UTILIZATION REVIEW REPORT

To The Minnesota Legislature

By the MN Health Care Consumer Advisory Board

November 15, 1998

LEGISLATIVE DIRECTIVE: For Health Care Consumer Advisory Board

The Patient Protection Act of 1997 created the Minnesota Health Care Consumer Advisory Board and authorized it to make two reports to the legislature. The legislative directive given the board regarding utilization review is highlighted below:

The Patient Protection Act of 1997

The Consumer Advisory Board "shall advise the commissioners of health and commerce on the following (1) the needs of health care consumers and how to better serve and educate the consumers on health care concerns and recommend solutions to identify problems, and (2) consumer protection issues in the self-insured market, including but not limited to, public issues. The commissioners of health and commerce, in consultation with the Consumer Advisory Board and other affected parties, shall make recommendations to the legislature by January 15, 1998, on developing a complaint resolution process for health plan companies to make available for enrollees.... *The consumer advisory board shall consider the use of physicians by utilization review organizations including whether only Minnesota licensed physicians should be used for utilization review, whether appropriate types of medical practitioners are being used for utilization review, and whether Minnesota's utilization review statutes afford adequate consumer protection*. The Consumer Advisory Board may report findings to the legislature prior to the 1998 legislative session."

Members of the board "must be public, consumer members who: (1) do not have and never had a material interest in either the provision of health care services or in an activity directly related to the provision of health care services, such as health insurance sales or health plan administration, (2) are not registered lobbyists and (3) are not currently responsible for or directly involved in the purchasing of health insurance for a business or organization."

BACKGROUND

Statute Definitions:

"Utilization Review" means the evaluation of the necessity, appropriateness, and the efficacy of the use of health care services, procedures and facilities, by a person or entity other than the attending physician, for the sole purpose of determining the medical necessity of the service or admission. Utilization review also includes review conducted after the admission of the enrollee. It includes situations where the enrollee is unconscious or other wise unable to provide advance notification. Utilization review does not include the imposition of a requirement that services be received by or upon referral from a participating provider. (MN statute 62M.02, subd. 20)

"Utilization Review Organization" (URO) means an entity including but not limited to an insurance company licensed under chapter 60A to offer, sell, or issue a policy of accident and sickness insurance...; a health service plan...; a health maintenance organization...; a community integrated service network...' a fraternal benefit society operating under chapter 64B...;' a joint self-insurance employee health plan...; a multiple employee welfare arrangement, as defined in section 3 of the Employee Retirement Income Security Act of 1974 (ERISA)...; a third party administrator licensed under section 60A.23, subd. 8, which conducts utilization review and determines certification of an admission, extension of stay or other health care services for a Minnesota resident, or any entity performing utilization review that is affiliated with, under contract with, or conducting utilization review on behalf of, a business of in this state. (MN statute 62M.02. subd. 21)

The Consumer Advisory Board began looking at the Utilization Review process by inviting testimony from various stakeholders in the process. They also held two public hearings in the metro area and one hearing in Rochester. Organizations and individuals that provided testimony during hearings and board meetings included:

1. **Departments of Health and Commerce**
2. **Managed Care, HMO's (Health Partners, Medica, Blue Cross/Blue Shield)**
3. **Indemnity Plans**
4. **Utilization Review Organizations (including Preferred One)**
5. **Companies (3M, small businesses, DHS and DOER-public employees)**
6. **Physicians and mental health providers**
7. **Consumers**

Based on the information gathered from our interviews and hearing process, the Consumer Advisory Board is submitting this report which includes a summary of the major issues and concerns brought forward. The views expressed to us ranged from HMO's and health plans, who felt everything worked just fine, to consumers and physicians who were often frustrated or uneducated about the utilization review process.

We also have developed several recommendations and drawn some conclusions about Utilization Review and its impact on consumers. It must be noted that collecting additional data and doing an extensive literature search was not possible because of the time and funding constraints of this board. It is also important to note that board members experience reflects the knowledge of the general public regarding utilization review, so it was difficult to know how and where to begin researching this issue.

SUMMARY OF BOARD'S CONCERNS AND FINDINGS FROM TESTIMONY

Directive #1: Consider use of physicians by Utilization Review Organizations (URO); including if only MN licensed physicians should be used for utilization review (UR).

- According to Department of Health and testimony from HMO's, insurance companies, and businesses, most URO's are already using MN licensed physicians. The board did not determine how many non-Minnesota licensed physicians are involved in the UR process.
- The Board is concerned that physicians working for URO's can not be held legally liable for their health care decisions.
- HMO's testified to doing their own UR, however, it wasn't clear what level of expertise the people have who provide the criteria and decisions.

Directive #2: Whether appropriate medical practioners are being used for Utilization Review?

- It could not be determined through the testimony what the credentials are of people who are developing UR criteria, reformulating it, interpreting it and applying it to health care decisions.
- UR criteria may be either purchased from an outside entity and then reformulated by personnel hired by a URO, or developed by the URO itself. The Board has questions regarding the validity of the original purchased criteria, such as, was it developed by physicians and/or specialists.
- The consumer advisory board questions whether or not physicians involved in decisions have an adequate level of expertise versus that of a specialist.

Directive #3: Whether Minnesota Utilization Review statutes offer adequate consumer protection?

- Consumers are overwhelmed and often feel unable to protect themselves in the health care system.
- ERISA plans only have to comply with 62M if they contract with a Minnesota URO. Even then, the employer can override any decisions made by the URO.
- The definition of "medical necessity/appropriate care" within the statute, is not clearly defined. Does it depend on ethics, financial consideration and/or effectiveness of treatment?
- Mental health coverage seems to be more limited than other forms of medical care and is carved out (contracted out) by many plans. Availability of prompt service, range of services and choice of providers is often severely limited.

- **Complaint Process:**

  - Many consumers do not know UR exists and how it impacts medical decisions. (ie, referrals to specialists, length of hospital stays and surgical decisions, etc)

  - Most consumers don't know that there is a separate complaint process or that complaints could be made to the Department of Health or Department of Commerce.

  - Some consumers testified that they were never told about how to appeal UR decisions.

  - Consumers who used the Departments of Health and Commerce complaint process often found the outcome to be unhelpful.

- Enforcement of consumer protection legislation is very difficult, in part because of the costs associated with enforcement. MN Statute 62M is problematic in that it does not adequately protect consumers in decisions made by URO's.

- Testimony from both physicians and consumers reflected the concern that dealing with the UR process adds expense to the system by requiring additional personnel, resources & time.

- MN Statute 62M.09, subd. 5 requires that URO's decisions must be supported by written clinical criteria and review procedures. MN Statute 62M.10, subd. 7 states that "*upon request, a URO shall provide to an enrollee or to an attending physician or provider, the criteria used for a specific procedure to determine the necessity, appropriateness, and efficacy of that procedure and identify the database, professional treatment guideline, or other basis for the criteria*". Most consumers do not have any idea that such criteria exists or that is available to them if they request it. Several consumers testified that no URO criteria was available to them when they requested it and they were told that it was confidential information.

- Consumer experience and perception of UR is that it is a cost containment tool and does not contribute to the quality of their health care.

- Currently, URO's can not be sued and can be for-profit organizations.

- In the past, physicians were able to help their patients receive high quality, timely health care. Physicians fear reprisals for advocating for patients or for disputing UR decisions. They may also face financial disincentives for pursuing treatments that may be costly. This leaves the consumer alone to fight for their own health care; and consumers repeatedly testified that this often occurs when they or their families are least able to advocate for themselves.

- **Case Management:**

  - HMO's and health plans testified that they are moving toward case management for certain expensive cases that trigger in the system. (ie, Multiple Scleroses, cancer and chronic illness)

  - Case management can be beneficial to the consumer if it is not solely used as a cost containment tool and if it provides coordination of care.

  - Some consumers reported they have no actual contact with the assigned case manager.

RECOMMENDATIONS:

1. **The public needs to be educated about patient rights, the utilization review process and the appeal process.**
   - **All available agencies, including the Department of Health and Department of Commerce, along with the Office of Consumer Assistance should actively educate public about patient rights.**
   - **HMO's, insurance companies and employers should be responsible for educating consumers.**
   - **All education should make allowances for language and cultural diversity.**
   - **Adequate funding of the Office of Consumer Assistance is needed to accomplish these important education goals.**

2. **Utilization review criteria should be developed by specialists and/or physicians appropriately trained and experienced in the current treatment of specific conditions. Utilization review organization's written clinical criteria should be made public.**

3. **Utilization review organizations should not be protected from lawsuits. Current protections from lawsuits does not hold the organization accountable for criteria or decisions that contribute to poor quality health care.**

4. **Physicians, nurses and other health care providers as well as consumers need to know there is statutory support for "whistle blowing" and fear of reprisals by HMO's and insurance companies.**

5. **The increased use of case management or primary care coordinators, if used as part of the health care team who knows and understands the consumer's health care needs, could be beneficial for consumers. Our concern is that case management is NOT used solely as a cost containment tool and it is vital that there is on-going contact between the case manager and consumer.**

6. **When a consumer is denied coverage, the consumer has a right to know the name, business address and qualifications of the professional who provided the utilization review decision.**

7. **The Departments of Health and Commerce need adequate funding to enforce the consumer protections in Mn Statute 62M.**

8. **Independent and adequately funded research is necessary to determine: (1) The true cost effectiveness of utilization review, and (2) Whether or not criteria and decisions under utilization review should be restricted to only Minnesota physicians.**

CONCLUSION

The most striking conclusion drawn by the Consumer Advisory Board about Utilization Review is how confused consumers are about what UR is and how it affects their health care. It was difficult for our board to even understand the intricate workings of the utilization review process. Some of the unanswered questions that remain include:

Does the current UR process benefit consumers?
Does UR contribute to quality health care?
Is UR cost effective?

In addition to the recommendations outlined above, it is imperative that extensive research be done to determine the answer to these questions and others. We also need to track true costs incurred in the UR process. Consumers need access to independent advocates to help them with their health care denials and also an independent appeals process through which they can challenge the UR decisions that affect their lives.

Respectfully Submitted,

The Minnesota Health Care Consumer Advisory Board

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