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BILL SUMMARY

- Makes a health insuring corporation liable for damages for harm to an enrollee proximately caused by the health insuring corporation's failure to exercise ordinary care in making a health care coverage decision or its delay in reaching a decision.
- Makes changes to the law governing health insuring corporations to expedite enrollee appeals of health care coverage decisions by health insuring corporations.
- Requires the Department of Insurance to annually prepare a brochure that enables the public to evaluate and compare the health plans offered by health insuring corporations.
- Requires health insuring corporations to make additional information on health plans available to enrollees.
- Allows female enrollees to obtain health care services from a participating obstetrician or gynecologist without a referral.
- Requires a health insuring corporation to name a licensed physician to act as its medical director.

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CONTENT AND OPERATION



Background

The bill deals with appeals of utilization review decisions by health insuring corporations, liability for those decisions, and other issues related to the operation of health insuring corporations. "Health insuring corporation" is defined under current law as a corporation that, pursuant to a policy, contract, certificate, or agreement, pays for, reimburses, or provides, delivers, arranges for, or otherwise makes available, basic health care services, supplemental health services, or specialty health care services, or a combination of basic and either supplemental health care services or specialty health care services, through either an open panel or closed panel plan (R.C. 1751.01(N)).¹

Health insuring corporations are subject to regulation by the Superintendent of Insurance and are required to meet credentialing, disclosure, and coverage requirements. A health insuring corporation is not required to perform utilization review; but if it does, current law specifies how the health insuring corporation is to perform utilization review and the time and manner in which it informs enrollees of its utilization review determinations.

Current law defines "utilization review" and "utilization review organization" as follows:

(1) "Utilization review" means a process used to monitor the use of, or evaluate the necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Areas of review may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, or retrospective review (R.C. 1751.77(N)).

(2) "Utilization review organization" means an entity that conducts utilization review, other than a health insuring corporation performing a review of its own health care plans (R.C. 1751.77(O)).

¹ "Open panel plan" is defined by current law as "health care plan that provides incentives for enrollees to use participating providers and that also allows enrollees to use providers that are not participating providers" (R.C. 1751.01(R)(1)).

"Closed panel plan" is "a health plan that requires enrollees to use participating providers" (R.C. 1751.01(D)).

A "provider" is "any natural person or partnership of natural persons who are licensed, certified, accredited, or otherwise authorized in this state to furnish health care services, or any professional association organized under Chapter 1785. of the Revised Code . . ." (R.C. 1751.01(V)).

Health insuring corporation liability

(sec. 1751.87)

Duty to exercise ordinary care

The bill requires a health insuring corporation or health care review entity to exercise ordinary care when making health care coverage decisions pertaining to an enrollee.² "Ordinary care" is defined by the bill as the degree of care that a health insuring corporation or health care review entity of ordinary prudence would use under the same or similar circumstances. In the case of an employee, agent, or representative of a health insuring corporation, "ordinary care" means the degree of care that a person of ordinary prudence in the same profession, specialty, or area of practice as the employee, agent, or representative would use in the same or similar circumstances.

Liability for damages

The bill provides that a health insuring corporation is liable for damages for harm to an enrollee that is proximately caused by the health insuring corporation's, or its designated health care review entity's, failure to exercise ordinary care in making the decision whether to provide health care coverage, including harm that is proximately caused by a denial of coverage or delay in reaching a decision.³ The bill also provides that a health insuring corporation is liable for harm to an enrollee that is proximately caused by its employee's, agent's, or representative's failure to exercise ordinary care in making a health care coverage decision, if the health insuring corporation has the right to exercise influence or control over the decision or has actually exercised influence or control. (See **COMMENT**.)

Liability defenses

The bill provides that it is a defense to any action asserted against a health insuring corporation that neither the health insuring corporation nor its employee, agent, or representative, for whose conduct the health insuring corporation is

² "Health care review entity" is defined by the bill as "a utilization review organization or any other entity designated by the health insuring corporation to make health care coverage decisions for the health insuring corporation."

³ The definition of proximate cause has been the subject of considerable litigation. Black's Law Dictionary contains several definitions of proximate cause, one of which is "the last act contributing to an injury, without which the injury would not have resulted." (Black's Law Dictionary 1225 (6th Ed. 1990).)

liable, controlled, influenced, or participated in the health care coverage decision, and the health care insuring corporation did not deny or delay payment for any treatment prescribed or recommended for the enrollee by a participating provider.

The bill provides that neither the provision in current law specifying that a health insuring corporation is not considered to be practicing medicine nor the provision prohibiting the practice of medicine by a corporation are to be asserted as a defense by a health insuring corporation in an action brought against it for failing to use ordinary care in making a health care coverage decision.

Employer liability

The bill specifies that an employer providing health care coverage to employees through a contract with a health insuring corporation is not liable for any harm proximately caused by the health insuring corporation's breach of the contract.

Physician indemnification

The bill prohibits a health insuring corporation from seeking indemnification from its participating physicians for liabilities imposed on the health insuring corporation for its health care coverage decisions.⁴

Utilization review

(secs. 1751.33 and 1751.78)

General requirements

Current law imposes certain requirements on any health insuring corporation that provides or performs utilization review services in connection with its policies, contracts, and agreements providing basic health services and on any designee of the health insuring corporation in connection with its policies, contracts, or agreements of the health insuring corporation providing basic health services.

⁴ Black's Law Dictionary defines an indemnification agreement as "a contractual arrangement whereby one party assumes the liability inherent in a situation, thereby relieving the other party of the responsibility." (Black's Law Dictionary 731 (6th Ed. 1990).)

Information on utilization review process

Current law requires each health insuring corporation to provide to its subscribers, by mail, a description of the health insuring corporation, its method of operation, its service area, and its complaint procedure. The bill continues that requirement and specifies that each health insuring corporation is to provide to its subscribers a description of its utilization review process for the determination of the eligibility of an enrollee for health services, and its procedures governing the standard appeal of an adverse determination and the review of the appeal.⁵

Enrollee requests for utilization review

Current law requires each health insuring corporation to be responsible for monitoring all utilization review activities carried out by, or on behalf of, the health insuring corporation and for ensuring that all requirements of Ohio law are met. The bill continues that requirement and provides that on an enrollee's request, a health insuring corporation must perform utilization review to determine the eligibility of the enrollee for health care services that are requested by, or have been provided to, the enrollee.

Utilization review: procedures and time frames

(sec. 1751.81(A) to (F)(1))

General requirements

Current law requires a health insuring corporation to maintain written procedures for making utilization review determinations and for notifying enrollees, and participating providers and health care facilities acting on behalf of enrollees, of its determinations. The bill continues this requirement and provides that the written procedures must require the health insuring corporation with regard to utilization review to consult with at least one physician working in the field of the admission, procedure, or health care service that is the subject of the review.

⁵ "Adverse determination" is defined by current law as "a determination by a health insuring corporation or its designee utilization review organization that an admission, availability of care, continued stay, or other health care service covered under a policy, contract, or agreement of the health insuring corporation has been reviewed and, based upon the information provided, the health service does not meet the health insuring corporation's requirements for benefit payment, and is therefore denied, reduced, or terminated" (R.C. 1751.77(A)).

Current law generally requires a health insuring corporation to make initial, concurrent review, and retrospective review determinations within specified time frames and to provide notifications of those determinations to enrollees and to providers or health care facilities within specified time frames.

Initial determinations

For initial determinations, a health insuring corporation must make the determination within two business days after obtaining all necessary information regarding a proposed admission, procedure, or health care service requiring a review determination. In the case of a determination to certify an admission, procedure, or health care service, the health insuring corporation must notify the provider or health care facility rendering the health care service by telephone or facsimile within three business days after making the initial certification. In the case of an adverse determination, the health insuring corporation must notify the provider or health care facility rendering the health care services by telephone within three business days after making the adverse determination, and must provide written or electronic confirmation of the telephone notification to the enrollee and the provider or health care facility within one business day after making the telephone notification.

Concurrent review determinations

For concurrent review determinations, a health insuring corporation must make the determination within one business day after obtaining all necessary information.⁶ In the case of a determination to certify an extended stay or additional health care services, the health insuring corporation must notify the provider or health care facility rendering the health care service by telephone or facsimile within one business day after making the certification. In the case of an adverse determination, the health insuring corporation must notify the provider or health care facility rendering the health care service by telephone within one day after making the adverse determination, and must provide written or electronic confirmation to the enrollee and the provider or health care facility within one business day after the telephone notification. The health care service to the enrollee must be continued, with standard copayments and deductibles, if applicable, until the enrollee has been notified of the determination.

⁶ "Concurrent review" is defined under current law as "utilization review conducted during the patient's hospital stay or course of treatment." (R.C. 1751.77(G).)

Retrospective review determinations

For retrospective review determinations, a health insuring corporation must make the determination within 30 business days after receiving all necessary information.⁷ In the case of a certification, the health insuring corporation may notify the enrollee and the provider or health care facility rendering the health care service in writing. In the case of an adverse determination, the health insuring corporation must notify the enrollee and the provider or health care facility rendering the health care service, in writing, within five business days after making the adverse determination.

Expedited review determinations

Current law provides that the time frames for determinations and notifications are to be followed unless the seriousness of the medical condition of the enrollee otherwise requires a more timely response from the health insuring corporation. The health insuring corporation must maintain written procedures for making expedited utilization review determinations and modifications of enrollees and providers or health care facilities when warranted by the medical condition of the enrollee.

Utilization review: right of appeal

(sec. 1751.82(F)(2))

The bill does not modify the time frames in current law for initial, concurrent review, or retrospective review determinations or for required notifications to enrollees, providers, or health care facilities. The bill does, however, authorize an enrollee to proceed with an appeal (see "**Utilization review: procedure for appeals**" below) if the health insuring corporation fails to make a determination and notification within the appropriate time frame. The health insuring corporation's failure to make a determination and notification within the appropriate time frame is deemed to be an adverse determination by the health insuring corporation for the purpose of an enrollee's initiation of an appeal.

⁷ "Retrospective review" is defined under current law as "utilization review of medical necessity that is conducted after health care services have been provided to a patient." "Retrospective review" does not include "the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding, or adjudication of payment." (R.C. 1751.77(L).)

Notification procedures: current law and changes

(sec. 1751.82(G))

Current law requires written notification of an adverse determination to include the principal reason or reasons for the determination, instructions for initiating an appeal or reconsideration of the determination, and instructions for requesting a written statement of the clinical rationale used to make the determination. A health insuring corporation must provide the clinical rationale for the adverse determination in writing to any party who received notice of the adverse determination and follows the instructions for the request. The bill continues these requirements and also provides that the instructions for initiating an appeal of an adverse determination must state that the Superintendent of Insurance must conduct the review of, and issue a decision in, any appeal involving either a life-threatening disease or condition or a serious impairment of any bodily function or organ of the body.

Information necessary for review and determination

(sec. 1751.82(H))

Current law requires a health insuring corporation to have written procedures to address the failure or inability of a health care facility, provider, or enrollee to provide all necessary information for review. If a health care facility, provider, or enrollee will not release necessary information, the health insuring corporation may deny certification. The bill continues these provisions and specifies that a health insuring corporation is prohibited from using unreasonable requests for information in order to delay making a utilization review determination. The bill also provides that an enrollee is prohibited from proceeding with an appeal based on a health insuring corporation's failure to make a timely determination if the health insuring corporation's delay in making a determination and notification is caused by the failure of a health care facility, provider, or enrollee to release all necessary information.

Utilization review: procedure for appeals

(sec. 1751.82(A) to (E))

Current law

In a case involving an initial determination or a concurrent review determination, a health insuring corporation must give the provider or health care service an opportunity to request in writing on behalf of the enrollee a reconsideration of an adverse determination by the reviewer. The reconsideration

must occur within three business days after the health insuring corporation's receipt of the written request for consideration and must be conducted between the provider or health care facility rendering the health care services and the reviewer who made the adverse determination. If that reviewer cannot be available within three business days, the reviewer may designate another reviewer.

If the reconsideration process does not resolve the difference of opinion involved, the adverse determination may be appealed by the enrollee or the provider or health care facility on behalf of the enrollee. Reconsideration is not a prerequisite to a standard or expedited appeal of an adverse determination. The time period allowed for a reconsideration of an adverse determination does not apply if the seriousness of the medical condition of the enrollee requires a more expedited reconsideration. The health insuring corporation must maintain written procedures for making an expedited reconsideration.

Changes proposed by the bill

The bill continues the appeals procedures in current law and in addition requires the Superintendent of Insurance to prescribe by rule pursuant to the Administrative Procedure Act procedures governing the standard appeal of an adverse determination. These procedures must require all of the following:

(1) Enrollees must be informed of the availability of appeal from an adverse determination at the time the enrollee requests utilization review and must be kept informed of the availability of appeal during all stages of a utilization review process.

(2) Enrollees must be informed of the Superintendent of Insurance's role in reviewing an appeal from an adverse determination involving either a life-threatening disease or condition or a serious impairment of any bodily function or organ of the body.

(3) Appeals involving either a life-threatening disease or condition (which is a disease or condition for which the likelihood of death is probable unless the course of the disease or condition is interrupted, or involving a serious impairment of any bodily function or organ of the body, which impairment has been certified by a physician) must be filed with the Superintendent of Insurance.

(4) The Superintendent of Insurance must issue a written decision to all parties to an appeal involving a life-threatening disease or condition within three days after filing an appeal and to all parties to an appeal involving a serious impairment of any bodily function or organ of the body within five days after the filing of an appeal.

(5) Enrollees must be informed in relation to an appeal not involving a life-threatening disease or condition or a serious impairment of a bodily function or organ of the body of where an appeal is to be filed, who is to conduct a review of an appeal, and the time allowed for the reviewer's issuance of a written decision.

The bill provides that in conducting a review of an appeal involving either a life-threatening disease or condition or a serious impairment of a bodily function or organ of the body, the Superintendent of Insurance may consider all information considered during the utilization review and any additional information that the Superintendent considers to be material and relevant to the appeal, including information that was not available at the time that the adverse determination was rendered. All parties involved in the appeal must furnish information in their possession to the Superintendent at the Superintendent's request.

The bill also provides that the Superintendent of Insurance may retain physicians, consultants, and such other independent contractors as may be reasonably necessary to assist the Superintendent in reviewing an appeal. A person so retained may not be associated with the conduct of utilization review for any health insuring corporation. The person must be under the direction and control of the Superintendent and must act in a purely advisory capacity.

The bill requires a health insuring corporation to provide any coverage required by the Superintendent's decision in an appeal of an adverse determination.

For an enrollee with a terminal condition, the review of an appeal will be done according to the procedures in current law.⁸

Access to specialists

(sec. 1753.13)

The bill provides that a health insuring corporation that does not allow direct access to all specialists must permit a female enrollee to obtain health care services from an obstetrician or gynecologist participating in the enrollee's health care plan without obtaining a referral or any other form or prior authorization for the services. These obstetricians and gynecologists must be authorized to provide

⁸ *Current law requires each health insuring corporation to establish a reasonable external, independent review process to examine the health insuring corporation's coverage decisions for enrollees with terminal conditions. The review must be conducted by experts selected by an independent entity and paid for by the health insuring corporation (R.C. 1753.24).*

health care services to a female enrollee in the same manner as the enrollee's primary care provider.

Health insuring corporation medical directors

(sec. 1753.02)

The bill provides that a health insuring corporation must name a person licensed to practice medicine and surgery or osteopathic medicine and surgery to act as the health insuring corporation's medical director.

Consumer information

(secs. 1751.11(B) and 1751.37)

Identification cards

Current law provides that every subscriber of a health insuring corporation that offers basic health care services is entitled to an identification card or similar document that specifies the health insuring corporation's name. Current law also requires the identification card or document to list at least one telephone number that provides the subscriber with access to health care on a twenty-four-hours-per-day, seven-days-per-week basis.

The bill retains the requirements of current law and also provides that the identification card or document must list information on the coverage available under the subscriber's health plan and information on the health plan's appeals process.

Brochure on health plans

The bill requires the Superintendent of Insurance to annually prepare and update a brochure that enables the public to evaluate and make a meaningful comparison of health care plans offered by health insuring corporations in Ohio and that aids the public in the selection of an appropriate plan. The Superintendent must prescribe by rule the content and format of the brochure. The brochure must include, but need not be limited to, information arranged in the following categories: provider qualifications and availability; quality controls; and financial stability.

The Superintendent must compile the brochure based on the Superintendent's analysis and interpretation of information that has been filed with the Department of Insurance and that is not prohibited by law from being used to prepare the brochure. The Superintendent may request from health insuring

corporations additional information the Superintendent considers to be necessary to prepare the brochure.

The Superintendent must make the brochure available to the public no later than June 30 of every year in a manner that the Superintendent considers most effective and efficient.

The Superintendent may adopt rules pursuant to the Administrative Procedure Act to carry out the bill's requirements concerning the brochure.

Complaint system

(sec. 1751.19)

Current law

Current law requires a health insuring corporation to establish and maintain a complaint system that has been approved by the Superintendent of Insurance to provide adequate and reasonable procedures for the expeditious resolution of written complaints initiated by subscribers or enrollees concerning any matter relating to services directly or indirectly provided by the health insuring corporation. A health insuring corporation must establish and maintain a procedure for accepting complaints over the telephone or in person and must provide a timely written response to each written complaint it receives. Responses to written complaints relating to quality or appropriateness of care must set forth a statement informing the complainant in detail of any rights that the complainant may have to submit the complaint to any professional peer review organization or health insuring corporation peer review committee that has been set up to monitor the quality or appropriateness of provider services rendered.

Changes proposed by the bill

The bill continues these requirements and enacts a new requirement that responses to written complaints relating to the scope of coverage for health care services note the availability of utilization review for the determination of the eligibility of an enrollee for health care services, including the role of the Superintendent of Insurance under the utilization review process in reviewing appeals of adverse determinations involving life-threatening disease or condition or a serious impairment of any bodily function or organ of the body. These responses must detail how an enrollee may request utilization review.

Certificates of authority

(sec. 1751.04)

Current law

A health insuring corporation is required by current law to obtain a certificate of authority. Current law provides that on the receipt by the Superintendent of Insurance of a complete and properly supported application for a certificate of authority to establish and operate a health insuring corporation, the Superintendent is required to transmit copies of the application and accompanying documents to the Director of Health. The Director must review the application and accompanying documents and make findings as to whether the applicant has met certain requirements with respect to any basic health care services and supplemental health care the applicant will furnish. One of those findings is that the applicant has developed a procedure to gather and report statistics relating to the cost and effectiveness of its operations, the pattern of utilization of its services, and the quality, availability, and accessibility of its services. Within 90 days after the Director's receipt of the application and subject to certain hearing requirements, the Director must certify to the Superintendent whether the applicant satisfies the statutory requirements.

Changes proposed by the bill

The bill amplifies the requirement that the applicant for a certificate of authority develop a procedure to gather and report statistics relating to the cost and effectiveness of its operations, the pattern of utilization of its services, and the quality, availability, and accessibility of its services. The bill specifies that this information must be presented in a written report and that the report be designed to include, but need not be limited to, information and statistics specifically related to the following: the number and frequency of adverse patient care incidents; the number and percentage of unlicensed personnel providing direct patient care to enrollees at participating health care facilities; mortality and infection rates; outcome data on five leading health conditions of the health insuring corporation's enrollees; patient and provider satisfaction survey results; methods employed to adjust staffing levels based on patient care needs; and accreditation level from the National Committee for Quality Assurance.

Evidence of coverage filing requirements

(sec. 1751.11(A) and (C) to (E))

Current law

Current law entitles every subscriber of a health insuring corporation to an evidence of coverage for the health plan under which health benefits are provided. "Evidence of coverage" is defined under current law as "any certificate, agreement,

policy, or contract issued to a subscriber that sets out the coverage or other rights to which such person is entitled under a health care plan." An evidence of coverage or an amendment to an evidence of coverage cannot be delivered, issued for delivery, renewed, or used, until a health insuring corporation files the evidence of coverage or amendment with the Superintendent of Insurance. Current law sets forth a procedure governing the Superintendent's approval or disapproval of a filed evidence of coverage or amendment.

Changes proposed by the bill

Current law generally prohibits the delivery, issuance for delivery, renewal, or use of an evidence of coverage or amendment unless the document satisfies certain criteria. The bill provides that in addition to information that must currently be provided, an evidence of coverage or amendment must include a clear, concise, and complete statement of the following:

(1) The availability of utilization review for the determination of the eligibility of an enrollee for health care services;

(2) The Superintendent of Insurance's role under the utilization review process in reviewing appeals of adverse determinations involving either a life-threatening disease or condition or a serious impairment of any bodily function or organ of the body.

(3) The enrollee's right to bring an action against the health insuring corporation for harm proximately caused by the health insuring corporation's failure to exercise ordinary care in making health care coverage decisions, including harm that is proximately caused by a denial of coverage or delay in reaching a decision.

The bill provides that an evidence of coverage may not be delayed, issued for delivery, renewed, or used if it contains provisions that limit an enrollee's right to an reconsideration or appeal of an adverse determination or limit a subscriber or enrollee's right to bring a civil action against a health insuring corporation or that limit damages that may be recovered from such an action.

COMMENT

Liability and ERISA

State regulation of self-insured health care plans is governed primarily by the federal Employee Retirement and Income Security Act of 1974 (ERISA). Suits against a qualified self-insured employer plan that conducts utilization review may

be preempted by ERISA.⁹ Under such circumstances, the enrollee would be limited to the much more restrictive remedies afforded by ERISA.

ERISA preempts all state laws insofar as they "relate to an employee benefit plan," but exempts from preemption any state law that "regulates insurance." (29 U.S.C.A. 1144(a) and (b).) The United States Supreme Court has held that common-law tort and contract claims alleging the improper processing of a benefit claim by an ERISA-regulated benefit plan are preempted by ERISA because the claims "relate to" an employee benefit plan. *Pilot Life Insurance v. Dedeaux*, 107 S.Ct. 1549 (1987). The United States Sixth Circuit Court of Appeals, the jurisdiction of which includes Ohio, has held that claims against a managed care organization for an improper refusal to authorize benefits are also preempted by ERISA. Specifically, the court held that utilization review is a means of processing claims, and, therefore, a beneficiary who is harmed by a utilization decision is limited to the remedies available under ERISA. *Tolton v. American Biodyne*, 1995 FED. App. 0075P (6th. Cir.).

The cases cited above were based on common law principles, rather than a statute like the one the bill would enact specifically permitting suits against managed care organizations. In 1997, Texas enacted such legislation allowing enrollees to sue a managed care organization for medical malpractice. Subsequently, Aetna sued the State of Texas, claiming the Texas law conflicted with ERISA. In September 1998, a federal district court in Texas upheld an enrollee's right to sue a managed care organization for medical malpractice, but the court struck down the state's independent review process for managed care enrollees who are denied treatment by their insurer. *Corporate Health Insurance v. Texas Dept. of Insurance*, No. 97-2072 (D. Tex. September 18, 1998).

HISTORY

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Introduced	01-20-99	pp. 84-85

⁹ According to the National Conference of State Legislatures, nationally about 40% of persons who receive insurance through an employer are in health care plans subject to ERISA, "Insurer Liability," Federal Health Policy Tracking Service, December 31, 1998.

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