SUBJECT: Health benefit plan utilization review policies

COMMITTEE: Insurance — committee substitute recommended

VOTE: 9 ayes — Smithee, Van de Putte, Averitt, Bonnen, Burnam, Eiland, G. Lewis, Olivo, Wise

0 nays

0 absent

SENATE VOTE: On final passage, March 6 — voice vote

WITNESSES: (*Witnesses testified for or against individual amendments, which were rolled into a complete committee substitute. No witnesses registered solely for or against the bill as a whole.*)

BACKGROUND: Utilization review (UR) is a system for prospective or concurrent review and determination of the medical necessity and appropriateness of health care services provided to an individual. An "adverse determination" is a determination by a UR agent that health care services furnished or proposed to be furnished to a patient are not medically necessary or appropriate.

UR agents are required to be certified and are regulated under the Insurance Code, art. 21.58A, which also contains requirements related to UR standards, grievance and appeals processes. Insurers and HMOs are exempt from UR requirements if they perform UR for their insureds or enrollees only, but they are subject to *some* of the art. 21.58A requirements if they perform UR for others, such as for self-insured plans.

DIGEST: CSSB 384 would amend art. 21.58A to require HMOs and insurers that perform UR for payors other than themselves to comply with *all* of the requirements under art. 21.58A, except for those pertaining to certification of UR agents.

CSSB 384 also would grant the commissioner of insurance explicit authority to adopt rules relating to UR, compel the production of documents necessary to evaluate whether violations are occurring or have occurred, notify the

HMO or insurer of alleged violations of a UR agent and assess administrative penalties for violations of UR laws.

The bill would take effect September 1, 1997, and would apply to UR performed on or after that date.

UR personnel. CSSB 384 would eliminate the use of registered records administrators or technicians and add mental health providers to the list of utilization review personnel authorized to obtain medical information regarding a patient from a health care provider. UR would have to be conducted under the direction of a physician licensed in Texas, and provisions allowing direction by physicians licensed by any state would be removed.

UR procedures. UR decisions would have to be made in accordance with currently accepted medical, mental health, or health care practices, taking into account special circumstances of each case that may require deviation from the norm. Screening criteria would have to be objective, clinically valid, compatible with established principles of health or mental health care and flexible enough to allow deviations. Denials would have to be referred to an appropriate physician, dentist or other health care provider to determine medical necessity. Delegation of UR responsibilities to qualified personnel in health care facilities would not relieve the agent from full responsibility to comply with art. 21.58A.

UR agents would have to develop procedures to handle oral, as well as written, complaints. The complainant would have to receive a written response from the agent in 30, instead of 60, days.

A UR agent would have to provide to the commissioner of insurance a written description of the procedures to be used when responding to a request for poststabilization care after emergency treatment.

Access to or disclosure of confidential information would be specified and would include provisions allowing the commissioner to access confidential records in order to ensure agent compliance with UR requirements.

UR agents could not require as a condition of treatment approval the

observation of a psychotherapy session or the submission or review of a mental health therapist's precess or progress notes.

Specialty UR. Specialty UR agents would be defined as those who conduct UR for specialty health care services, such as dentistry, chiropractic or physical therapy. A specialty UR agent would not be subject to certain requirements relating to UR standards or appeals of adverse determinations that require physician oversight and approval.

Specialty UR agents would instead have to comply with specified requirements that provide for

- the review of the utilization review plan by a health care provider of an appropriate specialty;
- appropriately trained personnel who obtain information from a physician or health care provider to include a provider of the same specialty as the UR agent;
- UR direction to be conducted by a specialty provider licensed in any U.S. state;
- questions of medical necessity to be directed to the health care provider, with an opportunity to discuss the plan of treatment with a specialty UR agent of the same specialty as the provider;
- and appeals decisions to be made by an appropriate specialty provider.

Adverse determinations. A notification by a UR agent to an enrollee or enrollee's provider of an adverse determination would have to include the clinical basis for the adverse determination, in addition to current notification provisions. Deadlines for submission of written notification would be specified according to the circumstances of the service delivery and the patient's condition.

Appeal of an adverse determination could be made orally or in writing by an enrollee, and a UR agent would have to acknowledge the receipt of the appeal to the appealing party within five working days and send written notification of the resolution of the appeal within 30 days. Specialty reviews would have to be completed within 15 working days of the receipt of the request. Review of denials for emergency care of hospitalization would have to be made within one working day by a provider who is of the

same or similar specialty as the health care provider who typically manages such a medical condition.

SUPPORTERS SAY:

CSSB 384 would tighten UR requirements on HMOs and insurers and help guarantee that patients receive needed medical care in a timely and appropriate fashion. Good UR requirements are necessary because patients who are sick or hurting do not have the wherewithal to "battle" their health benefit plan when desired or rendered services are refused for coverage.

Requiring UR to be conducted under the direction of a physician licensed in Texas would improve HMO UR accountability and response by placing a doctor subject to state sanctions and regulation over overall system quality and activities. This provision would not increase the costs of HMO practices because requiring a UR program to be directed by a Texas doctor would not mean that the Texas doctor would have to review every case or medical judgment. It would not limit patient access to expert review because the use of a Texas director would not preclude the use of national physician experts for individual cases. Also, the candidate pool for a physician director would not necessarily be limited to doctors who reside in Texas; the bill would not specify the type of license a doctor would have to have, and could include a limited purpose license, which was recently established by the Board of Medical Examiners.

CSSB 384 would make special provisions for non-physician health care providers by establishing specialty UR agents and specialty UR requirements. Currently, there are no specifications for what type of professional reviews the recommendations of another health care provider, and all UR activities are under the direction of a medical doctor. This would ensure a patient's circumstance and non-medical provider's recommendation would be reviewed by an appropriate specialist, similar to provisions that now work successfully under the workers' compensation act.

CSSB 384 would not change current law that exempts from state UR requirements the Medicaid and Medicare programs, and any program of the Texas Department of Mental Health and Mental Retardation and the Texas Department of Criminal Justice, because the removal of the exemption

would dramatically increase state program costs and could be viewed as granting to TDCJ inmates inappropriate rights to appeal that could be abused.

OPPONENTS SAY:

Requiring UR to be performed under the direction of a physician licensed in Texas would add unnecessary costs and delays in responding to patient appeals, as HMOs restructure their UR processes to fit the requirement, recruit Texas physicians to direct UR activities or refer cases to a Texas physician for approval after usual UR processes have been utilized. Currently multi-state HMOs have UR centers located around the nation, but not necessarily within every state they are licensed.

Medical judgments, unlike legal judgments, are not dependent upon the location of the physician. Cancer is cancer whether the patient is in Texas or Kansas, and practice standards are consistent enough around the U.S. that good medical decision making depends more on the experience and expertise of the physician than on where that physician is licensed. This requirement reflects a parochial perspective that does not work well in the modern world of communications and technology, and could limit patient access to a review by an experienced and appropriate expert who was licensed in another state.

Direction of UR by a Texas-licensed physician would add very little accountability or enforcement power to the state. CSSB 384 would place HMOs under strict UR oversight and enforcement requirements that would offer sufficient enrollee recourse and state penalties for suspected violations.

OTHER OPPONENTS SAY:

Enrollees in managed care plans established under the Medicaid program or the Texas Department of Mental Health and Mental Retardation (MHMR) should receive the same UR protections as enrollees in privately funded plans. However, art. 21.58A, sec.14(b) of the Insurance Code currently exempts such plans from UR requirements. Public as well as private plans are shifting to managed care as a way to contain health care expenditures, but state or local tax dollar savings should not spring from inappropriate denials of care to publicly funded enrollees. Any costs associated with placing UR requirements on these programs would be offset by savings associated with avoidance of lawsuits stemming from clients who were harmed or injured by unsubstantiated denials of necessary services.

Specialty UR provisions are unnecessarily complicated and could increase HMO costs or reduce HMO accountability by carving up case reviews according to body part or practice philosophy without a centralized oversight authority. If dentists, chiropractors and other health care providers want to ensure that their recommendations are reviewed by an appropriate specialist, current UR program requirements could simply be amended to require the inclusion of such specialists in a review when appropriate.

If UR is best directed by a Texas-licensed physician, then specialty UR should similarly be directed by a Texas-licensed specialty health care provider.

NOTES:

Changes made by the committee substitute to the Senate version include requiring UR to be performed under the direction of a physician licensed in Texas; adding references to current mental health practices in UR decision criteria; and prohibiting UR agents from requiring observation of psychotherapy sessions.

Other HMO or managed care related bills on the calendar today include SB 382 by Madla, SB 383 by Cain and SB 385 by Sibley.