U.S. House of Representatives
Committee on Commerce
Room 2125, Rayburn House Office Building
Washington, DC 20515–6115

DEMOCRATIC STAFF

FAX COVER SHEET

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371-4000 - EXT. 127 591-2220

The Patient Access Coalition
Member Organizations

4466-6550 - PETER THOMAS

PATIENT ACCESS
... Dedicated To Putting Patients First

Allergy and Asthma Network - Mothers of Asthmatics, Inc.
Alexandria Graham Bell Association for the Deaf, Inc.
American Academy of Allergy and Immunology
American Academy of Child and Adolescent Psychiatry
American Academy of Dermatology
American Academy of Facial Plastic and Reconstructive Surgery
American Academy of Neurology
American Academy of Ophthalmology
American Academy of Orthopaedic Surgeons
American Academy of Otolaryngology - Head and Neck Surgery
American Academy of Pain Medicine
American Academy of Physical Medicine & Rehabilitation
American Association for Hand Surgery
American Association for Holistic Health
American Association for the Study of Headaches
American Association of Clinical Endocrinologists
American Association of Clinical Urologists
American Association of Hip and Knee Surgeons
American Association of Neurological Surgeons
American Association of Oral and Maxilofacial Surgeons
American Association of Orthopedic Foot and Ankle Surgeons
American Association of Private Practice Psychiatrists
American College of Allergy and Immunology
American College of Cardiology →
American College of Foot and Ankle Surgeons
American College of Gastroenterology
American College of Nuclear Physicians
American College of Osteopathic Surgeons
American College of Radiation Oncology
American College of Radiology
American College of Rheumatology
Ameican Dental Association
American Diabetes Association
American EEG Society
American Gastroenterological Association
American Heart Association
American Liver Foundation
American Lung Association
Ameican Medical Rehabilitation Providers Association

Nancy McLean

Tom Shorda

American Orthopaedic Society for Sports Medicine
American Osteopathic Academy of Orthopedics
American Osteopathic Surgeons
American Pain Society
American Physical Therapy Association
American Podiatric Medical Association
American Psychiatric Association
American Psychological Association – PETER N. 332-5182
American Sleep Disorders Association
American Society for Dermatologic Surgery
The American Society of Dermatophathology
American Society for Gastrointestinal Endoscopy
American Society for Surgery of the Hand
American Society for Therapeutic Radiology and Oncology
American Society of Anesthesiology
American Society of Cataract and Refractive Surgery
American Society of Clinical Pathologists
American Society of Colon and Rectal Surgery
American Society of Dermatology
American Society of Echocardiography
American Society of Foot and Ankle Surgeons
American Society of General Surgeons
American Society of Hand Therapists
American Society of Hematology
American Society of Nephrology
American Society of Pediatric Nephrology
American Society of Plastic and Reconstructive Surgeons, Inc.
American Society of Transplantation
American Society of Transplant Surgeons
American Thoracic Society
American Urological Association
Amputee Coalition of America
Arthritis Foundation
Arthroscopy Association of North America
Association of American Cancer Institutes
Association of American Medical Colleges
Association of Freestanding Radiation Oncology Centers
Association of Subspecialty Professors
Asthma & Allergy Foundation of America
California Access to Specialty Care Coalition
California Congress of Dermatological Societies
College of American Pathologists
Congress of Neurological Surgeons
Cooley's Anemia Foundation
Crohn's and Colitis Foundation of America
Cystic Fibrosis Foundation
Diagenetics
Digestive Disease National Coalition
The Endocrine Society
Epilepsy Foundation of America

Eye Bank Association of America
Federated Ambulatory Surgery Association
Gullain-Barre Syndrome Foundation
Huntington's Disease Society
Infectious Diseases Society of America
Joint Council of Allergy and Immunology
Lupus Foundation of America
National Association for the Advancement of Orthotics and Prosthetics
National Association of Epilepsy Centers
National Association of Medical Directors of Respiratory Care
National Committee to Preserve Social Security and Medicare
National Foundation for Ectodermal Dysplasias
National Hemophilia Foundation
National Multiple Sclerosis Society
National Organization of Physicians Who Care
National Osteoporosis Foundation
National Psoriasis Foundation
National Rehabilitation Hospital
National Right to Life Committee
North American Society of Pacing and Electrophysiology
Oregon Dermatology Society
Orthopaedic Trauma Association
Outpatient Ophthalmic Surgery Society
The Paget Foundation for Paget's Disease of Bone and Related Disorders
Pain Care Coalition
Patient Advocates for Skin Disease Research
Pediatric Orthopedic Society of North America
Pediatrix Medical Group: Neonatology and Pediatric Intensive Care Specialists
Pituitary Tumor Network
Renal Physicians Association
Scoliosis Research Society
Sjogren's Syndrome Foundation Inc.
The Society for Cardiac Angiography and Interventions
Society for Excellence in Eyecare
Society for Vascular Surgery
Society of Cardiovascular & Interventional Radiology
Society of Critical Care Medicine
Society of Gynecologic Oncologists
Society of Nuclear Medicine
Society of Surgical Oncology
Society of Thoracic Surgeons
The TMJ Association, Ltd.
United Ostomy Association

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KAISER FAMILY FOUNDATION/HARVARD UNIVERSITY SCHOOL OF PUBLIC HEALTH

SURVEY OF PHYSICIANS AND NURSES

SUMMARY OF FINDINGS AND CHART PACK

July 1999

THE HENRY J. KAISER FAMILY FOUNDATION

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THE HENRY J. KAISER FAMILY FOUNDATION

THE KAISER FAMILY FOUNDATION/HARVARD UNIVERSITY SCHOOL OF PUBLIC HEALTH

Survey of Physicians and Nurses

News Release

THE HENRY J. KAISER FAMILY FOUNDATION

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9:00 a.m. EDT, Wednesday, July 28, 1999

NEW SURVEY SHOWS THAT PROVIDERS AND HEALTH PLANS CLASH OFTEN OVER PATIENT CARE

Doctors and Nurses Give Plans Good Marks in a Few Areas, But Many Report Frequent Denials of Coverage and Adverse Health Consequences for Their Patients

MENLO PARK, CA – A survey of doctors and nurses released today sheds new light on how frequently health plans and care providers disagree about the appropriate care for patients, and what implications those disagreements have for patients' health.

Almost nine out of ten doctors (87%) said that their patients have experienced health plan denials of coverage for health services over the last two years, with denials reported most frequently for prescription drugs (61% of doctors said they see denials for prescriptions they order on a weekly or monthly basis). Many doctors -- between a third and two-thirds, depending on the type of denial -- also reported that (in their judgement) health plan denials of drugs, hospital stays, diagnostic tests or referrals to specialists or mental health services resulted in adverse health consequences for their patients. About half of nurses (48%) said that within the last two years a health plan decision has resulted in a decline in health for their patients.

Two-thirds of doctors said they often or sometimes intervened with plans on their patients' behalf. And these doctors said their interventions often led to a resolution in the patient's favor, with plans responding positively 42% of the time, or compromising 21% of the time. Close to one-half of doctors (48%) and nurses (46%) said that they have exaggerated the severity of a patient's condition to get coverage for medical care they felt was required by the patient.

"There is a great deal of inappropriate care in the health care system and it is the managed care industry that has taken on the unpopular job of controlling costs, but this level of conflict and administrative haggling between doctors and plans can't be good for our health care system or for patients who are often caught in the middle," said Drew Altman, Ph.D., president of the Kaiser Family Foundation.

Both doctors and nurses see the growing influence of managed care as having primarily negative effects on health care. Doctors cited increases in paperwork and nurses cited decreasing quality of care as the prime downsides. But both also gave more positive marks to health plans for preventive care and for practice guidelines and disease management protocols they find helpful.

- More -

The *Survey of Physicians and Nurses* is a national random survey of 1053 doctors and 768 nurses conducted by researchers at the **Kaiser Family Foundation** and the **Harvard School of Public Health**. The survey collected quantitative information from doctors and nurses about their non-elderly patients, as well as verbatim descriptions of patient experiences with health plan decisions. The survey reports doctors' judgements on the impact of denials; health plans or independent reviewers might disagree with these judgements in some cases.

Provider Reports of Patient Experiences

The survey asked doctors and nurses for specific information about the nature and frequency of health plan decisions to deny coverage. The most frequent denials reported by doctors were for prescription drug coverage (61% said it occurred weekly or monthly -- 33% weekly; 28% monthly), followed by denials for diagnostic tests (42% -- 16% weekly; 26% monthly), overnight hospital stays (31% -- 9% weekly; 22% monthly), referrals to specialists (29% -- 10% weekly; 19% monthly); and referrals for mental health services (18% -- 6% weekly; 12% monthly).

Among the doctors who reported that their patients experienced denials, many said that a decline in health status had occurred as a result:

- **Mental Health** - of those doctors who reported a denial, 65% said their most recent denial had resulted in a "very serious" (16%) or "somewhat serious" (49%) health decline;
- **Referrals to Specialists** - 50% said their most recent denial resulted in a "very serious" (12%) or "somewhat serious" (38%) health decline;
- **Diagnostic Tests** - 46% said their most recent denial resulted in a "very serious" (8%) or "somewhat serious" (38%) health decline;
- **Overnight Hospital Stays** - 39% said their most recent denial resulted in a "very serious" (6%) or "somewhat serious" (33%) health decline; and
- **Prescription Drugs** - 37% said their most recent denial had resulted in a "very serious" (5%) or "somewhat serious" (32%) health decline

Of the 48% of nurses who said a health plan decision over the last two years had resulted in a decline in a patient's health, almost two-thirds said it happened on a weekly or monthly basis (26% weekly, 37% monthly).

In order to get patients coverage for care they thought was medically necessary, 48% of doctors reported that within the last two years they had exaggerated the severity of a patient's condition (including 5% who said they did it often, 21% who said they did it sometimes, and 22% who said they did it rarely; 51% said they never did it at all).

"The detailed descriptions of denials of coverage provided by doctors underscore the challenges of addressing the unique needs of individual patients within the rules of managed care," said Dr. Karen Donelan, assistant professor at the Harvard School of Public Health.

Attitudes of Physicians and Nurses

Most health care providers see the growing influence of managed care as having primarily negative effects on health care:

- 95% of doctors and 92% of nurses said that managed care has increased the amount of administrative paperwork for providers and patients;
- 86% of doctors and 82% of nurses said that managed care has decreased their patients' ability to see medical specialists;
- 83% of doctors and 85% of nurses said managed care has decreased the amount of time they spent with patients; and
- 72% of doctors and 78% of the nurses said that managed care has decreased the quality of care for people who are sick

Though many providers also see positive aspects in managed care:

- 68% of the doctors and 51% of nurses said that managed care has increased the use of practice guidelines and disease management protocols in patient care; and
- 45% of doctors and 42% of nurses said that managed care has increased the likelihood that patients would get preventive services

Many doctors also reported that health plans sometimes acted to help them improve patient care in their own practices: 47% said that health plans "often or sometimes" provide them with innovative screening tools to help them manage their patients' illness; 33% said that plans "often or sometimes" help them encourage patients to lead healthier lives; and 25% said that plans "often or sometimes" provide them with clinical data to help better manage their patients' care.

In reflecting on their own experiences in medicine, 58% of doctors said spending too much time on administration and not enough time with patients was a "great concern." Fewer said not having enough clinical autonomy (47%) and not making as much money as they had planned (26%) were also "great concerns." Almost seven in ten nurses (69%) cited inadequate staffing levels as a "great concern." Fewer pointed to not having enough clinical autonomy (33%), inadequate training to cope with changes (28%) and not making as much money as they had planned (26%).

Most doctors (79%) and nurses (70%) said their views of managed care were shaped primarily by their own experiences as health care providers. Fewer cited reports from professional organizations (31% for doctors; 29% for nurses) and the media (22% for doctors; 27% for nurses) as major influences. Nurses were more likely than doctors to say they were influenced a great deal by their personal experiences as patients (38% vs. 23%) or by reports from friends and family members (47% vs. 39%).

Views Are Not Homogenous

Physicians views and experiences with managed care varied substantially by specialty designation and practice setting. Specialists (71%) were more likely to say that managed care had a negative impact on patients than primary care physicians (58%). Doctors who contract with multiple health plans (74%) were also more likely than doctors who work predominantly with a single HMO (52%) to report negative effects of managed care on patients.

Methodology

The 1999 *Survey of Physicians and Nurses* was designed and analyzed by researchers at the Kaiser Family Foundation and the Harvard School of Public Health. The survey was administered by mail by the National Opinion Research Center to a national random sample of 1053 physicians and 768 nurses nationwide between February 11 and June 5, 1999. Because fewer Medicare beneficiaries are in managed care plans, the survey asked doctors and nurses only about their experiences with patients under 65 years of age. The physician sample was drawn from the American Medical Association's Masterfile and included physicians who indicate that they care for patients 20 or more hours each week. The sample was proportionately stratified to represent primary care physicians (general and family practitioners, general internists, pediatricians) and specialists (medical specialists and surgeons). The sample of registered nurses was drawn from a list provided by Medical Marketing Services, Inc. that was compiled from state nurse registries and other sources for use in surveys of nurses. Respondents were ineligible if they had not cared for patients in the year prior to the survey. The survey data are weighted by age, gender and region to be representative of national samples of patient care physicians and registered nurses and to account in part for non-response.

The survey collected quantitative information about physicians' and nurses' experiences with and attitudes towards health plans, particularly as it relates to patient care. The survey also collected verbatim responses from physicians and nurses in order to assess their judgements about the consequences of health plan denials for their patients. Reported verbatim responses were randomly selected from a total of 601 responses provided by physicians and 365 responses provided by nurses. Data presented on the consequences of health plan denials represents the judgements of the physicians surveyed, not independent clinical reviews. The maximum margin of sampling error for responses in a survey of 1,053 physicians is +/- 3% and for 768 nurses is +/- 4%. Estimates from smaller subgroups may be subject to higher margins of error based on the subgroup size.

The Kaiser Family Foundation, based in Menlo Park, California, is an independent national health care philanthropy and is not associated with Kaiser Permanente or Kaiser Industries. Copies of the questionnaire and topline data for the findings reported in this release are available online at **www.kff.org** or by calling the Foundation's Publications Request Line at **1-800-656-4533** (ask for document # 1503).

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Kaiser Family Foundation/Harvard University School of Public Health

SURVEY OF PHYSICIANS AND NURSES

RANDOMLY SELECTED VERBATIM DESCRIPTIONS FROM PHYSICIANS AND NURSES OF HEALTH PLAN DECISIONS RESULTING IN DECLINES IN PATIENTS' HEALTH STATUS

July 1999

THE HENRY J. KAISER FAMILY FOUNDATION

The Northrup rider prevents DOL from using any funds to implement this reg. (They are looking for an ident. health #)

(PROPOSED REG, NOT FINAL

HIGHLIGHTS OF DOL'S PATIENTS' RIGHTS REGULATION — ENSURING *FASTER, FAIRER, & FULLER* HEALTH CARE CLAIMS PROCEDURES [redacted]

I. FASTER DECISIONS

1. Faster initial coverage decisions. Old rule: 90 days. New rule: 72 hours (urgent care), 15 days (pre-service), or 30 days (post-service), depending on the type of claim.
2. Faster appeals. Old rule: 60 days. New rule: 72 hours (urgent care), 30 days (pre-service), or 60 days (post-service), depending on the type of claim.
3. In urgent care situations, decisions may be communicated orally.

II. FAIRER PROCESS

this is what the reg does

1. Plans may not preclude individuals from representing patients, and in urgent care situations, the patient's doctor will be deemed to be a representative.
2. Plans cannot impose fees or costs as a condition to making or appealing a claim.
3. More time for patients to file appeals. Plans must give patients at least 180 days to decide whether to appeal the denial.
4. The decisionmaker on appeal must be different from, and not subordinate to, the decisionmaker at the initial stage. And, the decisionmaker on appeal must consult with a qualified health care professional who is different from, and not subordinate to, any health care professional who part in the initial denial.
5. If plan doesn't comply with regulation, patient can take claim immediately to court.
6. Arbitration with safeguards is permitted.

Court can only order plan to provide benefit. Can not provide compensation for harm caused by delay.

III. FULLER DISCLOSURE

1. When a worker enrolls in a health plan, the worker must get a full description of the plan's claims procedures.
2. When a plan denies a claim, the patient must get a very specific written explanation of the reasons for the denial, and of his or her appeal rights.
3. When a plan denies a claim, the patient can get access to all documents, records, and information relevant to the claim.
4. When conducting an appeal, the plan may not rubberstamp the initial denial; the reviewer must make a new finding, considering any new evidence submitted.

Department of Labor's Patients' Rights Claims Procedure Regulation

Of all the important patients' rights that must be addressed for American workers and their families, there is one that we can address without delay -- that is the right to know why you're your request for health care benefits has been turned down, the right to appeal that refusal, and the right to a fair answer without delay.

This right is one that American workers are entitled to today under the law. But, with the growing use of managed care, the regulation that fulfills that right is now woefully outdated.

The President directed the Department to propose new guidance, updating those patients protections, to fulfill his promise to do everything within his power to deliver patients' rights to the American people.

Since that time, we have talked with a broad variety of important voices on this issue -- with patients and their doctors, with employers, insurers, and HMOs, with patients' advocates, with Members of Congress, with many, many others.

The appropriations bill marked up today brings this important work to a halt. But we must work together to change that. This vital work must continue. If strong patients rights legislation is enacted, we must be ready with regulations to fulfill its promise. If no legislation can be delivered to the American people, then this regulation -- which helps patients and families more meaningfully exercise those few rights they have now -- is even more urgent.

This appropriations language, at this critical time in this public policy debate, sends a terrible signal -- it keeps workers in the dark about why they are not getting the health care benefits they were promised under their plan and how they can appeal and get a fair answer while there is still time.

U.S. House of Representatives
Committee on Commerce
Room 2125, Rayburn House Office Building
Washington, DC 20515–6115

DEMOCRATIC STAFF

FAX COVER SHEET

DATE: _____

TO: Chris Jennings / Devorah

FROM: Amy

FAX NUMBER: 456 5552

NUMBER OF PAGES: 8
(Including Cover)

COMMENTS: Texas liability

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MANAGED CARE LIABILITY
TEXAS LEGISLATION
SUMMARY AND BILL

AUGUST 1997

SB 386--MANAGED CARE RESPONSIBILITY ACT
BY SIBLEY/SMITHEE

RESPONSIBILITY

This measure provides that health insurance carriers, health maintenance organizations and other managed care entities have the responsibility to exercise ordinary care when they make a health care treatment decision involving necessary medical treatment for their insureds. They may also be responsible for the acts of their employees, agents and representatives acting on their behalf. This act only involves medical services covered by the health care plan and does not require them to provide services which are not covered by the plan. Employers are specifically excluded from liability under the act. Managed care organizations (MCO) are prohibited from retaliating against a health care provider for advocating on behalf of the patient. Managed care organizations also may not have indemnification and hold harmless clauses in their contracts with providers.

LIMITATIONS OF CAUSE OF ACTION

Ordinarily a patient cannot bring a liability action under this legislation without exhausting the internal appeals process and the independent review process provided in this legislation. If the patient has failed to do this, the patient is required to give a 30 day notice to the managed care organization who has 14 days to request that the patient submit to an independent review. If the harm has already occurred because of the conduct of the MCO and such review would not be beneficial to the patient, suit can be filed without going through the independent review unless the patient was found to be acting in bad faith to avoid the review process. If the patient failed to comply with the appeals and review process, the court has the authority to order the patient to submit to an independent review or to mediation or other alternate dispute resolution and abate the action for up to 30 days.

INDEPENDENT REVIEW OF MANAGED CARE DECISIONS

This legislation provides that a patient has the right to the review of a denial of medical services by the managed care organization by an independent review organization (IRO). This independent review organization is certified by the commissioner of insurance and it is the commissioner who makes the assignment for the review. The commissioner sets the standards for certification. The review must occur within the earlier of 15 days after the date the IRO receives the necessary documents for review or 20 days after the request for review is received. In the case of a patient with a life-threatening condition, the patient has the right to skip the internal appeals process of the MCO and appeal directly to an independent review organization. The review by the IRO must be completed within the earlier of 5 days after receiving the necessary documents or 8 days after receipt of the request for review.

SB386--MANAGED CARE RESPONSIBILITY ACT
BY SIBLEY/SMITHEE

SECTION 1. CHAPTER 88. HEALTH CARE LIABILITY

Sec. 88.001. DEFINITIONS

(1) "Appropriate and medically necessary" means the standard for health care services as determined by health care providers in accordance with the prevailing practices and standards of the medical profession and community.

(2) "Enrollee" means a person enrolled in a health care plan and includes covered dependents.

(3) "Health care plan" means any plan which provides, arranges for, pays for or reimburses any part of the cost of any health care services.

(4) "Health care provider" uses the definition from Art. 4590i.

(5) "Health care treatment decision" means a determination made when medical services are actually provided by the health care plan and a decision which affects the quality of the diagnosis, care, or treatment provided to the plan's insureds or enrollees.

(6) "Health insurance carrier" means an authorized insurance company that issues policies of accident and insurance in Texas.

(7) "Health maintenance organization" means an organization licensed under the Texas Health Maintenance Organization Act.

(8) "Managed care entity" means any entity which delivers, administers, or assumes risk for health services with systems or techniques to control or influence the quality, accessibility, utilization, or costs and prices of such services to a defined enrollee population, but does not include an employer purchasing coverage or acting on behalf of its employees or the employees of one or more subsidiaries or affiliated corporations or the employer of a pharmacy licensed by the State Board of Pharmacy.

(9) "Physician" means (1) an individual licensed to practice medicine; (2) a professional association or 5.01(a) non-profit entity; or (3) another person wholly owned by physicians.

(10) "Ordinary care" means, in the case of a health insurance carrier, health maintenance organization or managed care entity, that degree of care that such an entity of ordinary prudence would use under the same or similar circumstances. In the case of a person who is an employee, agent, ostensible agent, or representative of a health insurance carrier, health maintenance organization or managed care entity, "ordinary care" means that degree of care that a person of ordinary prudence in the same profession, specialty, or area of practice as such person would use under the same or similar circumstance.

Sec. 88.002. APPLICATION

(a) A health insurance carrier, health maintenance organization or managed care entity (for purposes of this summary hereinafter referred to as "managed care organization" or "MCO") for a health care plan has the duty to exercise ordinary care when making health care treatment decisions and is liable for damages for harm to an insured or enrollee proximately caused by its failure to exercise such ordinary care.

(b) A managed care organization is also liable for damages for harm to a. . insured or enrollee proximately caused by the health care treatment decisions made by its emplo ees, agents. ostensible agents. or representatives who are acting on its behalf and over wht m it has the right to exercise influence or control or has actually exercised influence or contro)

(c) It shall be a defense to any action against a managed care organizatic 1 if the organization or its employees. agents or representatives for whose conduct the organi :ation is liable did not participate in a health care treatment decision and did not deny or delay recommended treatment.

(d) This section creates no obligation on the managed care organization to provide treatment for services which are not covered by the plan.

(e) This chapter does not create any liability on the part of an employer or a pharmacy.

(f) A managed care organization may not remove a health care provide from its plan or fail to renew for advocating on behalf of the patient for necessary medical care.

(g) MCO's may not include indemnification or hold harmless clauses i ; their contracts with providers.

(h) A managed care organization may not assert the prohibition of the ; orporate practice of medicine as a defense.

(I) A physician or other health care provider may not be regarded as ar employee, agent or representative of an MCO merely because the physician's or health care pr ovider's name appears on an approved list of providers.

(j) This chapter is not applicable to Worker's Compensation cases.

(k) A plaintiff under this section shall comply with the expert witness nd cost bond requirements of the Medical Liability and Improvement Act (Sec. 13.01, Art. 4590i)

Sec. 88.003. LIMITATIONS ON CAUSE OF ACTION

(a) A person may not maintain a cause of action under this chapter ur less he has exhausted the appeals process of the MCO and the independent review or gives not ce of the claim to the managed care organization and agrees to submit to an independent rev ew as provided in subsection (c).

(b) The notice in (a) must be provided 30 days before the claim is fil d.

(c) The enrollee must submit to an independent review if requested b / the managed care organization. Such request by the MCO must be made within 14 days of its r ceipt of notice of the claim.

(d) If the party has failed to complete the appeals process and indepe ident review process required in subsection (a), the court cannot dismiss the action but has the a uthority to order the enrollee to submit to an independent review or mediation or other nonbi ding alternate dispute resolution and may abate the action for a period not to exceed 30 days.

(e) The enrollee is not required to comply with subsection (d) if (1) t e harm has already occurred because of the conduct of the managed care organization and (2) the review would not be beneficial to the enrollee unless the court finds that such pleading w s not filed in good faith.

(f) The statute of limitations is tolled when the enrollee is required t ; comply with the appeals process of the MCO and the independent review or to give notice of t e claim.

(g) This chapter does not preclude the enrollee from pursuing other ppropriate

relief available under law (including injunctive relief) when exhausting the appeal and review process would place the enrollee's health in serious jeopardy.

SECTION 2. UTILIZATION REVIEW APPEALS AND INDEPENDENT REVIEW

(1) Provides that notification of a determination of an appeal within the MCO appeals process must be given within 30 days of the notice of the appeal and that notice should be given of the enrollee's right to appeal to an independent review organization(IRO).

(2) When a "life-threatening condition" is involved, the enrollee is entitled to an immediate appeal to an IRO without exhausting the MCO's internal appeals process. "Life-threatening condition" means a disease or other medical condition with respect to which death is probable unless the course of the disease or condition is interrupted.

SECTION 3. INDEPENDENT REVIEW OF ADVERSE DETERMINATION

A utilization review agent shall:

(1) permit any denial to be appealed to an independent review organization;

(2) provide medical records, pertinent information and notice to IRO within 3 business days:

(3) comply with decision of IRO: and

(4) pay for the review.

SECTION 4. CONFIDENTIAL INFORMATION

Confidential information can be provided to the IRO by the utilization review agent subject to rules adopted by the commissioner.

SECTION 5. HMO NOTICE TO ENROLLEE OF RIGHT TO IRO

An HMO is required to give notice to the enrollee of the right to appeal an adverse determination to an IRO.

SECTION 6. COMPLAINT SYSTEM

The commissioner is given the right to examine the HMO's complaint system.

SECTION 7. REVIEW OF ADVERSE DETERMINATIONS

(a) The HMO complaint system must include the following:

(1) notification to the enrollee of the right to appeal to an IRO;

(2) notification to the enrollee of the procedure for such appeal.

(3) notification to an enrollee who has a life-threatening condition of the right to an immediate review by an IRO and the procedure for doing so.

(b) Provisions in UR statute relating to IRO's also apply to HMO's.

(c) (1) "Adverse determination" means a denial of care as not being medically necessary.

(2) "Independent review organization" means an organization as defined in 21.58C of the Insurance Code.

(3) "Life-threatening condition" has the meaning assigned in the UR Act.

SECTION 8. Art. 21.58C. STANDARDS FOR UTILIZATION ORGANIZATIONS

Sec. 1. DEFINITIONS

(1) "Life-threatening condition" has the meaning assigned in the UR Act (Art. 21.58A, Insurance Code)

(2) "Payor" has the meaning assigned by the UR Act.

Sec. 2. CERTIFICATION AND DESIGNATION OR INDEPENDENT REVIEW ORGANIZATIONS.

(a) The commissioner shall:

(1) promulgate rules and standards for:

(A) the certification, selection and operation of IRO's; and

(B) the suspension and revocation of a certification:

(2) designate annually each organization that meet the standards;

(3) charge payors fees necessary to fund the operations of the IRO's; and

(4) provide ongoing oversight of the IRO's to ensure compliance.

(b) The standards required shall ensure:

(1) the timely response of the IRO;

(2) the confidentiality of medical records;

(3) the qualifications and independence of each health care provider making review determinations for an IRO;

(4) the fairness of the procedure used by the IRO; and

(5) timely notice to the enrollee of the results including the clinical basis for the decision.

(c) The standards must require the IRO to make its determinations:

(1) not later than the earlier of:

(A) the 15th day after the date the IRO receives the information necessary to make the determination; or

(B) the 20th day after the date the IRO receives the request for the determination;

(2) in the case of a life-threatening condition, not later than the earlier of:

(A) the 5th day after the date the IRO receives the information necessary to make the determination; or

(B) the 8th day after the date the IRO receives the request that the determination be made.

(d) The application of an organization seeking approval to be an IRO must include:

(1) name of each stockholder or owner of more than 5% of any stock or options;

(2) the name of any holder of bonds or notes of the applicant that exceed $100,000;

(3) the name and type of businesses that is owned or affiliated with the applicant;

(4) the name and biographical sketch of each officer, director and executive of the applicant and a description of certain relationships:

(5) the % of applicant's revenues expected to be earned from reviews;

(6) a description of the areas of expertise of the professional to be making the determinations; and

(7) the procedures to be used in making determinations.

(e) The IRO shall annually submit this information and shall update the information when a material change occurs.

(f) An IRO may not be owned by payors or a trade association of payors.

(g) An IRO has immunity from liability for conducting reviews unless acting in bad faith or grossly negligent.

SECTION 9. Chapter 88, the liability section applies to actions accruing on or after the effective date of the Act.

SECTION 10. (a) The change in law in Sections 2 through 4 and 6 through 8 apply to adverse determinations made after the effective date of this Act.

(b) The change in Section 5 of this Act applies to evidence of coverage that is delivered, issued for delivery, or renewed on or after Jan. 1, 1998.

SECTION 11. This Act takes effect of Sept. 1,1997.

SECTION 12. EMERGENCY CLAUSE