1992 SUNRISE REVIEW

OF

HEALTH CARE UTILIZATION REVIEW

SUBMITTED BY THE
COLORADO DEPARTMENT OF REGULATORY AGENCIES
JUNE 1992

June 15, 1992

The Honorable Bob Schaffer
Joint Sunrise/Sunset Review Committee Chairman
Room 348, State Capitol Building
Denver, Colorado 80203

Dear Senator Schaffer:

We have completed our evaluation of the sunrise application for health care utilization review and are pleased to submit this written report which will be the basis for my office's oral testimony before the Sunrise and Sunset Review Committee. The report is submitted pursuant to section 24-34-104.1, Colorado Revised Statutes, the "Sunrise Act", which provides that the Department of Regulatory Agencies shall conduct an analysis and evaluation of proposed regulation to determine whether the public needs and would benefit from the regulation.

The report discusses the question of whether there is a need for the regulation in order to protect the public from potential harm, whether regulation would serve to mitigate the potential harm and, whether the public can be adequately protected by other means in a more cost effective manner.

Sincerely,

Steven V. Berson
Executive Director

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I. INTRODUCTION

The Department of Regulatory Agencies has evaluated the proposal submitted by the Colorado Medical Society and the Colorado Prospective Payment Professionals for the regulation of health care utilization review. The applicants seek to regulate Private Utilization Review Firms, Third Party Payer Audit firms, and insurance companies and self-funded plans, performing private utilization review and/or third party payer audits. Pursuant to the Colorado Sunrise Act, C.R.S. 24-34-104.1, the applicants must prove the benefit to the public of their proposal for regulation according to the following criteria:

1. Whether the unregulated practice of the occupation or profession clearly harms or endangers the health, safety, or welfare of the public, and whether the potential for the harm is easily recognizable and not remote or dependent upon tenuous argument;

2. Whether the public needs and can reasonably be expected to benefit from, an assurance of initial and continuing professional or occupational competence; and

3. Whether the public can be adequately protected by other means in a more cost-effective manner.

II. METHODOLOGY

The applicants are two groups seeking to improve the delivery of health care.

The Colorado Medical Society represents physicians' concerns, with the goal of promoting the science and art of medicine, the betterment of public health, and the welfare of the medical profession and the patients it serves; and promoting the similar interests of its component county and district medical societies.

The Colorado Prospective Payment Professionals (CPPP) is a nonprofit organization of Hospital Utilization Review/Quality Assurance reviewers, Peer Review Organization representatives, Medical Records Directors, and Business Office representatives.

These applicants submitted answers to the sunrise application questions and other supportive materials. The Department contacted and interviewed the applicants, independent utilization review and audit firms, insurance company representatives, the Colorado Hospital Association, the American Managed Care and Review Association (a national association of utilization review firms associated with the Utilization Review Accreditation Commission (URAC)), and the Colorado Division of Insurance. The laws of several other states were also surveyed, and will be summarized in this report.

III. DEFINITIONS

For the purposes of this report, the following terms have the following definitions:

Utilization Review (UR): Any review of the medical necessity, appropriateness, or efficiency of medical services, done on behalf of a hospital or health care benefit plan.

Private Utilization Review (PUR): UR done by an entity other than a hospital or a public reviewer following federal guidelines. This category may include, Private Utilization Review Firms, Health Maintenance Organizations, (HMOs) Preferred Provider Organizations (PPOs), and insurance companies and self-funded plans.

Third Party Payor Audits: Review of charges made by a medical provider or physician for services rendered, but not of the necessity or appropriateness of care.

IV. THE APPLICATION

SCOPE OF APPLICATION

The applicants propose regulation of anyone performing Private Utilization Review and/or third party payor audits. This includes two types of independent firms, Private Utilization Review companies and Third Party Payor Audit Firms. It also includes subdivisions of large payer organizations performing UR, such as insurance companies, as well as self-funded plans performing their own UR.

A Third Party payor audit firm compares medical records or charts with items charged. These records may not be exact, requiring some determination of whether or not a service was medically necessary in order to judge the correctness of the bill. The applicant includes audit firms only in regards to this necessity function.

Finally, other forms of payers seeking to aggressively control costs would also fall within the applicants' definition. This category includes Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) which seek to lower the cost of care through managed networks of physicians. It also includes non-profit plans such as Blue Cross and Blue Shield.

The applicants request either separate licensure of PURs, or regulation by an administrative agency, such as the Insurance Commissioner or the Colorado Department of Health. Although the application does not provide a specific plan, it does describe the different types of review necessarily involved.

Reviewers acting outside of the doctor and patient relationship use several different methods to check for documentation in medical records supporting charges, and to examine the utilization and necessity of health care services provided:

1. Prospective review (or pre-admission certification) reduces the number of inappropriate or unnecessary hospital admissions by requiring patients or physicians to obtain certification or a second opinion prior to a scheduled procedure, surgery, or inpatient admission. The reviewer usually designates a specific, appropriate length of stay, which may be extended after further review if necessary.

2. Concurrent review involves review of a patient's medical record during hospitalization to ensure that continued inpatient care is necessary, and to examine the possibility of lower cost outpatient alternatives. It may include discharge planning review.

3. Retrospective review and Audits reduce costs by examining patient records after service performance. Initially, these focused on hospital payments, but they may involve examination of outpatient services as well.

REASONS GIVEN FOR APPLICATION

According to the applicants, the following problems arise from unregulated PUR:

> Unqualified reviewers improperly deny authorization for payment. Providers must then spend time appealing these decisions. Patients denied authorization either forego care or remain personally financially responsible.
>
> Some PUR occurs on-site, but many companies based in other states conduct telephone review. The difference in time zones and working hours makes communication difficult, and inadequate numbers of telephone lines result in long waits on hold. Establishing the identity of a UR company on the phone takes additional effort and endangers medical record confidentiality.
>
> Information requests vary, requiring still more provider time spent in response. Responding to PUR requests can necessitate hiring an extra employee, and since most payers exercise some degree of health care management, added expenses shift to uninsured patients in the form of higher bills.

Although these problems can occur with any PUR firm, when interviewed the applicants stated that most difficulties stemmed from small, independent firms and self-insured plans, rather than the larger reviewers, insurance companies, and HMOs.

PROPOSED MINIMUM STANDARDS

To minimize difficulties, the applicants suggest the following PUR competency requirements be enacted into law:

1. Hours of operation reflective of hours of operation customary in Colorado.

2. Sufficient personnel and telephone lines to allow reasonable access to the reviewers, with waits on hold of less than 5 minutes.

3. A reviewer with training equivalent to a licensed nurse or accredited medical records technician.

4. Supervision by a medical advisor, licensed in the state of Colorado who is required to review all denials. (The application does not state whether this advisor must be an M.D., but this is probably the case.)

5. Published criteria for determination of medical necessity, appropriateness, and effectiveness, based upon scientific and accepted data.

6. Methodology to assure ready identification of the reviewers as bona fide representatives of their company and to assure confidentiality.

7. Appeal process whereby differing opinions between patients, providers and reviewers can be arbitrated.

These minimum requirements parallel standards set in some other states, as well as guidelines set by the Utilization Review Accreditation Commission (URAC), a national organization advocating voluntary PUR regulation and headquartered in Washington, D.C. In order to better understand their origin and impact, however, it is necessary to look at the development of PUR, third party audits, and the groups which they affect.

V. THE UTILIZATION REVIEW PROCESS

OVERVIEW

One way to better understand the position of utilization review in the health insurance industry is by analogy with other types of insurance. For example, when a house suffers storm damage and its owner files a claim requesting payment, the insurance company first determines whether the home owner's policy covers the type of damage involved. If the type of damage is covered, a claims adjustor then evaluates the situation and negotiates payment based on the necessity and appropriateness of any repairs. Utilization reviewers occupy a similar position to that of the claims adjustor, but the judgments they make can be far more sensitive.

To reduce payer costs, health care UR concentrates on preventing unnecessary (providing no significant clinical benefit), and inappropriate (could be given in a less costly manner) care. A UR firm can deny authorization for a procedure normally covered by a health insurance policy. Similarly, it can authorize treatment which, though necessary, will not be paid for because it falls outside of a benefit plan.

Many hospitals perform in-house UR and Quality Assurance (QA) reviews to make sure that benefit plan requirements are met, to prevent retrospective payment denials based on medical necessity, and to improve the quality of care. Since the hospital itself is not a payer, it does not actually approve or deny any benefits. The proposed regulation thus does not involve this type of hospital review. It covers only external, or non-hospital review.

ORGANIZATIONS PERFORMING EXTERNAL REVIEW

Both public and private organizations engage in external review. Public UR consists of federal programs reviewing Medicare and Medicaid expenditures. The current federal system employs independent Peer Review Organizations (PROs) which follow strict guidelines set up by the Health Care Finance Administration.

Non-governmental agencies and PROs with private review contracts perform Private UR (PUR). PUR grew rapidly in the 1980s, and now includes independent review and audit firms, along with larger insurance companies, HMOs and PPOs. No national PUR regulations or requirements exist, although PROs may continue to use federal guidelines for their private contracts, and URAC provides a set of voluntary guidelines.

Private organizations conducting utilization review face a choice, performing UR directly or hiring an independent reviewer. Some also pass that choice to a third party. An employer, for example, who chooses not to perform UR directly or to hire an independent review firm, can find a cost effective insurance company, HMO, or PPO plan. The insurance company, HMO, or PPO then faces the same choice as the employer; performing its own review through an in-house division or subsidiary (the overwhelming choice of HMOs and PPOs), or contracting with an independent review firm. Third Party Administrators performing claims services for larger insurance firms or for self-insured employers also engage in UR. The sequence of steps involved in a review by any of these organizations, demonstrates how UR works on a daily basis.

PROSPECTIVE REVIEW

When a UR firm engages in prospective review, normally the health benefit plan enrollee must notify the reviewing agent of any proposed medical procedure, surgery, or inpatient admission. Physicians, nurses, or hospital staff often notify the reviewer on the patient's behalf. Indeed, many patients are ill informed of their responsibilities in this area. In an emergency situation most UR firms allow notification within a short period of time after seeking treatment. Failure to notify the UR agent can result in financial penalties, including a refusal to pay all or part of a claim.

Once contacted, the reviewer examines the proposed medical service and makes a determination approving or denying the procedure. Evaluation methods vary among PUR firms, and some reviewers refuse to reveal their criteria, stating fear of business competitors and of doctors changing their billing structure to fit UR procedures. Usually a Registered Nurse, Accredited Records Technician, or Registered Records Administrator, performs initial review over the telephone. This first reviewer uses a list of medical procedures describing how much and what kind of payment is usually authorized, whether the benefit plan requires a second opinion before payment, or whether special circumstances warrant a waiver of review criteria.

Computer models determining the appropriateness of care are also available. A 1990 study of some of the most frequently used programs, found that they could improve the efficiency of review determinations. However, the study also determined, that in practice, "an instrument-based judgment that care is non-acute [unnecessary] should always be followed up by the judgment of a physician reviewer." (Strumwasser, Ira, et al. "Reliability and Validity of Utilization Review Criteria: Appropriateness Evaluation Protocol, Standardized Medreview Instrument and Intensity-Severity-Discharge Criteria." Medical Care 28, no. 2 (February 1990):95 - 109)

Most UR decisions result in approval of the proposed care, but if initial review produces a denial, the enrollee and provider should, and generally do, have the right to appeal. Ideally, a physician advisor knowledgeable in the medical specialty involved reviews the case. This advisor can speak directly to the providing physician before reaching a final decision. If the denial stands, a patient does face the choice of either foregoing or personally paying for care.

CONCURRENT AND RETROSPECTIVE REVIEW

Once treatment begins, a PUR firm conducts concurrent and/or retrospective review. Usually pre-certification for hospital admission establishes a certain number of inpatient days. Concurrent review can include requests for extension beyond this set number of days, review of a treatment's progress, and review of emergency situations where care began before notification of the review agent. Retrospective review is most often a review of medical charges and billing, but also includes necessity and appropriateness of care, especially when emergency care results in an absence of pre-certification.

All types of review also sometimes occur on-site, and may include medical records requests. On-site review usually requires contact with a UR coordinator at the location where medical care occurs. Reviewers may have contracts allowing them access to a hospital (some hospitals require them), and should arrange visits in advance to ensure record availability. Usually an insurer has permission to examine medical records for the purposes of claims payment, and this permission extends to agents conducting reviews. Medical records confidentiality does, however, require positive identification of review agents before information is released.

EFFECTS OF REVIEW

How PUR affects the long term overall cost of health care remains to be seen. The few empirical studies done show some short term cost savings, but these depend on the structure of the PUR program itself. One 1989 study, for example, states that:

> **"UR represents a viable approach to cost containment that can help improve the efficiency with which medical care resources are consumed...[but]...The stringency with which UR guidelines are applied and the level of penalties invoked for noncompliance, as well as other factors specific to the UR program, are likely to influence outcomes."**

"Does Utilization Review Reduce Unnecessary Hospital Care and Contain Costs?" Thomas M. Wickizer et al., Medical Care 27, No. 6 (June, 1989): p. 646.

Despite variations in effectiveness, PUR's seeming ability to reduce costs means that there is little likelihood its use will fall in the near future. To be effective, however, its administrative costs cannot outrun its savings, and its effect on the quality of care has not been evaluated as well as its effect on costs. New complications in health care delivery do accompany PUR, but the extent of their impact remains unclear.

Currently, a number of different voluntary and legislative approaches exist to solve perceived problems in the UR industry. Current PUR guidelines include those established by URAC, local voluntary guidelines, and some state legislation. Additionally, one non-profit organization, the American Board of Quality Assurance and Utilization Review Physicians (ABQAURP), offers certification as a QA/UR professional.

IV. DISCUSSION OF HARM

INTRODUCTION

When discussing problems associated with poorly conducted PUR, it is important to maintain a sense of perspective regarding its ultimate goals and effects. Utilization Review, as described above, is often a contractual part of health insurance coverage. It can be an effective cost control measure, and is not wrong or abusive in and of itself. There is room, however, to improve coordination between UR firms and providers and to reduce delays.

A nationwide directory of utilization review firms published in 1991, lists 324 firms offering some type of review services. Although it names only one independent firm along with the federal PRO (Colorado Foundation for Medical Care) as based in Colorado, in-house reviewers and the increasingly large number of companies conducting national review do have a significant local impact.

The Institute of Medicine (IOM) completed one of the most comprehensive studies of UR to date in 1989. It found that, aside from improper denials of payment, harms from improperly performed UR could include discouraging appropriate care and mishandling confidential information. Unfortunately, little documentation exists as to the actual extent of these problems in relation to overall health care.

(See: Institute of Medicine. Controlling Costs and Changing Patient Care?: The Role of Utilization Management. Institute of Medicine Committee on Utilization Management by Third Parties. Washington, D.C.: National Academy Press, 1989.)

Sources of the difficulties associated with PUR include personnel qualifications and administrative or "hassle" factors. Included in the administrative area is the quality of UR criteria, which cause many of the same problems as unqualified personnel. Harmful effects fall mainly on two groups, patients and providers.

HARM TO PATIENTS

Harm to patients is one of the least studied aspects of PUR. That there is little documentation available in this area may be traced to a variety of reasons, including the lack of separation of complaints and claims denied due to UR, from those due to other causes. Additionally, the main strategy of UR has, according to the 1989 IOM study cited above, been to,

> **"Discuss and negotiate appropriate care rather than to refuse prior authorization of benefits explicitly. Denials rates appear to run about 1 to 2 percent of cases with some later changed upon appeal."**

Despite the time consuming process of negotiation between a UR firm and a provider often required to reach this low denial rate, patients seldom suffer the most direct effects of

mishandled PUR; loss of payment or total discouragement of care.

Since complete and final denials of authorization are rare and may reflect legitimate cost saving decisions, any significant losses stem more from patient anxiety and delays in medical services. Delay affects those receiving health care services in two ways, the actual wait for payment of services, and the possible postponement or foregoing of services. One example of how such delays occur lies in emergency care.

Benefit plan enrollees should receive emergency care regardless of PUR authorization. However, a patient unaware of PUR policies or unsure of what constitutes an emergency, and unable to contact the PUR (it's a weekend, night, or past business hours and the PUR does not have a sufficient system to receive calls), suffers both possible harms. If the patient seeks medical care for what later turns out not to have been an emergency, the PUR company might deny payment in a retrospective review. On the other hand, a patient aware of PUR policies might delay necessary emergency treatment and or else suffer some anxiety as to whether insurance will pay for it.

The Colorado Division of Insurance does receive some complaints when companies deny payment after retrospectively determining that care was not an emergency or medically necessary. However, the extent of overall postponement, which also occurs when a patient or physician seeks pre-authorization and the PUR requests additional information or refuses initial certification, is unclear. Likewise, there is little information on how often a patient forgoes needed care after a PUR refuses authorization.

One additional possible harm is that physicians forced to hire extra personnel to comply with PUR requests will shift this cost to their patients. Managed care programs and insurers set limits on charges. Physicians thus cannot recover additional expenses from managed patients and the burden would fall on the uninsured. UR itself, however, is designed to lower costs overall. Cost shifting does defeat that purpose, but physicians might also bear some of the responsibility for that action (they could, for example, try to bill the review firm for costs).

Finally, breach of confidentiality is a risk to the patient when PUR companies conduct telephone review. Providers, however, also bear some of the burden in this area by ensuring that they give information only to legitimate reviewers.

HARM TO PROVIDERS

The IOM study does cite significant costs to hospitals, as well as time spent by providers in performing review functions. These costs include those listed by the applicant, such as reaching out of state review firms by telephone, gathering information for a PUR firm, and ensuring that confidential records are released only to authorized personnel. Copying medical records can also add to expenses, though providers can sometimes recover these costs by billing the PUR company for duplication.

Providers also face possible liability if they refuse treatment based on a UR review. Coupled

with a physicians duty to care for patients, this risk prevents any denial of service truly believed necessary, even when unauthorized by the PUR.

Ultimately, the decisions made by unqualified review agents are not the cause of most provider harms. Instead, as mentioned above, reviewers add to the "hassle" factor associated with UR when providers must spend time explaining procedures in order to obtain approval.

Though providers eventually acquire most authorizations, they are further antagonized by the feeling that someone with very little medical knowledge is questioning their judgment. The refusal of some UR firms to reveal their criteria only adds to that impression, making physicians feel that decisions regarding care are made arbitrarily, by an unknown and unqualified reviewer in another state.

GENERAL HARM

Another problem with inefficient UR, linked to the irritation of providers, is actually a lessened ability for UR to cut costs. If one phone call saves a substantial amount by reducing the number of hospital inpatient days, then UR serves a valuable purpose. If a reviewer or provider has to make five calls, records requests are confused, and the time and effort involved add up to half of the amount of money saved, then UR, though still worthwhile, is much less effective. Additionally, if physicians refuse to cooperate with UR firms because of the hassles involved, then UR also loses its punch. Thus, one reason for improving the efficiency of UR might be not just to avoid its possible harms, but also to ensure its benefits.

The difficulties facing both patients and providers can also often be linked to the obscurity of UR firms. Small firms may open, operate for a few years, close when they receive complaints, and then re-open under a different name. The difficulty of finding UR firms also makes dissemination of guidelines and information to small UR firms difficult. Some of those firms might then enter the field, without the necessary knowledge and qualifications to perform effective UR. If improving the efficiency of UR is the goal, uniformity of regulation would be ideal. UR, while an important cost containment measure is one of many and must operate within the larger health care realm. The difficulties described above, while certainly present, have not yet materialized in a quantifiable manner.

VI. NATIONAL GUIDELINES

Because PUR lacks standardization or coordination, and because most review occurs across state lines, some sort of national rules would provide the best solution to industry difficulties. However, although the American Medical Association (AMA) recently sent out information describing attempts at federal UR regulation, no real action has yet been taken in that area and the Association advocated caution in overruling state laws. URAC's guidelines are thus the only national standards currently available.

URAC is a non-profit organization that emerged from a meeting held by the American Managed Care and Review Association (AMCRA), in 1989. Its stated goal is to "continually improve the quality and efficiency of the interaction between the UR industry and the providers, payers and purchasers of health care." It also seeks to discourage individual state regulation, believing that an overly burdensome regulatory framework would dampen UR cost cutting initiatives.

The current URAC board includes, among others, members of the American Hospital Association, American Medical Association, American Psychiatric Association, American Nurses Association, National Association of Insurance Commissioners, and the Blue Cross/Blue Shield Association. It began registering firms in 1991. As of April 1, 1992 it had approved 23 review organizations, and had a list of others awaiting accreditation. URAC charges a base registration fee of $3,500, plus $1,500 per review site, up to a maximum of $11,000, for 12 sites.

The URAC standards describe basic good business practices for UR firms. They specify that family or physicians should be able to contact a UR firm on the patient's behalf; establish limits on the amount of data requested for initial review; require written procedures to assure that reviews are conducted in a timely manner; require both an expedited and standard appeals process; and require written procedures for assuring that information will be kept confidential. UR staff must possess qualifications equivalent to nurses, physicians and other licensed health professionals, and the UR company must provide licensed specialty reviewers. Finally, URAC requires access to review staff by a toll free or collect call phone line at least 8 hours during the normal business day in the provider's local time zone, and requires that on-site reviews be arranged at least one day in advance.

VII. STATE REGULATION AND GUIDELINES

STATE REGULATIONS IN GENERAL

Currently 24 states have some type of PUR regulation and an additional 14 states have proposed legislative bills pending, but not yet enacted. The laws passed include ones developed before URAC's existence or without reference to URAC, as well as ones which have incorporated the URAC standards. Additionally, several states set up voluntary local guidelines, either prior to or in conjunction with, their statutes.

Most regulations establish a licensing or registration requirement administered by a department such as Colorado's Department of Health or Division of Insurance. Additionally, most states exempt various reviewers from their requirements.

PROs are often exempt when performing Medicare reviews because of the federal requirements placed on that program. Some states also exclude HMOs, PPOs, and insurance companies performing in-house reviews of their own insured. Finally, one obstacle to state regulation creating additional exemptions is the possible pre-emption of any regulations relating to the self-insured by the federal Employee Retirement Income Security Act (ERISA).

ERISA preempts state laws regarding private employee benefit plans. The position of PUR firms in relation to this fact, however, is unclear. Regulatory officials interviewed by phone in both Kentucky and Missouri, two states that do not specifically exempt self-insured plans, remarked that ERISA created substantial enforcement problems. Kentucky, in particular had just solicited its third legal opinion on the status of ERISA, after receiving letters from groups claiming exemption.

According to an article on the legal implications of utilization review by lawyer William A. Helvestine, ERISA pre-emption may depend on whether or not the UR firm is considered a "fiduciary" under the federal act. According to Helvestine, this would be the case if the UR firm exercised discretionary authority or control over the plan (which it basically does when it approves or denies authorization).

- Helvestine, William A. "Legal Implications of Utilization Review." Appendix A in Controlling Costs and Changing Patient Care?: The Role of Utilization Management. Institute of Medicine Committee on Utilization Management by Third Parties. Washington, D.C.: National Academy Press, 1989: 169-204.

Thus, while it remains unclear when exactly ERISA will preempt state regulations, the likelihood is that direct state regulation of UR firms does not reach single-employer self-insured organizations. Unfortunately this is one of the groups most complained of by the applicants.

EXAMPLES OF LAWS THAT DO NOT INCORPORATE URAC

The oldest state law regulating UR is Maryland's, passed in 1988. It requires certification of all UR firms conducting review in the state with the Department of Health, but has not been successfully enforced. According to a Deputy Director of Licensing and Certification at the Maryland Department of Health, most complaints arise from substance abuse and psychiatric facilities and new questions continue to arise, such as rules governing sub-contracted firms. The end result of the law has been a paper trail, with little change in the way UR firms do business. Maryland has seemingly found no effective way to reach out-of-state firms, and its law apparently inserts the state between providers and insurers but does not satisfy either group.

Another of the "older" laws, passed by Arkansas in 1989, attempts enforcement through Health Insurance payers. If the insurance firm uses an uncertified UR process, or contracts with an uncertified reviewer, it must pay any covered benefit where medical necessity is disputed.

An example of a more recent law that does not specifically use URAC guidelines is that of Virginia. The Virginia law regulates only independent review firms. It does not cover HMOs, PPOs, insurance companies, or health services plans performing in-house reviews. The law requires certification of UR firms by the State Corporation Commission, without which a private review agent may not conduct UR.

Although the Virginia program is too new to have produced definite results, the state has kept track of complaints. Ironically, since the law's implementation, the only complaints received have been against self-insured plans and insurance companies doing review in-house, neither of which is covered by the statute.

STATES INCORPORATING URAC GUIDELINES

Since the URAC guidelines went into effect a number of states have implemented laws incorporating its standards. Current law in the District of Columbia requires URAC accreditation for those firms conducting workers compensation UR. After July 1, 1993, Nebraska will require that all UR organizations receive URAC accreditation, and in Connecticut, Indiana, North Dakota, and Tennessee, the Insurance Commissioner can waive state certification requirements for URAC accredited firms. New Hampshire is considering a bill using URAC as the acceptable standard for licensure while spelling out minimum state standards. Finally, Iowa has adopted URAC as the only standard for state licensure.

Iowa, especially, provides a good example of extensive URAC use. The state did not expand the powers of any of its departments to cover UR firms. Instead, enforcement is through payers already regulated. The law forbids any third-party payor providing health benefits to enrollees in Iowa from contracting with any outside reviewer that does not meet the URAC standards. Although it is too soon to tell the results of this law, it does have the advantage of enforcing state guidelines while maintaining a national perspective.

Overall, statutory solutions to PUR problems need to address a complicated range of review activities. The oldest, Maryland's, suffers from enforcement problems not easily solved given the national activities of UR firms. Requiring state licensure but also accepting URAC guidelines, does make established standards more uniform while attempting to provide some mechanism beyond a voluntary association. Unfortunately this route will also probably be difficult to truly enforce. ERISA's exemption places further limits on the reach of state statutes. Despite the growing number of states passing regulations, this approach seems likely to require more effort to implement than it is worth in terms of ending PUR difficulties.

STATE EXPERIENCE WITH LOCAL VOLUNTARY GUIDELINES

Two states, Tennessee and Missouri, began with, or continue to adopt, their own voluntary standards. Tennessee was actually one of the first states to establish any guidelines at all. The Tennessee Health Relations Group, a group of insurers and UR firms, wrote its own rules which later became the basis for URAC.

The state postponed regulation of UR firms pending URAC's establishment. Recently, however, it passed a bill mandating compliance with state regulations and waiving that requirement for URAC accredited firms. A representative of the Tennessee Hospital Association stated that, though satisfied with the voluntary guides, state health care organizations felt that PUR firms would be better put on notice, and standardization better achieved, if URAC guidelines were statutorily implemented.

In Missouri, voluntary guidelines emerged virtually simultaneously with a state act. The group writing the voluntary guides continues to revise and advocate them as a valuable measure of cooperation, despite the passage of the statute which does not officially go into effect until November 11, 1992.

The Missouri Department of Insurance has been given jurisdiction, but limited resources for enforcement. If nothing else, the department hopes that the law will establish a better record of which UR firms are operating in the state and which cause the most difficulties. Patients and providers should, then, at least know which company to complain about if there is a problem.

STANDARDS IN OR NEAR COLORADO

Of the states surrounding Colorado, New Mexico, Wyoming and Utah have no provisions governing UR review. Only Nebraska has passed a law accepting URAC guidelines, and since it was enacted in the first quarter of 1992 it has not yet had any measurable effects.

A stiff Kansas proposal that would have required all reviewers to be licensed in the same profession as the provider which they were reviewing died in committee in 1990. Instead, the Kansas Special Committee on Public Health and Welfare recommended that the standing committees continue to observe the progress made by URAC, and the effectiveness of its accreditation mechanism.

Recently, representatives of PUR companies, physicians, insurers, businesses, hospitals, the Colorado Medical Society and the Colorado Hospital Association have worked to create their own set of voluntary guidelines. This "PUR task force" includes those both for and against state regulation and the guidelines state their intention that they not be "an addendum to, or substitute for any current or future state laws or regulations." ("Voluntary Private Utilization Review Guidelines: Draft." Colorado, 1992. Colorado Medical Society, Colorado Hospital Association, Colorado Prospective Payment Professionals, Colorado Claims Association et al.). Nevertheless, the cooperation of all the parties involved could reduce tensions and problems between providers and insurers.

These voluntary guidelines are based on the URAC, Tennessee, and Missouri efforts, using the parts from each most agreed on. They should be completed in 1992, and the group plans to distribute them as widely as possible and then follow the results for 6 months. Given the complicated nature of any UR regulations and the newness of URAC, these guides may constitute the best solution currently available.

VIII. CONCLUSIONS AND RECOMMENDATIONS

Although there is some merit to the problems expressed by the applicants, the Colorado Department of Regulatory Agencies finds that licensure of utilization review agents is not the answer at this point in time. The extent of the harm caused by UR is too unclear to meet the standard required by the Sunrise law. If, in the future, data emerges showing that PUR poses a much larger threat, or showing that state regulation works well to solve the industry's difficulties, then a licensing statute could be reconsidered.

Additionally, in view of the fact that UR could be done with better coordination between providers and payers, the Department makes the following recommendations:

Recommendation 1: **The "PUR task force" creating the Colorado voluntary guidelines should complete its task and follow up as planned for at least six months. Even if the voluntary nature of this plan prevents it from being effective, the follow up procedure should produce a better picture of the extent and nature of PUR problems in this state.**

Recommendation 2: **The applicants should explore the possibility with the Division of Insurance of maintaining an informational listing of entities conducting PUR in Colorado.**

Recommendation 3: **Because one of the greatest difficulties in implementing any state PUR guidelines is identifying all of the agents actually conducting reviews in the state, and because this lack of identification also poses the greatest threat to patient record confidentiality, the department also offers the following amendment to the medical records laws:**

A requirement should be added to C.R.S. Title 25, Article 1, Part 8, dealing with patient rights in regards to medical records. It should state the following:

1. Subject to 2, Providers are authorized to release necessary medical records information to a utilization review agent that has previously identified itself in writing. Said identification should include the name of the review firm, along with its address, phone number, and the name of the entity for which it is conducting review.

2. No portion of this act shall be construed to place liability on a provider for releasing information to a reviewer in an emergency care situation. In such an emergency, however, written identification should follow as soon as is reasonably possible.

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Colorado Medical Society. 1700 E. Dorado Place, Englewood, CO 80111. Edie Register and Robert McCartney, M.D.

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