WEEKLY SESSION UPDATE

February 10, 2017

Dayton seeks quick vote on MinnesotaCare 'buy-in'
From the MINNEAPOLIS STAR : Minnesota would become one of the first states in the nation with a "public option" in the marketplace for individual health insurance under a plan pitched by Gov. Mark Dayton and endorsed Monday by two outstate DFL legislators. Private health insurance options are dwindling for rural Minnesotans, said Rep. Clark Johnson, DFL-North Mankato, so opening more space in the 25-year-old MinnesotaCare program makes sense.
http://www.startribune.com/dayton-seeks-quick-vote-on-minnesotacare-buy-in/412915013/

HMOS: from **David Montgomery** via *Pioneer Press*, **VERBATIM**: "Minnesota legislators swept away a 40-year-old law last month, a controversial add-on to a rescue package for Minnesotans' health insurance premiums...The change lets for-profit companies be licensed as health maintenance organizations, or HMOs, in the state. Minnesota had restricted HMOs to nonprofits ever since it first authorized HMOs in 1973…Supporters say the move could introduce more competition to the state's troubled individual insurance market, where premiums have soared in recent years…**QUOTE:** "I favor a chance to have a real market and real competition in the health care world," said state Sen. **Jim Abeler**, R-Anoka. "Not (just) to drive prices down, but also to make sure people are satisfied…There's no law against health insurance companies in Minnesota being for-profit. But until last month, there was a law against those for-profit companies operating here as HMOs…Removing that restriction will make it easier for an existing HMO to enter Minnesota's individual market, because now they don't have to reorganize themselves in order to do so." **READ:** http://bit.ly/2kjWnq5

Federal Surprise Billing Solution
An article by the Brookings Institute argues for a federal answer to surprise billing. The full article can be found here.

via Star Tribune: In rural Minnesota, hospitals balk at tight networks

HF 582 – Supplemental Nursing Services Agencies
HF 582 (Schomacker), which clarifies language regarding who may be employed by supplemental nursing service agencies was heard in the House Aging and Long Term Care committee last week. The bill passed out of the committee without any opposition and is now in the HHS Reform Committee.

MHA Worker's Comp Letter

As an FYI, a copy of the Minnesota Hospital Association's letter to the MN Department of Labor & Industry is attached.

Treatment delay may cost insurer

Minnesota Lawyer | By: Barbara L. Jones February 2, 2017 0

A breach-of-contract action may proceed against Blue Cross Blue Shield Minnesota for its initial refusal to pay for cancer treatment ultimately deemed medically necessary in a statutory external-review process.

Although the company ultimately paid for the proton-beam radiation treatment it had initially deemed "investigative," the insureds, James and Gloria Linn, argue that the delay of more than a year was a breach of the contract's timeliness requirements and caused consequential damages.

The Court of Appeals said that the results of the external review process were binding on the insurer and that the District Court judge erred in interpreting the health-care contract medical necessity provision.

The unanimous opinion in *James Linn et al. v. BCBSM, Inc.*, was written by Judge Lucinda Jesson.

'Huge implications'

The opinion is significant for what it said as well as what it didn't say, said the Linns' attorney, Brandon Schwartz of Oakdale. What it said was that the external review opinion is binding on the insurance beyond the question of payment for a procedure and that implies consequences to the company that wrongfully refuses coverage, he said. It also reminds patients that there is a review process after a denial of coverage, of which some may not be aware, he said.

Those consequences also are important when it comes to what the court didn't say, Schwartz said. The court did not say that compensatory damages are unavailable in this contract breach case. Instead, it left the issue open on remand. "This has huge implications for wrongful denial of coverage cases," he said.

A third surgery and the following proton-beam radiation, which resulted in the external review process, eliminated James Linn's cancer. If he had received the treatment when the doctor recommended it, there would never have been an adverse review, Schwartz said.
Attorneys from BlueCross Blue Shield Minnesota could not be reached for comment.

Proton-beam treatment called investigative

The contract between the parties provided that BCBSM would not pay for services not medically necessary or related to investigative care. The latter is defined as care that has not received FDA marketing approval, is the subject of ongoing clinical trials, or medically reasonable conclusions have not been established about its safety and/or efficacy.

Linn was diagnosed with chondrosarcoma, a type of bone cancer that affects cartilage, in March 2014. After two surgeries, proton-beam radiation therapy was recommended, although under the contract it was considered investigative when treating the thoracic spine, where the tumor was located.

A radiation oncologist provided a letter of medical necessity to BCBS, which still denied it. That decision was appealed.

By this time, nine months had gone by since the original diagnosis. In mid-December, it was determined that the tumor had wrapped around the spinal cord and the proton-beam therapy was again requested. After about a week, Linn had surgery although BCBS had not responded. On Dec. 29, it again denied coverage.

In February, the plaintiff requested external review pursuant to Minn. Stat. sec. 62Q.73. It was referred to the MAXIMUS Center for Health Dispute Resolution, which in April 2015 overturned the denial of coverage. BCBS then agreed to pay for the proton-radiation therapy.

A Ramsey County District Court judge granted BCBSM's summary judgment motion, saying that the insurer did not breach its contract as a matter of law because the procedure wasn't covered, and also that BCBSM did not improperly interfere with or delay the internal appeal. The court also held that no breach had occurred since the claim had been paid.

'Binding means binding'

The Court of Appeals framed the issue as whether the external reviewer's determination of medical necessity binds the company on the contract term as well as the payment obligation. In other words, is the reviewer's determination superimposed on the contract definition of medical necessity?

The court determined that it was.

The external-review process was created in Minnesota in 1999. Under the statute, the medical-necessity determination requires that expert review must determine whether the adverse determination was consistent with the statutory definition of medical necessity. The statute defines medically necessary as appropriate to the diagnosis and includes diagnostic testing and preventive services. It also must be within generally accepted healthcare practice parameters. The decision is binding on the health plan but not the enrollee.
The statute applies to BCBSM because of its status as a nonprofit corporation.

The court rejected the insurer's argument that the external-review decision is binding only as to payment, not to the definition of medical necessity.

"The plain language of the external-review statute does not limit the binding nature of the external-review determination on the health-plan company to the payment of claims that have been submitted for external review," Jesson wrote.
The court declined to add a caveat to the word binding, saying that "binding means binding." The Legislature could have limited the term to liability to pay claims but did not.

The court also noted that a broad application of the medical-necessity definition to licensed nonprofits outside the realm of external review reinforces the statutory meaning as not restricted to a payment decision.

The court further commented that the purpose of nonprofit health-service statute is to promote a wider, more economical and timely availability of services, which is consistent with finding that the

medical-necessity decision binds the company under the whole contract. "Conversely, we note that public policy supports the insured's ability to seek legal redress following an adverse determination on external review," the court continued.

The court was also influenced by the U.S. Supreme Court 2001 decision in *Rush Prudential HMO Inc. v. Moran*, which it said "intimated "that the right to an independent review of a medical-necessity determination essentially equates to the right to a conclusive determination of the HMO's medical obligation. Similarly, in this case the external-review determination replace[s] that of the [health-plan company] as to what is 'medically necessary' under [the] contract, the court said, citing *Moran*.

"Without question, this is a complex area of the law. However, we conclude that the district court erred by addressing on summary judgment whether proton-beam radiation therapy was 'medically necessary' under the health-plan contract. Once the external-review entity determined that proton-beam therapy was medically necessary to treat Linn's condition, Blue Cross was required to adhere to that decision both as a matter of payment and a matter of contract. No further contractual analysis of that issue is warranted," the court continued.

The court went on to hold that the plaintiff's breach-of-contract claim relating to timeliness must be addressed by the District Court. The case should be remanded for consideration of the failure to approve the therapy when requested. The Court of Appeals suggested that the District Court request further briefing or submit the issue of timeliness to a jury. It also left the issue of the appropriate scope of damages to the District Court.