SUBJECT: HMO complaint and appeal procedures

COMMITTEE: Insurance — committee substitute recommended

VOTE: 8 ayes — Smithee, Eiland, Burnam, J. Moreno, Olivo, Seaman, Thompson, Wise

0 nays

1 absent — G. Lewis

WITNESSES: For — Jeff Kloster, Texas Association of Health Plans; Cynthia Leiferman, Advocacy, Inc.

Against — None

BACKGROUND: Last session, several bills were enacted amending HMO complaint and utilization review procedures. Every HMO is required to maintain a complaint system, following specified procedures. If complaints are not resolved to the complainant's satisfaction, the HMO must provide an appeals process, also following specified provisions.

A "complaint" is defined in the Insurance Code, chpt. 20A, as any dissatisfaction expressed by a complainant with any aspect of the HMO's operation, including but not limited to plan administration, appeal of an adverse determination, and the denial, reduction or termination of a service.

"Adverse determination" is defined in the Insurance Code, Art. 20A.02, as a determination by an HMO or a UR agent that the health care services furnished or proposed to be furnished to an enrollee or insured were not medically necessary. Adverse determination is defined slightly differently in art. 20A.12A, which governs review and appeal of such determinations.

SB 386 by Sibley amended the Civil Practices and Remedies Code to hold health insurance carriers, HMOs and other managed care entities liable for failure to exercise ordinary care when making health treatment decisions, and

amended the Insurance Code to create standards for actions by utilization

review (UR) and independent review organizations (IROs).

In general, in order to maintain a cause of action, a person would first have had to exhaust the entity's utilization review and appeals processes or give written notice of the claim of harm to the insurer, HMO or managed care entity and agree to submit the claim to a review by an independent review organization (IRO). Parties whose appeal of an adverse determination was denied by a UR agent or HMO could seek review of the determination by an IRO.

DIGEST:

CSHB 3021 would limit complaints about adverse determinations only to the procedures used to review or appeal adverse determinations. An enrollee's or provider's dissatisfaction with the adverse determination itself would not constitute a complaint. Also, only dissatisfactions with the denial, reduction or termination of a service for reasons not related to medical necessity would be considered a complaint.

"Adverse determination" as it relates to the appeals process, would be redefined as a determination by an HMO or a UR agent that the health care services furnished or proposed to be furnished to an enrollee or insured were not medically necessary or appropriate.

CSHB 3021 would require HMOs to maintain an internal appeal system that would provide reasonable procedures for the resolution of a disagreement or dissatisfaction over an adverse determination. The appeal system would have to include procedures for notification, review and appeal in accordance with the standards and procedures used to review appeals of adverse determinations by UR agents. HMOs or UR agents would have to regard the expression of dissatisfaction or disagreement as an appeal of the adverse determination and review and resolve the appeal.

The bill would take effect September 1, 1999, and would apply only to complaints expressed or appeals related to adverse determinations made on or after that date.

SUPPORTERS SAY:

CSHB 3021 is a clean-up bill to make conforming and clarifying changes to inconsistent areas of the law, which were the result of the enactment of several bills last session governing HMO complaints and appeals. The bill would make complaints distinct from expressions of dissatisfaction with

adverse determinations and by doing so would clarify the process by which a complainant must follow to access review by an IRO, if necessary.

CSHB 3021 also would help patients who have special conditions, or a special combination of medical conditions, appeal adverse determinations over services considered to be inappropriate. Many times for these patients require services considered normally inappropriate for most patients. "Appropriateness," just like "medical necessity" is a matter of subjective judgment that also should receive the right for review and appeal.

OPPONENTS SAY:

No apparent opposition.

NOTES:

The committee substitute changed the original version by defining adverse determination to include determinations that the services in question were not appropriate.

HB 3021 originally was sent to the Local and Consent Calendars Committee and subsequently was transferred to the Calendars Committee.

HB 3016 by Smithee, amending provisions relating to HMO utilization review requirements, also is on today's calendar.