SUBJECT: The use of independent review by managed care organizations

COMMITTEE: Insurance — favorable, without amendment

VOTE: 7 ayes — Smithee, Eiland, Burnam, G. Lewis, J. Moreno, Olivo, Seaman

0 nays

2 absent — Thompson, Wise

SENATE VOTE: On final passage, April 30 — voice vote

WITNESSES: None

BACKGROUND: Last session, 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. It 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 first must exhaust the entity's utilization review and appeals processes. The person also may 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). A claim has to be submitted to an IRO review if the insurer, HMO or managed care entity against whom the claim is made requests the review within 14 days after the notice is received.

In September 1998, U.S. District Judge Vanessa Gilmore held that the federal ERISA law pre-empts state insurance regulations over self-insured entities, so self-insured managed care organizations cannot be forced to comply with the IRO provisions established by SB 386. The judge, however, did uphold a patient's right to sue under SB 386. The judgment was in response to a lawsuit filed by Aetna Inc. and currently is being appealed before the 5th U.S. Circuit Court of Appeals.

DIGEST:

SB 1884 would amend the Civil Practices Code to specify that people who wish to maintain a cause of action against an HMO that is required to comply with state utilization review requirements, or against one that otherwise complies with those requirements, would have to follow the utilization review requirements or the notification requirements as set forth in the Civil Practices Code.

The bill also would require that IRO reviews, as requested by the insurer, HMO, or managed care entity, would have to be performed in accordance with standards for IROs as established in the Insurance Code. The managed care entity requesting the review would have to agree to comply with standards for utilization review in the Insurance Code.

The bill would take effect September 1, 1999, and would apply to causes of action that accrue on or after the effective date.

SUPPORTERS SAY:

SB 1884 would amend the law enacted last session concerning IRO review to address concerns raised by the recent federal court decision. SB 1884 indirectly would authorize HMOs voluntarily to use the IRO process. It would specify that if they do so, they would have to adhere to the procedures and requirements as set out in state law, such as agreeing that the decision of the IRO is binding.

If the current law regarding the independent review process is later upheld, it would not be affected by the changes in SB 1884 because the bill would not specifically permit the IRO process to be voluntary. It only would acknowledge that some HMOs may *otherwise* choose to comply with the law.

Review by an IRO has proven to be a successful and effective mechanism for minimizing litigation while addressing patient concerns. As of March 1999, 480 cases have been received by the IRO and 462 cases have been completed, about half of which were found in favor of the patient. Both consumer advocates and HMO representatives are satisfied with the IRO proceedings.

OPPONENTS SAY:

No apparent opposition.

NOTES:

HB 3012 by Smithee, which would amend HMO complaint and appeals procedures, passed the House on May 13 and was passed with amendments by the Senate on May 18.