April 8, 1997

The Honorable Edward M. Kennedy
United States Senate
Washington, D.C. 20510

Dear Senator Kennedy:

On behalf of the American Society of Internal Medicine (ASIM), I am pleased to share with you our recommendations on the Health Insurance Bill of Rights Act of 1997, S. 373.

We commend you for introducing this important legislation. ASIM concurs with the need to mandate some basic standards to protect patients enrolled in managed care organizations (MCOs) and other plans. Although we support many of the key provisions of the bill, there are some requirements that raise questions or concerns for us that preclude us from endorsing the bill in its entirety. Those concerns are explained more fully later in this letter. Notwithstanding those concerns, we are committed to working with you and other members of Congress to get legislation enacted that would include the following requirements from S. 373:

- Plans must use a prudent layperson standard in making coverage decisions on initial visits to a hospital emergency room.

- Plans must provide an updated list of participating providers. Enrollees must be permitted to obtain services from any provider within the plan identified in the plan documents as available to the enrollees.

- If a plan provides benefits for prescription drugs within a formulary, the plan must allow physicians to participate in the development of the plan formulary, disclose the nature of formulary restrictions, and provide for exceptions when medically necessary.

- Plans are required to establish a quality assurance and improvement program that uses data based on performance and patient outcomes.

- Plans must provide information on: procedures for emergency care, selecting and changing physicians, and obtaining consultations. Information provided must describe coverage, financial responsibilities of the enrollees, methods of obtaining referrals, utilization review processes, grievance procedures, and how providers are paid.

- Plans are prohibited from placing restrictions on medical communications, including health status, medical care, treatment options, provisions of the plan's utilization review requirements, or any financial incentives that may alter the treatment of the enrollee.

- Plans must collect and disclose data on patient satisfaction and other quality indicators. As noted below, ASIM believes that such disclosure should not be extended to include physician-specific outcomes data, and the reporting requirements should not place an undue administrative burden on physicians.

- Plans must develop improved utilization review, appeals and grievance positions. As noted below, ASIM has several suggestions for improving the provisions in S. 373 that address these elements.

ASIM recommends, however, that changes be made in several of the other provisions in S. 373. Although we support the intent of most of them, we have some concerns about the specific requirements that are proposed. Our concerns and recommendations for improvement are as follows:

Access to Specialty Care: The bill would require that enrollees with life-threatening, degenerative and other serious conditions must be provided access to the appropriate specialists or centers of excellence capable of providing quality care for the condition. The plan must allow the patient to see an out-of-plan specialist at no additional cost if it does not have a participating specialist for the condition covered under the plan. The plan must also have a procedure to allow individuals requiring on-going specialty care to receive care from a specialist who will "coordinate all care for that individual."

ASIM agrees that patients must have access to the physician who is most qualified to treat them and agrees that for some patients, a specialist may be the best qualified person to provide ongoing care. We are concerned, however, that the bill is not clear on who will decide if the patient's condition requires specialty care. The bill states that the specialty care that would be provided shall be "developed by the specialist and approved by the issuer, in consultation with the designated primary care provider or specialist and the enrollee (or the enrollee's designee)." ASIM is concerned that this provision would prohibit arrangements that make the primary care physician responsible for determining if the patient requires ongoing specialty care.

We are also concerned that the section that requires plans to have a procedure by which an enrollee may receive a referral to a specialist who shall be responsible for "providing and coordinating the enrollee's primary and specialty care" could result in patients receiving primary care services from specialists who do not have the training and experience required to provide comprehensive primary care. ASIM supports the concept of allowing patients with certain ongoing conditions to select a specialist as their principal care physician, *provided however that the specialist has demonstrated training and experience in providing comprehensive primary care.* Most internal medicine subspecialists have such training and experience, since all internist-subspecialists were originally trained in general internal medicine, and many have continued to practice general internal medicine in addition to their subspecialty practice. This is not necessarily true of other specialists, however. ASIM also opposes designating in law any specific specialty as a "primary care provider."

Continuity of Care: The bill states that if a plan or provider terminates a contract for reasons other than failure to meet quality requirements, the plan must allow an enrollee treatment with the provider for a transitional period. Time frames vary depending upon type of care being provided.

ASIM supports the concept of protecting continuity of care, but is concerned if this section would require that a plan continue to pay for care for a provider who has been "de-selected" by a plan for legitimate reasons that may not involve specific failure to meet quality requirements.

Collection of standardized data: The bill would require that plans report certain standard information to state agencies and the public according to uniform national standards to be developed by HHS. Information must include utilization data, demographic data, mortality rates, disenrollment statistics and satisfaction surveys, and quality indicators.

ASIM generally supports such a requirement, provided that the Secretary is prohibited from requiring that health plans disclose physician-specific outcomes data. Without adequate severity adjustors and other protections, release of physician-specific outcomes data could inappropriately tarnish the reputations of physicians who provide high quality care, but may appear to have worse outcomes because they have a sicker patient population. Further, the Secretary should be directed to assure that any reporting requirements on the health plans do not cause the plans to place an undue burden on participating physicians.

Standards for utilization review activities: The bill defines utilization review as clinical necessity and efficacy. Written criteria are required. Review must be supervised by a licensed physician. Incentives to render adverse determinations are prohibited. Deadlines for response to requests for authorization of care are established in the bill. Adverse determinations must be in writing and include the reasons for determination.

ASIM generally supports these requirements. We believe that the requirement that plans "shall utilize written clinical review criteria . . . with the input of appropriate physicians" should be strengthened to require that health plans establish mechanisms to incorporate the recommendations, suggestions and views of enrollees and participating physicians that improve quality of care into medical policies of the plans, quality and credentialing criteria, utilization review, and other medical management procedures. It should be clearly stated the enrollees and their physicians should have access to all utilization review protocols and algorithms, credentialing standards, and other health plan policies that directly affect clinical decision-making.

Provisions relating to appeals of review determinations: The bill would specify the components of a plan's system to handle complaints, including staffing and staff accessibility, information about appeals processes, and the time frame by which the plan must respond. It requires a two-stage review appeal process, with requirements for "a review panel of non-involved providers and consultants employed by the plan in the second stage." Written explanations and timely responses are required. Examples of adverse determinations include denial for emergency care, access to specialists, choice of provider, continuity of care, and payment for routine costs of an approved clinical trial. For other important appeals, the plan must either participate in an independent review process established by the state or establish a third stage of appeal within the plan certified by the Secretary as fair, impartial and involving independent reviewers.

ASIM supports expanded grievance and appeals rights. We are concerned, however, the specific requirements in this section--particularly, the requirement for independent reviewers--may impose an excessive administrative burden on health plans that will be passed onto patients and employers in the form of higher premiums.

Notwithstanding the specific concerns described above, ASIM congratulates you on introducing S. 373, and looks forward to working with you on enactment of bipartisan legislation to establish reasonable minimum patient protection standards for all health plans that would include many of the provisions proposed in your bill.

Sincerely,

Alan Nelson, MD
Executive Vice President