SUBJECT: Assistance program for health benefit plan consumers

COMMITTEE: Insurance — committee substitute recommended

VOTE: 9 ayes — Smithee, Eiland, Averitt, Burnam, G. Lewis, J. Moreno, Olivo, Seaman, Thompson

0 nays

0 absent

WITNESSES: (*On original version:*)
For —Sheri Larivee; Lisa McGiffert, Consumers Union; Kim McPherson, Texas Mental Health Organization; Charlsa Stark

Against — Will Davis, Texas Association of Life & Health Insurers

On — Becky Parker; Audrey Selden, Texas Department of Insurance

BACKGROUND: In 1999, the 76th Legislature enacted HB 3021 by Smithee, which established the consumer assistance program for health maintenance organizations (HMOs) to help consumers with concerns regarding HMOs regulated by the Texas Department of Insurance (TDI). Many individuals, however, are covered by insurance plans that are not regulated by TDI and may not understand their options when they choose a health care plan or when their payments are delayed or denied.

DIGEST: CSHB 2430 would repeal the HMO consumer assistance program and create a consumer assistance program through the Office of Public Insurance Counsel (OPIC) to offer information to all health insurance consumers who had questions about insurance options and would assist persons who were experiencing problems with their coverage.

The bill would establish a consumer assistance program in OPIC related to health benefit plans. OPIC could contract through a request for proposals with a nonprofit organization to operate the program. If OPIC entered into a contract, OPIC would monitor the performance of the nonprofit organization

that operated the program.

The program would have to do the following:

- assist individual consumers who wished to appeal the denial, termination, reduction of, or refusal to pay for health care services by a health benefit plan, including appeals related to utilization review or Medicaid and Medicare fair hearings;
- provide information to Texas consumers about available health benefit plans and the rights and responsibilities of enrollees in those plans;
- establish a statewide toll-free telephone number and an interactive website that consumers could use to obtain information, advice, or assistance from the program;
- collect data on inquiries, problems, and grievances handled by the program and periodically distribute a data compilation and analysis to employers, issuers of health benefit plans, regulatory agencies, and the public; and
- refer consumers to appropriate private or public individuals or entities as necessary to ensure the prompt and efficient handling of inquiries, problems, or grievances involving health benefit plans.

The program could do the following:

- operate a statewide clearinghouse for objective consumer information about health benefit plan coverage, including options for obtaining health benefit plan coverage; and
- accept gifts, grants, or donations from any source for the purpose of operating the program.

OPIC or any entity contracting to implement CSHB 2430 could establish an advisory committee composed of consumers, health care providers, and representatives of issuers of health benefit plans. A nonprofit organization contracting with OPIC could not be involved in providing health care or issuing health benefit plans and would have to demonstrate expertise in providing direct assistance to consumers who had concerns or problems involving health benefit plans.

The program would have to supplement and not duplicate services provided

by existing and private programs or state agencies, including TDI and OPIC, and it would refer consumers to other programs or agencies when appropriate. If TDI received a complaint from a consumer involving a health benefit plan that was not subject to regulation by that department, TDI would inform the consumer about the services provided by the program and supply the consumer with the program's toll-free telephone number.

An issuer of a health benefit plan would have to include in its enrollment information materials notice of the availability of the program and describe the services provided by the program. Membership information materials would have to include the program's toll-free telephone number and state that a consumer could call the program for information or assistance in resolving a problem with filing a complaint involving a health benefit plan. A health insurance issuer would have to provide the information required under this bill in writing to any person who made an oral or written complaint to the issuer involving the plan. The notice requirements would not apply to the medical assistance program, the federal Medicare program, or a self-insured employee benefit plan that was subject to the Employee Retirement Income Security Act of 1974, as amended, other than a multiple employer welfare arrangement that held a certificate of authority provided by law.

If the program were not continued by the Texas Sunset Act as it applied to OPIC, the program would be abolished, and the provisions of the legislation would expire September 1, 2005.

This bill would take effect September 1, 2001.

NOTES:

LBB estimates that CSHB 2430 would cost $2.9 million for the 2002-03 biennium. The bill would make no appropriation, although $1 million was recommended for the program in Article 11 of the House version of SB 1 by Ellis, the fiscal 2002-03 general appropriations bill.

The committee substitute created the program in OPIC, rather than through the commissioner of insurance and TDI. Also, the substitute applied the Texas Sunset Act in regard to the program. CSHB 2430 also removed the

authorization for the program to charge reasonable fees to consumers to support it.