quality assurance and credentialing program.

In creating this provision, the commissioner has exceeded the scope of the statutes. The requirement that the clinical director hold a current license to practice medicine would eliminate or greatly inhibit chiropractors from owning independent review organizations.

Chiropractors and medical doctors are licensed under separate sections of the statutes and are governed by separate examining boards. The chiropractic profession has statutory protection under 632.87 (3)(b)(1) to insure that clinical decisions related to chiropractic care are made by a chiropractor. This is necessary because medical doctors do not have the clinical training necessary to evaluate chiropractic treatment. In addition, because the two professions aggressively compete over a broad range of neuro-musculoskeletal conditions once could not reasonably expect that there would not be a medical bias in their reviews of chiropractic claims.

Recommendation

18.10 (5) **(a)** The independent review organization **that reviews medical claims** shall have a medical director or clinical director with professional post-residency experience in direct patient care who holds a current license to practice medicine, has a clinical specialty appropriate to the type of reviews conducted and oversees the medical aspects of the quality assurance and credentialing program.

18.10 (5) **(b)** The independent review organization **that reviews chiropractic claims** shall have a ~~medical director or~~ clinical director with professional ~~post residency~~ experience in direct patient care who holds a current license to practice ~~medicine~~ **chiropractic**, has a clinical specialty

appropriate to the type of reviews conducted and oversees the ~~medical~~ **chiropractic** aspects of the quality assurance and credentialing program.

18.10 (5) **(c)** The independent review organization **that review both medical and chiropractic claims** shall have separate a medical director ~~or~~ and **chiropractic** clinical director with professional post-residency experience in direct patient care. **The medical director shall** ~~who~~ holds a current license to practice medicine **and the chiropractic clinical director a current license to practice chiropractic and each shall have** ~~has~~ a clinical specialty appropriate to the type of reviews conducted and oversees the **respective** medical **and chiropractic** aspects of the quality assurance and credentialing program.

2. Chiropractic expert definition (Draft language - Page 12)

A Medical peer reviewer must:

> 18.10 (4) (c) Hold a non-restricted license in a state of the United States and, for physicians, a current certification by a recognized American medical specialty board in the area or areas appropriate to the subject of the independent review.

The chiropractic profession wants to ensure that the reviews on behalf of its patients are conducted with the same degree of relative expertise as those of the medical profession. The process by which chiropractors attain specialty status is similar to that of the medical profession; however, the chiropractic profession uses a different nomenclature for its doctors with specialized education.

Recommendation

18.10 (4) (c) Hold a non-restricted license in a state of the United States. ~~and, for physicians,~~ **Physicians shall hold** a current certification by a recognized American medical specialty board **and chiropractors shall be diplomate eligible in a program requiring at least 300 hours of postgraduate credit hours and that has approved by a college of chiropractic, the American Chiropractic Association or the International Chiropractic Association,** in the area or areas appropriate to the subject of the independent review.

3. Clinical experience of reviewers (Statute excerpt)

> 632.835 (5) (a) The commissioner shall promulgate rules for the independent review required under this section. The rules shall include at least all of the following:
>
> 632.835 (5) (a) 5. Standards for the practices and conduct of independent review organizations.

The commissioner's draft is silent on the amount of clinical experience a reviewer must have to be qualified to conduct a review. In the absence of such a standard, recently graduated doctors, with little or no clinical experience, would be allowed to conduct reviews.

Recommendation

A medical doctor or chiropractor shall have at least 10 years of clinical experience prior to serving as a clinical peer reviewer.

4. Documentation requirements (Statute excerpt)

The insurer has the following obligation when a patient requests an independent review.

> 632.835(3)(b) Within 5 business days after receiving written notice of a request for independent review under par. (a), the insurer shall submit to the independent review organization copies of all of the following:
>
> 632.835(3)(b)1. Any information submitted to the insurer by the insured in support of the insured's position in the internal grievance under s. 632.83.

The insurance commissioner's rules do not require an insurer to list the documents they have forwarded to the independent review organization. Historically, this has been a major area of conflict as insurers routinely fail to send to the reviewer all of the clinical files they received from the provider.

Recommendation

An insurer shall provide a list all of the clinical documentation forward to the independent review organization.

5. Quality assurance plans (Statute excerpt)

> 632.835 (4) (ag) An independent review organization shall have in operation a quality assurance mechanism to ensure the timeliness and quality of the independent reviews, the qualifications and independence of the clinical peer reviewers and the confidentiality of the medical records and review materials.

The commissioner's rules do not contain a require an independent review organization to submit their quality assurance plans to the insurance commissioner's office. Since patients have the right to select the independent review organization, this information would greatly assist them in making a more informed decision.

Recommendation

Each independent review organizations shall, on annual basis, submit their quality assurance plans to the insurance commissioner's office.

We appreciate your consideration of our recommendations. I look forward to providing you with any additional information that you may require.

Sincerely,

Russell A. Leonard
Executive Director

Wisconsin Association
of Health Plans

January 9, 2001

The Honorable Connie L. O'Connell
Commissioner of Insurance
P.O. Box 7873
Madison, WI 53707-7873

Dear Commissioner O'Connell:

Enclosed are the initial comments of the Wisconsin Association of Health Plans regarding the first draft of Clearinghouse Rule 00-169, relating to health plan grievance requirements and independent review organizations.

The Association supported the passage of Senate Bill 350, which created the independent review process for adverse determinations and experimental treatment determinations made by health plans.

In some cases, however, we believe the proposed rule goes beyond the Legislature's intent by creating requirements that are not consistent with the statutes and may actually contradict the statutes. In other areas the proposed rule contains provisions that are inconsistent with existing provisions of the Administrative Code.

We continue to believe that the independent review process can serve the public interest by providing for a cost-effective and timely review of coverage disputes that are not resolved through the standard grievance process. Our comments include suggested language changes that we believe will allow the process to work more efficiently and better reflect the intentions of the Legislature.

Thank you for the opportunity to comment on this rule. The Association looks forward to working with you and your staff to review our comments in more detail.

Sincerely,

Joseph A. Kachelski
Deputy Director

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WISCONSIN ASSOCIATION OF HEALTH PLANS

Office of the Commissioner of Insurance (OCI) Rule on Independent Review Organizations (IROs)

Comments on Rule Provisions (1/9/01)

Topic	Page Number & Section	OCI Rule Language	Specific Suggested Change/Rationale
Definition of "complaint"	Page 2 s. Ins 18.01 (3)	"any expression of dissatisfaction expressed by the insured, or an insured's authorized representative, to the insurer about the insurer or a provider with whom the insurer has a direct or indirect contract."	"any verbal expression of dissatisfaction expressed by the insured, or an insured's authorized representative, to an insurer about an insurer's health benefit plan, the administration of a health benefit plan or the provision of services under a health benefit plan by an insurer's contracted providers. An expression of dissatisfaction shall not be considered a grievance for purposes of s. Ins 18.02 (4) unless it is submitted to the insurer in writing." **Rationale**: Our suggested language clarifies the distinction between complaints and grievances. There is no need to make grievances a subset of complaints. Our language specifies that the dissatisfaction must be related to a health benefit plan and eliminates the undefined distinction between "direct" and "indirect" contracts, consistent with s. Ins 9.01 (3).

Topic	Page Number & Section	OCI Rule Language	Specific Suggested Change/Rationale
Definition of "grievance"	Page 3 s. Ins 18.01 (6)	"any written expression of dissatisfaction with the administration, claims practices or provision of services by an insurer offering a health benefit plan as defined in this chapter."	"any dissatisfaction, expressed in writing to an insurer by or on behalf of an insured, about an insurer's health benefit plan, the administration of a health benefit plan or the provision of services under a health benefit plan by an insurer's contracted providers." **Rationale**: The rule draft's definition of grievance is inconsistent with the definitions of grievance in ss. Ins 3.67 and 9.01 (5). We recommend that final language be consistent throughout the Administrative Code. Our proposed language restores the "by or on behalf of an insured" reference and eliminates the reference to "as defined in this chapter" since that clause is not attached to other defined terms in the rule. Our language also parallels the definition of complaint. We believe "claims practices" need not be separately identified because the term "administration" is broad enough to include claims practices.
Determinations subject to independent review	Page 5 s. Ins 18.02 (2)	"For purposes of this subsection, denial or refusal of an insured's request for a referral from the insurer shall be considered an adverse determination."	Delete sentence. **Rationale**: According to the statutes [s. 632.835 (1) (a)], denial of referral is not an adverse determination. The draft rule language could be construed to mean that an insurer's denial of a request to cover the services of a specific provider would be considered an adverse determination, even if the service would be covered if performed by a different provider.

Topic	Page Number & Section	OCI Rule Language	Specific Suggested Change/Rationale
Notification of right to appeal an adverse determination or an experimental treatment determination	Page 5 s. Ins 18.02 (2) (b)	"The notice to insureds of their right to request an independent review shall comply with s. 632.835 (2), Stats., and shall be accompanied by the informational brochure developed by the office describing the independent review process."	"The notice to insureds of their right to request an independent review shall comply with s. 632.835 (2), Stats., and shall be accompanied by the informational brochure developed by the office describing the independent review process, or a substantially similar notification developed by the insurer. The brochure or its substitute need only be provided when the insured is notified of the disposition of a grievance related to an adverse determination or an experimental treatment determination." **Rationale**: An insurer should have the option of changing the brochure's format to meet its specific administrative needs. There should be no need to provide the brochure more than once in the grievance/independent review process.
Apparent typographical error in s. Ins 18.02 (2) (c)	Page 5 s. Ins 18.02 (2) (c)	"The notice to insureds shall also contain a statement that the grievance or independent review process need not be exhausted in order for insured to use other. However, the notice shall include a statement that references s. 632.835 (3) (f), Stats., informing insureds that once the independent review organization makes a determination, the determination is binding upon the insurer and insured."	Delete s. Ins 18.02 (2) (c). **Rationale**: The draft rule goes beyond the statutory language of s. 632.835 (2) (b) and appears to require the insurer to invite litigation. In addition, the statutory language specifically requires insureds to exhaust all levels of grievance before a case is sent for independent review. The brochure language can address the issue of binding determinations.

Topic	Page Number & Section	OCI Rule Language	Specific Suggested Change/Rationale
Notification requirements in response to complaints	Page 6 s. Ins 18.02 (3)	"In addition to other notices and provisions, including s. Ins 9.39, each time an insurer offering a health benefit plan receives complaints concerning administrative matters or makes other determinations affecting coverage, or . . . initiates disenrollment proceedings, the insurer shall notify the affected insured of the right to file a grievance. The insurer shall provide the following notice to insureds: (a) Their right to grieve the initiation of disenrollment, administrative matters or other determinations affecting coverage shall either direct the insured to the policy or certificate section that delineates the procedure for filing a grievance or shall describe, in detail, the grievance procedure to the insured. The notification shall state the specific reason for the administrative dispute, initiation of disenrollment or other determination affecting coverage. (b) A statement that the insured need not exhaust the grievance process in order to utilize other remedies."	Delete s. Ins 18.02 (3) and replace with: "In addition to other notices and provisions, including s. Ins 9.39, each time an insurer offering a health benefit plan denies a claim or benefit or initiates disenrollment proceedings, the insurer shall notify the affected insured of the right to file a grievance. For purposes of this subsection, denial or refusal of an enrollee's request for a referral from the insurer shall be considered a denial of a claim or benefit. When notifying an insured of the right to grieve the determination, the insurer shall either direct the insured to the policy or certificate section that delineates the procedure for filing a grievance or shall describe, in detail, the grievance procedure to the insured. The notification shall state the specific reason for the denial or initiation of disenrollment." **Rationale**: The draft rule language goes well beyond the current provisions of s. Ins 9.33 (2). It would require insurers to send invitations to file a grievance even when a verbal complaint is immediately addressed to the insured's satisfaction. Our suggested language is consistent with the current provisions of s. Ins 9.33 (2). It eliminates the requirement to acknowledge complaints with a written notification of the right to file a grievance. It also eliminates the requirement that insurers invite litigation, consistent with our comments on s. Ins 18.02 (2) (c).

Topic	Page Number & Section	OCI Rule Language	Specific Suggested Change/Rationale
Signature on written grievance decision	Page 7 s. Ins 18.02 (4) (g)	"The panel's written decision to the grievant as described in s. 632.83 (3) (d), Stats., which shall be signed by one voting member of the panel and include a written description of position titles of panel members involved in making the decision."	"The panel's written decision to the grievant as described in s. 632.83 (3) (d), Stats., which shall be signed by <u>one member</u> of the panel and include a written description of position titles of panel members involved in making the decision." **Rationale**: The change is consistent with the existing language in s. Ins 9.33 (5) (g). The requirement that the decision include written descriptions of panel members involved in making the decision is sufficient to distinguish between the signatory and the members who voted.
Reporting requirements	Page 8 s. Ins 18.02 (9) (c)	"Any provider providing services to the health benefit plan, either directly or indirectly, shall be required, by the insurer, to promptly identify complaints and grievances and forward complaints and grievances to the insurer in a timely manner for recording and resolution. Any insurer offering a health benefit plan shall require all direct or indirect contracts for provider or administrative services to include a provision to promptly identify complaints and grievances and forward these complaints and grievances in a timely manner to the insurer for recording and resolution."	"Any provider providing services to the health benefit <u>plan shall</u> be required, by the insurer, to promptly identify complaints and grievances and forward complaints and grievances to the insurer in a timely manner for recording and resolution. Any insurer offering a health benefit plan shall require <u>all contracts</u> for provider or administrative services to include a provision to promptly identify complaints and grievances and forward these complaints and grievances in a timely manner to the insurer for recording and resolution." **Rationale**: Our suggested change eliminates the undefined distinction between "direct" and "indirect" contracts, consistent with our comments on s. Ins 18.01 (3).
Reporting requirements	Page 8 s. Ins 18.02 (9) (d) 2	"Benefit services including denial of a benefit, denial of experimental treatment, quality of care, refusal to refer insureds or to provide requested services."	Move "quality of care" to its own category [create s. Ins 18.02 (9) (d) 3]. **Rationale**: This change is consistent with OCI's grievance reporting requirements for calendar year 2001.

Topic	Page Number & Section	OCI Rule Language	Specific Suggested Change/Rationale
Prohibited actions	Page 9 s. Ins 18.04	"Insurers offering a health benefit plan may not require binding arbitration or other requirements that restrict an insured's right to seek alternative remedies. Insurers may not require an insured to exhaust internal grievance or independent review prior to utilizing other sources for resolution of complaints. An insured may seek an alternative remedy at any time."	Delete. **Rationale**: The independent review law outlines the independent review process and its relationship to the existing grievance process. S. 632.835 (2) (c) describes that relationship and requires the grievance process to be exhausted prior to the initiation of the independent review process. The independent review law does not deal with "alternative remedies." This requirement creates a prohibition that has no basis in the independent review law. OCI's guidance in the past to insurers has been that if the statutes are silent on an issue, then there is no prohibition. Some insurers have OCI-approved language in their policies that requires the internal process to be exhausted.
Independent review procedures	Pages 9-10 s. Ins 18.10 (1)	"Independent review organizations shall have and demonstrate compliance with written policies and procedures governing all aspects of both the standard and expedited review processes as described in s. 632.835, Stats., including all of the following: . . . (b) A procedure to determine, upon receipt of the referral for review, all of the following: . . . 2. Whether the case relates to a clinical issue or an administrative issue."	Delete s. Ins 18.10 (1) (b) 2. **Rationale**: There should be no reason for an "administrative issue" to be the subject of an independent review, so the distinction between clinical and administrative issues is unnecessary.

Topic	Page Number & Section	OCI Rule Language	Specific Suggested Change/Rationale
Independent review procedures: what information shall be considered	Page 10 s. Ins 18.10 (1) (e) 1	"For cases referred to independent review organizations regarding an adverse determination, the independent review organization and its reviewer shall consider information pertinent to the case including all of the following: 1. The insured's medical records. . . . 3. The terms of coverage under the insured's health benefit plan. 4. Information accumulated regarding the case prior to its referral to independent review, including the rationale for prior review determinations.	1. Information the insurer received or considered in its initial adverse determination and its internal grievance determination, including information submitted to the insurer by the insured in support of the insured's position. 3. The policy or certificate language upon which the insurer relied in making its initial adverse determination and its internal grievance determination. 4. The insurer's rationale for its prior review determinations. **Rationale**: S. Ins 18.10 (1) (e) requires independent review organizations to consider types of information beyond the scope of what an insurer is required to provide to the independent review organization under s. 632.835 (3) (b). The draft rule language could be construed to create an obligation for insurers to provide and pay for information they do not possess or is otherwise not included in the statutory requirements. Under our proposed language, the insurer would be obligated to provide all information that it received or considered in making its initial adverse determination and its internal grievance determination. This would include any of the insured's medical records that were relevant to the insurer's decision and in the insurer's possession. This would also include the policy or certificate provisions upon which the insurer relied in making its decisions. Our suggested changes to ss. Ins 18.10 (1) (e) 1 and 3 would make s. Ins 18.10 (1) (e) 4, as drafted, largely redundant. Therefore, we are suggesting that it be modified to include only a reference to the insurer's rationale for its prior determinations.

Topic	Page Number & Section	OCI Rule Language	Specific Suggested Change/Rationale
Qualifications of clinical peer reviewers	Page 12 s. Ins 18.10 (4) (a)	"Be an expert in the treatment of the insured's medical condition that is the subject of the independent review."	Delete s. Ins 18.10 (4) (a). **Rationale**: The term "expert" is not defined and is probably not definable. Ss. Ins 18.10 (4) (b), (c), (d) and (e) are sufficient criteria to establish the qualifications of clinical peer reviewers.
Reporting requirements for independent review organizations	Page 14 s. Ins 18.14 (2) (e)	"The number of requests for independent review resolved and, of those resolved, the number resolved upholding the adverse determination by the insurer and the number resolved reversing the adverse determination by the insurer."	Create new s. Ins 18.15: "The office shall annually provide for and publish an independent audit of a statistically significant sample of cases referred to independent review organizations. The purpose of the audit shall be to establish the extent to which different independent review organizations reached similar conclusions in cases involving similar circumstances." **Rationale**: If the independent review process is effective, the audits should document a high rate of consistency among different independent review organizations. It is in OCI's interest to be aware of any significant variation in outcomes so that it may propose rule modifications, and it is in the public's interest to be informed of the effectiveness of the process.

State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Tommy G. Thompson
Governor

Connie L. O'Connell
Commissioner

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January 26, 2001

JAN 3 0 2001

Honorable Rodney C. Moen
State Senator
8 South Capitol
Madison WI 53702

RE: Ins 18 - Independent Review Organizations

Dear Senator Moen:

Thank you for sharing the comments of the Wisconsin Chiropractic Association (WCA) regarding our proposed administrative rules on Independent Review Organizations (IROs).

We recently held a public hearing on the rule where the WCA also shared their comments with us, and their comments will become part of the official record for this rule. In addition, OCI staff has met with the WCA to discuss their concerns. The comment period on the proposed rule closes February 9, 2001. Once the comment period has ended, we will consider all comments we have received, review the rule language, and make any needed amendments prior to forwarding the rule for legislative review.

If you have any additional questions or concerns, I would be happy to discuss this with you further.

Sincerely,

Connie L. O'Connell

Connie L. O'Connell
Commissioner

White, Melissa

From: Lonergan, Sandra
Sent: Tuesday, February 06, 2001 5:43 PM
To: White, Melissa
Subject: chiros & IER

Hi there --

Gregg decided to write a letter to Connie for the chiros. It's slightly stronger than Rod's but doesn't exactly say what Russ wanted. Somewhere in between I guess. Gregg just wants you guys to know that he isn't "going out in front" on this for them. When you read the letter, you'll understand! Dagny will send you a copy of the letter tomorrow (Wednesday).

I'll talk with you next week. Enjoy the snow & rain!

Rod -

FYI ... Russ Leonard, of Chiro Assn. described your letter as "lukewarm"

MW

No Shit —

He's lucky it WAS "WARM" @ all

R

State Representative
GREGG UNDERHEIM
Chair: Assembly Committee on Health

February 6, 2001

Connie O'Connell, Commissioner
Office of the Commissioner of Insurance
121 East Wilson Street
Madison, Wisconsin 53702

Dear Commissioner O'Connell:

I write regarding Clearinghouse Rule 00-169 creating INS 18 relating to health benefit plan grievance requirements and independent review organizations. Specifically, I bring to your attention the concerns set forth by the Wisconsin Chiropractic Association (WCA). I have recently had the opportunity to meet with them regarding this rule and in reviewing their December 15, 2000 memo to you, they have made two recommendations that I believe merit serious consideration.

The first recommendation deals with the requirement under Ins. 18.10 (5) that the independent review organizations "have a medical director or clinical director with professional post-residency experience in direct patient care who holds a current license to practice medicine, has a clinical specialty appropriate to the type of reviews conducted and oversees the medical aspects of the quality assurance and credentialing program".

The following language, submitted by the WCA, addresses their concern.

18.10 (5) **(a)** The independent review organization **that reviews medical claims** shall have a medical director or clinical director with professional post-residency experience in direct patient care who holds a current license to practice medicine, has a clinical specialty appropriate to the type of reviews conducted and oversees the medical aspects of the quality assurance and credentialing program.

18.10 (5) **(b)** The independent review organization **that reviews chiropractic claims** shall have ~~a medical director or~~ clinical director with professional ~~post-residency~~ experience in direct patient care who holds a current license to practice ~~medicine~~ **chiropractic**, has a clinical specialty appropriate to the type of reviews conducted and oversees the ~~medical~~ **chiropractic** aspects of the quality assurance and credentialing program.

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18.10 (5) **(c)** The independent review organization **that review both medical and chiropractic claims** shall have separate a medical director ~~or~~ and **chiropractic** clinical director with professional post-residency experience in direct patient care. **The medical director shall** ~~who~~ holds a current license to practice medicine **and the chiropractic clinical director a current license to practice chiropractic and each shall have** ~~has~~ a clinical specialty appropriate to the type of reviews conducted and oversees the **respective** medical **and chiropractic** aspects of the quality assurance and credentialing program.

The second recommendation deals with the requirement for a medical peer reviewer to hold "a current certification by a recognized American medical specialty board in the area or areas appropriate to the subject of the independent review" (18.10 (4) (c). The rules do not define a similar requirement for the chiropractic profession.

The following language change has been submitted by the WCA and I ask for your consideration of it.

18.10 (4) (c) Hold a non-restricted license in a state of the United States. ~~and, for physicians,~~ **Physicians shall hold** a current certification by a recognized American medical specialty board **and chiropractors shall be diplomate eligible in a program requiring at least 300 hours of postgraduate credit hours and that has approved by a college of chiropractic, the American Chiropractic Association or the International Chiropractic Association,** in the area or areas appropriate to the subject of the independent review.

Thank you for your prompt attention to this matter. If you have any questions or would like to discuss this personally, please feel free to contact me.

Sincerely,

GREGG UNDERHEIM
State Representative
54th Assembly District

GU/sjl

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June 20, 2001

Senator Rod Moen
PO Box 7882
Madison, WI 53707

Dear Senator Moen:

The Wisconsin Chiropractic Association has carefully reviewed INS. 9.33 and respectfully requests that the Senate Health Committee make the following modifications to the rule.

Reviewer qualifications Wi stat. 632.875 (6m) (c) states that "physicians" must hold a current certification by a recognized medical specialty board. Neither the statutes nor the proposed rule define a similar requirement for the chiropractic profession. Chiropractic patients have a right to expect that their reviews are conducted at the same relative level of professionalism as the reviews conducted by the medical profession.

Proposed change to the rule

Ins 18.12 (4) Reviewer Qualifications In addition to the requirements of s. 632.835 (6m), Stats., the independent review organization shall require all clinical peer reviewers assigned to conduct independent reviews to be physicians or other appropriate health care providers whose qualifications are verified every 2 years.

Chiropractors shall be diplomate eligible in a program requiring at least 300 hours of postgraduate credit hours and that has approved by a university or college of chiropractic, the American Chiropractic Association or the International Chiropractic Association, in the area or areas appropriate to the subject of the independent review.

Notification requirements Under 632.835(3) an insurer is required to *immediately* notify the commissioner and the independent review organization of the request for an independent review. To avoid friction and to eliminate unnecessary delays the time frame for immediate should be defined.

Proposed change to the rule

The rule should cross reference this section of the statutes and define the word *immediately* should be defined to mean within one business day.

Clinical documentation Under 632.835 (3) (b) 1 an insurer is required to submit to the independent review organization any information submitted to the insurer by the insured in support of the insured's position. To avoid conflicts, the insurer should be required to list all of the documentation forward to the independent review organization. This will allow the patient and the health care provider the opportunity to insure that the insurer has in fact submitted all of the clinical documentation that was part of the grievance procedure.

Proposed change to the rule

Ins 18.11 (3)(b) The insurer shall provide the information required in s.632.835 (3)(b), Stats, to the independent review organization without requiring a written release from the insured in

accordance with s. 610.70 (5)(f). **The insurer shall provide a list of the documents and the number of pages of each type of document to the independent review organization.**

Signed opinions Under 632.835 (3) (f) the decision must be in writing and signed on behalf of the independent review organization. The rules should specify the name of the individual that performed the review on behalf of the independent review organization to insure that conflicts have not occurred as defined under 632.835 (6).

Proposed change to the rule

Ins 18.12 (1) (h) Procedures to ensure that within 2 business days of rendering a determination, the independent review organization shall, in addition to the requirements of s.632.835 (3)(f), Stats., send to the insurer, the insured, or the insured's authorized representative a written notice of the determination that includes all of the following:

1. The question or issue that was referred for review.
2. A description of the qualifications of the reviewer or reviewers.
3. A clinical rationale or explanation for the independent review organization's determination, including supporting evidence **signed by the reviewer or reviewers.**

Quality assurance plans Under 632.835 (4) (ag) an independent organization must have in operation a quality assurance mechanism to ensure the timeliness and quality of the independent reviews, the qualifications and independence of the clinical peer reviewers and the confidentiality of the medical records and review materials. Independent review organizations should be required to submit their quality assurance plans to the commissioner's office where they would be available for public inspection. This will allow members of the public to make a more informed decision as to which independent review organization they ought to select to perform their independent review.

Proposed change to the rule

Ins. 18.12 (2) Quality Assurance Procedures. Independent Review organizations shall **annually file of copy of their quality assurance plan with the commissioner and** shall establish, maintain and demonstrate compliance with written quality assurance procedures that promote objective and systematic monitoring and evaluation of the independent review process and that includes, at a minimum, all procedures to ensure the following:

Experience requirement Under 632.835 (5) (a) 5 the commissioner must promulgate standards for the practices and conduct of independent rule organizations. To insure that independent reviews are performed by experienced practitioners, the rules should state that all clinical peer reviewer must have at least 10 years of clinical experience prior to serving as a clinical peer reviewer.

Proposed change to the rule

(a) All clinical peer reviewers shall have at least 10 years of clinical experience.

We appreciate your consideration of our recommendations.

Sincerely,

Russell A. Leonard
Executive Director

Wisconsin Association of Health Plans

June 21, 2001

TO: The Honorable Connie L. O'Connell
Commissioner of Insurance

FROM: Wisconsin Association of Health Plans Executive Committee

RE: Independent External Review Rule

We have completed a thorough review of the redraft of Clearinghouse Rule 00-169, relating to Independent External Review (IER). Following are our remaining concerns and our proposed resolutions to each.

1. S. Ins 18.10 (1), Definition of "Adverse Determination"

The definition of "adverse determination" is central to the implementation of the entire IER process. While the revised definition significantly improves upon the second draft of the rule, we continue to believe that the statutory definition of adverse determination speaks for itself and needs no modification or clarification. We are concerned that any attempt to expand upon the definition contained in the statutes will result in an unintended expansion of the scope of the law.

We remain concerned that references to providers, rather than services, stray from the Legislature's intent. We believe the revised definition could still be used to allow a request for a specifically excluded benefit associated with a non-participating provider, like acupuncture or aromatherapy, to proceed to IER. The Legislature clearly did not intend to give independent review organizations the power to rewrite insurers' policies by negating policy exclusions.

Proposed resolution: The definition of "adverse determination" should be identical to the definition in s. 632.835 (1) (a), Stats., with no additional qualifications.

2. S. 18.11 (2), Notification of IER Rights

We continue to believe that the sequence of events specified by the rule is problematic.

The rule requires insurers to provide notice of IER rights, a list of independent review organizations, and other information that would lead members to reasonably believe that they have an immediate opportunity to pursue IER. Insurers must provide this information before the grievance process is exhausted and indeed before the member even chooses to pursue a grievance. Insurers would be required to provide this information twice -- once before the grievance process and once after.

We believe that the IER notification is most appropriately provided at the point a grievance determination is made in favor of the insurer. We recognize that there are limited statutory exceptions to the requirement that insureds first exhaust the grievance process before pursuing IER. However, we believe these exceptions will be rare and can be accommodated in other ways.

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Proposed resolution: The IER notice should be required when the insured is notified of a grievance resolution in favor of the insurer. To accommodate a potential expedited IER, the notice should also be required when the insurer receives a request for an expedited grievance or expedited review. Since mutual agreement is required to bypass the grievance process in a non-expedited situation, the IER notice should not be required to inform insureds that they may bypass the grievance process unless it is the insurer's intent to agree to do so. It seems incongruous to compel an insurer to notify members of a "right" that members may not independently exercise.

3. S. 18.03 (2) (c), Provider Contract Requirements

The draft language expands the current rules [s. Ins 9.33 (7) (b)] significantly. We are not aware of any deficiencies in the existing rule that would suggest changes are needed.

PPOs?

Proposed resolution: Substitute existing language in s. Ins 9.33 (7) (b) for draft language in s. 18.03 (2) (c).

4. S. 18.05, Expedited Grievances
S. 18.11 (3) (d), Expedited Reviews

The language in ss. 18.05 and 18.11 (3) (d) is imprecise in defining the circumstances that would warrant an expedited grievance or review process. In both cases, the rule language creates a broader standard for expedited grievances or reviews than contemplated by the statutes or other rule provisions.

change definition of expedited grievance "could have"

Proposed resolution: Modify s. 18.05 as follows:

"Ins 18.05 **EXPEDITED GRIEVANCE PROCEDURE.** Sections 18.03 (2) to (4) and (6) do not apply to ~~situations where the normal duration of the grievance resolution process could have adverse health effects for the insured~~ expedited grievances. For these situations, an insurer offering a health benefit plan shall develop a separate expedited grievance procedure."

[The term "expedited grievances" is defined in s. 18.01 (3). That definition refers to "serious jeopardy" to life or health, "severe pain" or a physician's opinion. The language in s. 18.05 is far more vague ("could have adverse health effects") and seems to require insurers to develop an expedited grievance procedure for grievances that don't meet the rule's criteria for an expedited grievance].

Modify s. 18.11 (3) (d) as follows:

"(d) Subdivisions (a) to (c) do not apply to situations where the independent review organization determines that the normal duration of the independent review process ~~could~~ would jeopardize the life or health of the insured or the insured's ability to regain maximum function ~~result in adverse health effects for the insured~~."

[The proposed rule language ("could result in adverse health effects for the insured") is vague and strays from the relevant statutory language. Our suggested change mirrors the language from s. 632.835 (3) (g), Stats.]

Thank you for the opportunity to provide these additional comments.

WEA TRUST

P.O. Box 7338, Madison, WI 53707-7338 \ 45 Nob Hill Road, Madison, WI 53713-3959 \ PHONE 608.276.4000 \ 800.279.4000 \ FAX 608.276.9119

June 28, 2001

State Representative Gregg Underheim
Chair: Assembly Committee on Health
P.O. Box 8953
Madison, WI 53708-8953

RE: WEA Trust Response to IER rules to Legislature (CR Assembly 00-169)

Dear Representative Underheim:

The WEA Trust is pleased to see that much of the confusion in the prior draft of the rules has been clarified. However, some problems remain. We request that the Committee assure that these remaining problems be addressed, if necessary through a hearing.

1. Ins. 18.03, Grievance procedure, subsection (5) Authorization for Release of Information:

This entirely new rule is confusing. It correctly recognizes the fact that someone purporting to act on behalf of an insured must be *authorized* to do so, yet prohibits the insurer from verifying that authorization. In addition, the insurer must obtain a written release before sharing the insured's medical information with the representative, but must proceed with the grievance even if the insured refuses to provide the release. There is no purpose in activating a grievance procedure and convening a grievance panel if the relevant medical information cannot be discussed with the grievant's authorized representative. This is an untenable approach to dealing with confidential information, especially since use of confidential information is now highly regulated at both the state and federal level. (The reference in 18.11(3)(b) to Sec. 610.70(5)(f) suggests that a misinterpretation of that statutory section may have led to this odd rule.)

Proposed Action: Delete 18.11(3) (b) entirely, and revise subsection (5) as follows:

(5) Authorization For Release of Information. ~~An insurer offering a health benefit plan shall not require the insured to sign a release in order to have an authorized representative act on the insured's behalf.~~ An insurer may require the insured, or the insured's authorized representative, legal guardian or court appointed representative, to provide a written release to the insurer to *act on the insured's behalf, activate the grievance procedure,* share the insured's personal medical information with the insurer's grievance panel, independent review organization and the insurer's authorization representative if that individual is not *already* a legally recognized representative. The insurer must include the release form with the acknowledgment of receipt of the grievance as described in sub. (4), *either upon request or if the insurer has reason to believe the insured intends to use a representative.* The release form shall contain information describing the scope, duration and purpose for the release of personal

medical information. The insurer shall notify the insured that failing to sign and return the release form ~~may limit the information reviewed by he grievance panel to information in the possession of the insurer. The insurer shall not refuse to proceed with the grievance review solely due to the lack of a signed release form.~~ *will mean that the grievance review process, and ultimately the independent review process, cannot proceed.*

2. 18.04 Right of the Commissioner to Request OCI Complaints be handled as Grievances:

The section heading references OCI's right to "request" that an OCI complaint be handled under the statutory grievance process, and that is the appropriate approach. However, the provision grants OCI the right to "require" that an OCI complaint be handled as a grievance. Such a blanket right is not authorized by the statute and is not consistent with the statutory language.

3. Ins. 18.12(1)(f), IRO's scope of authority regarding experimental treatment:

The rule suggests that the standard for evaluating "experimental treatment" is "effectiveness and efficacy." The rules have now even deleted the minimal reference, previously at 18.01(5), to the statutory definition of "experimental treatment."

The statutes, in Sec. 632.835(3m)(b), clearly specify the criteria for an IRO determination that treatment is not experimental. The statute states that ". . . the IRO shall determine that the treatment is not experimental and find in favor of the insured only if the IRO finds all of the following : . . .," and then lists a series of criteria. Proposed rule 18.12(1)(f) ignores the very specific statutory criteria and instead substitutes a vague reference to "effectiveness and efficacy."

Proposed Action: Define "experimental treatment" in the rules using the statutory criteria, and then use the specific defined term "experimental treatment" in 18.12(1)(f) and elsewhere in the rules.

4. Standards for IRO Decisions:

The statute, at Sec. 632.835(3)(m), establishes standards for any IRO review. Foremost is that an IRO decision "must be consistent with the terms of the health benefit plan under which the adverse determination was made." Yet the statutory standards in general, and this standard in particular, are not referenced in the rules as a standard relevant to the IRO process. Instead, the only mention of the relevance of the terms of the health plan is at Ins. 18.12, Independent Review Organization *Procedures*, subsection (1)(e)3., where "the terms of coverage under the insured's health benefit plan" is listed as a piece of "pertinent information" for an IRO procedure. This is an inadequate and inaccurate reference to the statutory standard.

Proposed Action: Either add a "Standards" section to the rule which incorporates the statutory standards, or add the following to 18.12(1)(b):

6. Whether a decision in favor of the insured would be consistent with the terms of the health benefit plan under which the adverse determination was made, as required by Sec. 632.835(3m).

5. 18.11(1)(3) Independent Review Timeframes:

Sec. 632.835(3)(b) of the statute provides that an insurer must submit the relevant grievance information to the IRO "within 5 business days." Ins. 18.11(1)(3) requires the insurer to give "written notice of the IRO request to OCI and the IRO within 2 business days of receipt." This is either inconsistent with the rules or excessive procedure. Sending off the grievance information is clear notice to the IRO, and that is also most reasonable time to inform OCI of the IRO activation.

Proposed Action: In 18.11(1)(3), change "2" to "5."

Thank you for the opportunity to comment on these rules.

Sincerely,

Carol L. Rubin
Associate General Counsel

CLR/cll

cc: Connie O'Connell, Commissioner of Insurance
Michael Stoll, General Counsel, the WEA Trust

State Medical Society of Wisconsin
Working together, advancing the health of the people of Wisconsin

July 2, 2001

The Honorable Rodney Moen, Chair
Senate Committee on Health, Utilities, Veterans and Military Affairs
P.O. Box 7882
Madison, Wisconsin 53707-7882

The Honorable Gregg Underheim, Chair
Assembly Health Committee
P.O. Box 8953
Madison, Wisconsin 53708-8953

Dear Senator Moen and Representative Underheim:

Please accept this letter as written comments on behalf of the State Medical Society of Wisconsin in regard to Clearinghouse Rule 00-169.

Briefly, we note that three objections remain to the language of the final rule, particularly the involvement of physicians as conduits for complaints and grievances, the description of reviewer qualifications, and finally, the determination of when a treatment denied as "experimental" is payable. We request that these important changes now be incorporated into the final rule.

Specifically, the SMS strongly disagrees with the requirement that physicians be responsible for forwarding oral and written complaints as well as grievances to insurers. The purpose of this legislation was to create a grievance and independent external review (IER) function, *not* a complaint function. IER is designed to address grievances about denials of coverage. The addition of "complaints" dramatically expands the scope of the legislation and will unnecessarily clog the system and reduce the ability to accomplish its objectives.

Furthermore, sec. 18.01(2)(c) inappropriately inserts the physician into a contractual relationship between the insurer and the patient. Patients already complain frequently that doctors spend too little time with them. This unnecessary administrative burden, when added to all of the other administrative requirements demanded by various health plans, Medicare, Medicaid, and so forth, will further reduce the amount of time physicians may spend providing patient care.

The SMS also requests that sec. 18.12(2)(b) be strengthened and clarified to read as follows:

> **18.12(4) REVIEWER QUALIFICATIONS**: In addition to the requirements of s. 632.835(6m), Stats., the independent review organization shall require all clinical peer reviewers assigned to conduct independent reviews to be physicians or other [delete "appropriate"] health care providers (a) have the same training background and licensure as the

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providers in the case being reviewed. For example, podiatrists should be reviewers for podiatry cases; chiropractors should be reviewers for chiropractic cases, and physicians should be reviewers for cases involving allopathic or osteopathic medicine, and (b) hold a non-restricted license in a state of the United States, and for physicians, hold the same specialty and sub-specialty board certification (recognized by the American Board of Medical Specialties) as the physician in the case under review.

Finally, the SMS requests that the statutory criteria for evaluating proposed treatment be adopted. Instead of using the explicit statutory criteria at sec. 632.835(3m)(b), Stats., sec. 18.12(1)(f) of the rule sets the standard for evaluation of a treatment as its "effectiveness and efficacy," which is considerably more vague. At minimum, the statutory citation should be given. Better yet, the statutory language, which is short, should be inserted into the rule. The rule would then read as follows:

> A decision of an independent review organization regarding an experimental treatment determination is limited to a determination of whether the proposed treatment is experimental. The independent review organization shall determinate that the treatment is not experimental and find in favor of the insured only if the independent review organization finds all of the following:
>
> 1. The treatment has been approved by the federal food and drug administration, if the treatment is subject to the approval of the federal food and drug administration.
> 2. Medically and scientifically accepted evidence clearly demonstrates that the treatment meets all of the following criteria:
>   a. The treatment is safe.
>   b. The treatment can be expected to produce greater benefits than the standard treatment without posing a greater adverse risk to the insured.
>   c. The treatment meets the coverage terms of the health benefit plan and is not specifically excluded under the terms of the health benefit plan.

We appreciate the opportunity to provide our comments, and I am happy to answer any questions you may have.

Sincerely,

Marilyn Windschiegl

Marilyn Windschiegl, JD
Legislative Counsel

cc: Julie E. Walsh
Office of the Commissioner of Insurance

Judicial

State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Scott McCallum, Governor
Connie L. O'Connell, Commissioner

Wisconsin.gov

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July 3, 2001

Executive Committee Members
Wisconsin Association of Health Plans
10 East Doty Street, Suite 503
Madison WI 53703

Dear Members of the Executive Committee:

Thank you for your memo identifying outstanding concerns with the OCI's Independent Review rule. I appreciate the time you have spent looking into the rule. I would like to take this opportunity to respond briefly to each of the concerns that you raised. I believe the concerns raised can be resolved through the following explanation of the OCI's interpretation and our plan to include this information in an explanatory bulletin to insurers prior to the effective date of the rule.

1. The definition of "adverse determination." It is OCI's interpretation that as defined, adverse determination does not expand the authority of an independent review organization. It is our belief, and we will convey this to insurers through the bulletin, that nothing in the definition of adverse determination can be construed to require coverage of provider services that are inconsistent with the terms of the policy. Section 632.835 (3m) (a), Stats., specifically requires that the decision of the independent review organization be consistent with the terms of the health benefit plan and, in order for an independent review organization to continue to be licensed, it must demonstrate compliance with the statutes. Therefore, OCI expects that the definition of adverse determination could not be used to allow a request for services that are specifically excluded from the health benefit plan to be reviewed by the independent review organization.

2. Notification of independent review rights. The timing of when notices are sent to consumers is controlled by statute, not rule. The rule does not dictate the content of insurer notices other than to ensure that consumers be made aware that the independent review organizations exist and may be an appropriate forum. However, the OCI does not expect nor require the insurer to promote or encourage independent review through its notices. Rather, OCI would anticipate that an insurer would comply with the statute and provide the requisite notices in a concise manner. Again, we will address this requirement in a bulletin.

3. Provider contract requirements. The language in s. Ins 18.03, (2) (c) addresses a difficulty that the OCI has encountered over the past years. Specifically, in response to inquiries regarding consumer complaints involving providers, some insurers have repeatedly informed the OCI that because they do not contract directly with that provider, they need not respond to the complaint. Instead, the insurer forwards the complaint to the provider or the network with whom the provider contracts with no responsibility to ensure the consumer receives a timely response or any response to their concerns. The OCI sees this issue as one of consumer protection that also places all insurers on an equal playing field. It is unfair to the consumer not to receive a response to a concern, nor is it fair that some insurers may not be counting all complaints merely because they are related to a subcontracted provider. Further, the OCI needs to be sure that the insurer, the entity with whom the consumer contracts, is responsive to the consumer and ensures compliance with reporting requirements. The current language in s. Ins 9.33 (7) (b) is insufficient to protect consumers and maintain a level playing field among insurers.

4. Expedited grievances and reviews. The OCI is concerned that the Association believes the rule definitions and references stray from the statutes. By including specific cross-reference to the appropriate sections, the OCI has attempted to reinforce the statutes and the time frames and limitations contained within the statute, not broaden or confuse. There are slightly different rule requirements between expedited grievances and expedited reviews. This arises because of the lack of statutory guidance on grievances and the desire to parallel chapter Ins 18 with chapter Ins 9, by maintaining the existing definition of expedited grievances. In contrast, s. 632.835 (3) (g), Stats., provides specific guidance and limitations on expedited reviews that are then referenced within the expedited review section of the rule.

I trust this responds to your concerns. Again, it is the intention of the OCI to provide insurers with guidance through a bulletin prior to the effective date of the rule so that the above clarifications can be known to all Wisconsin insurers. Thank you again for alerting me of your concerns.

Sincerely,

Connie L. O'Connell

Connie L. O'Connell
Commissioner

CHCP
collaboration for healthcare consumer protection

Center for Public Representation
Medical Society of Milwaukee County
State Medical Society of Wisconsin
Wisconsin AARP
Wisconsin Nurses Association
Wisconsin Society of Podiatric Medicine

July 3, 2001

The Honorable Rodney Moen, Chair
Senate Committee on Health, Utilities, Veterans and Military Affairs
PO Box 7882
Madison, Wisconsin 53707-7882

The Honorable Gregg Underheim, Chair
Assembly Health Committee
PO Box 8953
Madison, Wisconsin 53708-8953

Dear Senator Moen and Representative Underheim:

Thank you for the opportunity to comment on the proposed IER Rules, Clearinghouse Rule 00-169. The participants of the Collaboration, who have signed below, would like the submit the following comments:

1. OCI proposes an order to repeal and recreate s. Ins 9.33 and to create ch. Ins 18. If 9.33 is repealed and replaced by ch. Ins 18 as ch. Ins 18 is currently written, OCI will no longer be required to produce an annual report. Without such a requirement it seems unlikely that an annual grievance report would be written. We feel the report is important and that OCI ought to still be required to produce it.

2. For clarity, we suggest changing the last sentence of the second paragraph of the OCI Analysis. The revised sentence should read:

   "All health benefit plans, including limited service health plans and preferred provider plans, are required to provide insureds the right to access the grievance process that has previously been required only for managed care plans."

3. It is unclear in our reading how 18.03(2) "Notification of Right to Appeal Determinations" and 18.11(2) "Notification of Right to Independent Review" are to be understood in relation to one another. 18.11 requires that each time an insurer makes an adverse determination the insured should be send notice of the right to request independent review. However, 18.03 requires that each time an insured is denied a claim or benefit the health benefit plan shall notify the insured of the right to file a grievance.

4. 18.04 "Right of the Commissioner to Request OCI Complaints be Handled as Grievances" is an idea that both the collaboration and WEA objected to

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previously. The rules should permit only an insured or an insured's authorized representative to file a grievance.

5. 18.06(2) seems to suggest that grievances need either be categorized into the broad categories of "plan administration" or "benefit services." We would like for the rules to specify more narrow categories. For example, the rules would clearly indicate that benefit services grievances should be broken down into denial of benefit, denial of experimental treatment, quality of care, and refusal to refer insureds or to provide requested services.

6. In 18.12(1)(f), the standard for evaluating a proposed treatment is "effectiveness and efficacy." The rule should require that the determination whether a treatment is experimental be made in accordance with the requirements of Sec. 632.835(3m)(b), giving the statute citation. For utmost clarity, it is important that the statutory criteria be quoted.

7. 18.12(1)(h)(3) should be amended so that the written notice of the determination includes "a clinical rationale or explanation for the independent review organization's determination, including supporting evidence and a clear statement of the decision."

8. In 18.12(2)(b), the requirements for a peer reviewer have been condensed to a suitable matching of reviewers to specific cases. This is not a clear standard and we propose the following:

18.12(4) REVIEWER QUALIFICATIONS: In addition to the requirements of s. 632.835(6m), Stats., the independent review organization shall require all clinical peer reviewers assigned to conduct independent reviews to be physicians or other [delete "appropriate"] health care providers (a) have the same training background and licensure as the providers in the case being reviewed. For example, podiatrists should be reviewers for podiatry cases; chiropractors should be reviewers for chiropractic cases, and physicians should be reviewers for cases involving allopathic or osteopathic medicine, and (b) hold a non-restricted license in a state of the United States, and for physicians, hold the same specialty and sub-specialty board certification (recognized by the American Board of Medical Specialties) as the physician in the case under review.

8. 18.12(6) states an IRO must employ or contract with a medical or clinical director, depending on the scope of the reviews being performed by the IRO. Specifically, it permits a limited-scope IRO to use a clinical director in while it requires a medical director in the section dealing with a non-limited IRO. This language is confusing, for two reasons. First, subsection (b), which is about a limited-scope IRO, talks about "full scope" of review, which would make more sense in subpart (a), which identifies the requirement for a non-limited IRO. Second, what is the difference between the medical director and clinical director, and why is one required in one instance and not the other?

9. Per 18.18(6), the IRO "may charge no more" than the filing fee if it determines that the matter is not within its authority to review. We had previously objected to an IRO receiving the $25 filing fee for deciding whether a claim is reviewable; we are still opposed to the IRO receiving the filing fee for such a decision.

10. We strongly disagree with the requirement that physicians be responsible for forwarding oral and written "complaints" and grievances to insurers. The purpose of this legislation was to create a grievance and independent external review function, NOT a complaint function. IER is designed to address grievances about denials of coverage. The addition of "complaints" dramatically expands the scope of the legislation and will unnecessarily clog the system and reduce the ability to accomplish its objectives.

    Furthermore, Sec. 18.01(2)(c) inappropriately inserts the physician into a contractual relationship between the insurer and the patient. Doctors already have limited time with patients. Patients frequently complain that doctors spend too little time with them. This unnecessary administrative burden will further reduce the amount of time physicians may spend providing patient care.

    For these reasons, both provisions should be removed from the final rule.

We appreciate the opportunity to comment and are happy to answer any questions you may have.

Sincerely,

Louise Trubek
Senior Attorney
Center for Public Representation

David Slautterback
AARP

Ron Stark, M.D.
Milwaukee County Medical Society

John Petersen, M.D.
Milwaukee County Medical Society

Victor S. Soderstrom, D.P.M.
President
Wisconsin Society of Podiatric Medicine

John E. Patchett
Executive Vice President
State Medical Society of Wisconsin

CC: Connie O'Connell, Commissioner of Insurance
Rep. Mark Miller

Wisconsin Academy of Family Physicians

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July 10, 2001

The Honorable Gregg Underheim
Chair, Health Committee
Wisconsin State Assembly
PO Box 8952
Madison, WI 53708-8952

Dear Representative Underheim:

The Wisconsin Academy of Family Physicians ("WAFP"), respectfully requests modification to the Independent External Review ("IER") rule. As a point of reference, WAFP is Wisconsin's largest single medical specialty in the state, representing over 1400 physicians. WAFP is also the most geographically dispersed physician group, providing cradle to grave primary health care to Wisconsin citizens in small towns and big cities, solo practices and large HMOs.

WAFP agrees with the comments made by the CHCP Collaboration and asks that the recommended amendments be included in the final rule. In addition to those comments, WAFP requests that the rules include a standard for the review of health plans' adverse decisions based on medical necessity.

As currently written, if a health care plan denies coverage for a patient's treatment because the plan determines that the treatment is not medically necessary and the adverse decision is reviewed by an independent review organization ("IRO"), the rule does not provide guidance or criteria for the IRO's review beyond that the decision must be "consistent with the terms of the health benefit plan under which the adverse decision was made." See s. 632.85(3m)(a), Stats. The rule requires IROs to consider pertinent information before making its determination, but does not require the IRO to apply a certain standard to that pertinent information.

The administrative rule could provide the standard by defining "medically necessary" care. In an unrelated OCI rule, OCI defines "medically necessary" as follows:

> "Medically necessary" means that the service or supply is:
> 1. Required to diagnose or treat an injury or sickness and shall be performed or prescribed by the physician;
> 2. Consistent with the diagnosis and treatment of the sickness and injury;
> 3. In accordance with generally accepted standards of medical practice;
> 4. Not solely for the convenience of the insured or the physician.

Ins. 3.54(3)(d), Wisconsin Administrative Code.

Alternatively, "medically necessary" and the standard could be defined as it is in the various pending federal "patient bills of rights." The standard from S. 1062, the Bipartisan Patient Protection Act, which passed in the U.S. Senate and is pending in the U.S. House of Representatives, is as follows:

> Standard for Determination. The independent medical reviewer's determination relating to the medical necessity and appropriateness, or the experimental or investigation nature, or the evaluation of medical facts of the item, service, or condition ***shall be based on*** the medical condition of the participant, beneficiary, or enrollee (including the medical records of the participant, beneficiary, or enrollee) and ***valid, relevant scientific evidence and clinical evidence, including peer-reviewed medical literature or findings and including expert opinion***.

S. 1062, section 104(d)(3) (emphasis added). The federal language is consistent with many states' independent review criteria. For example, in Minnesota, the rules provide the following standard:

> "Medically necessary care" means health care services appropriate, in terms of type, frequency, level, setting, and duration, to the enrollee's diagnosis or condition,

and diagnostic testing and preventive services. Medically necessary care must:

A. be consistent with generally accepted practice parameters as determined by health care providers in the same or similar general specialty as typically manages the condition, procedure, or treatment at issue; and

B. help restore or maintain the enrollee's health; or

C. prevent deterioration of the enrollee's condition; or

D. prevent the reasonably likely onset of a health problem or detect an incipient problems.

Minnesota Rules, part 4685.0100, subp. 9b. (emphasis added).

Thank you for considering these comments and request for modification to the IER proposed administrative rules.

Sincerely,

Brad Fedderly

Bradley Fedderly, MD
Chair, Legislative Committee

cc: Senator Rodney Moen
Ms. Connie O'Connell, Insurance Commissioner

NFIB
The Voice of Small Business

Wisconsin

FAX Memorandum

To: Mellissa White

Fax Number: 267-2871

From: Bill G. Smith
State Director
Fax: 608/255-4909
Bill

Date: 6-09-01

Re: Memo from Insurers -

You should receive 7 page(s), including this cover sheet.
If you do not receive all the pages, please call 608/255-6083.

Message: Mellissa -
Thought this memo was of interest - although it is dated 1993, it seems to show broad consensus in the insurance industry in favor of ~~community~~ modified community rating. Call for further discussion.

National Federation of Independent Business – WISCONSIN
10 East Doty Street, Suite 201 ♦ Madison, WI 53703 ♦ 608-255-6083 ♦ Fax 608-255-4909 ♦ www.nfib.com

WISCONSIN ASSOCIATION OF LIFE AND HEALTH INSURERS

SEP 21 1993

September 17, 1993

The Honorable Tommy G Thompson
Office of the Governor
Room 115 East, State Capitol
Madison, WI 53703

Dear Governor Thompson:

I am writing on behalf of the various members of the "Tenney Group" to thank you for meeting with us on Monday so that we could share with you, as well as Commissioner Musser and other members of your administration, our sincere interest in working to support passage of your Wisconsin Health Care Partnership Plan.

At our meeting we circulated a discussion paper which as it turned out needed some revision. We have corrected the discussion paper and the corrected copy is attached herewith (Attachment A).

As you noted at the meeting, "the devil is in the details" on some of the issues that remain to be resolved. We are anxious to meet with Commissioner Musser and her staff for this purpose.

Since our meeting, the Commissioner's staff has held a number of meetings with insurer and HMO representatives to discuss the recommendations presented to Commissioner Musser by her staff regarding extension of Act 250 provisions to the individual and group health insurance market (see Attachment B). It is fair to say that a number of these recommendations are highly controversial. I believe that many participants in these discussions remain hopeful that these issues can be worked out, but there are also many who believe that there are issues raised in Attachment B that could make timely resolution of outstanding concerns more difficult.

Sincerely,

Robert T. Kodl

Attachments

cc: Commissioner Musser
Secretary Whitburn
Secretary Klauser

Aid Association for Lutherans • American Family Insurance Group • Association Life Insurance Co. • Blue Cross & Blue Shield United of Wisconsin • Catholic Family Life Insurance
CUNA Mutual Insurance Group • Employers Health Insurance Co. • Equitable Reserve Association • International General Insurance Corp.
Midwestern National Insurance Corp. • Milwaukee Life Insurance Co. • National Guardian Life Insurance Co. • National Mutual Benefit
Northwestern Mutual Life Insurance Co. • Rural Security Life Insurance Co. • SECURA Life Insurance Co. • Sentry Life Insurance Co. • Time Insurance Co.
Wausau Insurance Companies • Wisconsin National Life Insurance Co. • Wisconsin Physicians Service Insurance Corp.

Kathleen E. Farnsworth
Executive Director

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September 17, 1993

To: The Honorable Tommy G. Thompson
The Honorable Josephine W. Musser

From: The Association of Wisconsin HMOs
Health Insurance Association of America
Mortenson, Matzelle and Meldrum, Inc.
The Wisconsin Chapter of the National
Federation of Independent Business
The Wisconsin Association of Health Underwriters
Independent Insurance Agents of Wisconsin
Professional Insurance Agents of Wisconsin
The Wisconsin Association of Life and Health Insurers
The Wisconsin Association of Life Underwriters
Wisconsin Restaurant Association

Re: Wisconsin Health Care Partnership Plan (WHCPP) -
Senate Bill 327

Representatives from the above organizations met several times to discuss the provisions of Senate Bill 327 and areas of mutual agreement and concern. We support the WHCPP provisions that call for the development of regional health councils to better assess and analyze local health care needs and to form purchasing pools to bolster the purchasing power of individuals and small employers who might otherwise have difficulty obtaining health care coverage.

support purchasing pools.

We also recognize the need for a change in the way that insurers and HMOs price their products and make those products available. Further, we believe the Office of the Commissioner of Insurance should provide appropriate regulatory oversight of the various actors in the system and coordinate activities among the regional health councils.

We do, however, have some questions and concerns about the way to accomplish the goal of making health care more available and more affordable. We offer our collective experience and suggestions to help make the WHCPP more workable and to take better advantage of the positive attributes of the current health care system. The remainder of this memo discusses those questions and concerns.

Q. How should insurance coverage be offered to participants in the purchasing pools?

A. Commissioner Musser and Senator Rosenzweig have agreed that the regional health councils will not solicit and enroll participants. Solicitation and enrollment will be done by licensed agents and licensed employees. See attached letters.

DISCUSSION: The current bill language calls for the regional health councils to solicit and enroll participants. While we believe it is important for the purchasing pools to provide information about coverage available through the pool, we believe it is equally important for the pool to draw upon existing market mechanisms and experience and allow insurers' and HMOs' licensed agents and licensed employees to continue to provide services to consumers. We understand the concern about the level of agent commissions but believe the better approach is to require disclosure of such commissions and allow the market to establish appropriate commission levels.

We also believe it more efficient to allow employers to continue to purchase coverage on behalf of their employees because of the savings for both employers and the regional health councils in administrative costs.

Q. How should premiums for the coverage offered through the pools be established?

A. Insurers and HMOs should establish the premium charged for coverage offered through the purchasing pools using a modified community rating approach.

DISCUSSION: We believe the implementation of a "pure" rating system as currently required under the bill would attract only those higher cost employers and individuals who find the pure community rate attractive when compared to the private market. This conclusion is supported by a data study conducted under the

auspices of the Health Insurance Association of America, a copy of which is attached.

We recommend the use of a modified community rating approach that would take into consideration the type of coverage, i.e. family or single, the plan benefits, and the age, sex, and location of participants, but not the health status or claim experience of participants. Under this approach, lower risk, lower cost employers and individual are more likely to seek coverage through the pool and ensure an adequate spread of risk.

The WHCPP also calls for the regional councils to establish the premium charged for coverage offered to pool members. Historically, this type of price control has not worked. We believe that consumers should select health coverage in the same way they select other products and that price should be a factor to consider when making a buying decision. Health insurance is similar to other products in that higher quality sometimes means a higher price. To the extent price controls fail to consider this fact, such controls may ultimately drive quality out of the system. Unfortunately, the kind of quality driven out could be the quality of an enhanced provider network with specialty and sub-specialty provider choices for consumers. We believe consumers are sufficiently equipped to select appropriate health care coverage where price as well as quality and provider choice form the basis for such a selection.

Q. ***Who will be able to offer coverage through the purchasing pool?***

A. Qualified insurers and HMOs and others meeting the same financial and other standards should be allowed to offer coverage through the pools.

DISCUSSION: We propose a mechanism under which the purchasing pools would allow insurers and HMOs to offer coverage to pool participants if they meet certain statutory requirements. We suggest that those statutory requirements include the use of

managed care techniques to help control costs and the ability to meet financial standards equivalent to those for insurers and HMOs to assure participants of the ability of anyone offering coverage to meet their promise to provide payment and/or services.

Q. ***Who should participate in the pools and under what restrictions?***

A. The following groups should be eligible to participate in the pools with the restrictions as noted:

- Public employees;
- Individuals and employers of 100 or fewer employees who will pay a re-enrollment fee to rejoin the pool after a termination of coverage; and
- Employers of 101 or more employees who agree to remain in the pool for three years and who remain outside the pool for three years after a termination of coverage.

Employers in the pool should offer coverage to all employees who work 30 or more hours per week.

DISCUSSION: To encourage participation in the pool and help ameliorate adverse selection, different eligibility rules should apply to different size employers. Smaller employers who experience more volatility in financial ability to pay premiums than larger employers should be allowed to enter and exit the pool more freely. The re-enrollment fee should be set at a level high enough to discourage frequent entries and exits but low enough not to discourage participation. Larger employers who, by and large, self-fund their health care plans should not be allowed such freedom because of the consequences to the pool's costs when they decide to insure through the pool because of bad claim experience. The three-year lock-in and three-year lock-out serve to limit self-funded employers from "dumping" bad claims experience into the pool and driving up costs for everyone else in the pool.

The volatility of small employers' financial situation should also be considered in mandating employee coverage. Many small employers simply cannot afford to offer coverage to employees working fewer than 30 hours per week. The 30-hour requirement suggested here tracks with current definitions of full-time employment under the small employer health insurance market reforms.

The issues discussed in this memo do not necessarily represent all organizations' concerns with the WHCPP. Each organization may have concerns with other issues that may not be necessarily raised in the general discussions presented here.

We remain ready as a group and individually to continue to offer our expertise and input to help make the WHCPP a better plan and to offer specific amendatory language should agreement be reached on revisions to the bill.