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Bill Analysis
Legislative Service Commission

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(As Introduced)

Sen. Drake

BILL SUMMARY

- Establishes the Office of the Managed Care Patient Advocate in the Department of Health and assigns duties to the office concerning complaints about coverage of health care services under the health care plans of health insuring corporations.
- Requires that a health care plan contact an enrollee within 72 hours regarding a denial of coverage for health care services.
- Requires a health care plan to notify its enrollees prior to the termination, reduction, or limitation of health care services.
- Repeals current law regarding complaint systems and requires that health care plans develop and maintain written complaint procedures and standardized forms to be used in processing complaints.
- Requires that health care plans file copies of the complaint procedures and standardized forms with the Office of the Managed Care Patient Advocate and requires the Director of Health to review the complaint procedure of each health care plan.
- Provides that an enrollee is not financially liable for health care services received while the enrollee's complaint is pending.
- Requires that a health care plan make mediation and other informal mechanisms for resolving complaints available at the discretion of the enrollee.
- Provides for the expedited review of a complaint in certain circumstances.

- Establishes requirements for first-level and second-level review of a complaint such as the qualifications of the reviewers, time limits, and the content of the written decision.
- Requires a health care plan to provide an enrollee all relevant information that is not confidential or privileged.
- Provides that an enrollee has the right to submit supporting material, to be assisted or represented by a person of the enrollee's choice, and to call and cross-examine witnesses at the second-level review meeting.
- Requires the health care plan to pay the enrollee's reasonable attorney's fees and expert witness fees if the enrollee substantially prevails at the second-level review meeting.
- Permits an enrollee to appeal a second-level review decision through the Office of the Managed Care Patient Advocate and prescribes time limits for an appeal.
- Provides that an administrative appeal is conducted by the Director of Health or the Director's designee and includes a complete review of the complaint.
- Provides for an expedited appeal to the Director of Health in certain circumstances.
- Permits an enrollee to appeal a decision of the Director of Health to the common pleas court of Franklin County.
- Requires the Department of Health to adopt rules to implement the complaint procedures described in the bill and to establish fines to be imposed on health care plans for violations of the rules.
- Requires that a female enrollee of a health care plan be permitted to designate an obstetrician or gynecologist as her primary care physician.
- Requires that the person serving as a health insuring corporation's medical director be a physician.

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CONTENT AND OPERATION

COMPLAINT PROCEDURES AND HEALTH INSURING CORPORATIONS

Office of the Managed Care Patient Advocate

(secs. 1753.32 and 1753.33)

The bill creates the Office of the Managed Care Patient Advocate in the Department of Health and requires that the Managed Care Patient Advocate be appointed by the Governor, with the advice and consent of the Senate, for a term of four years. The office is to operate independently of the Director of Health, although the Department is to bear its expenses.

The Managed Care Patient Advocate has the following duties:

- To provide assistance in filing and managing complaints under the complaint procedures developed by the health care plan of the person making the complaint;¹
- To maintain copies of the complaint procedures and of the standardized forms used by health care plans in processing complaints;
- To determine whether expedited review of a complaint is appropriate;
- To receive and screen appeals from health plan enrollees following second-level review.

Notice of denial or termination of health care coverage

(sec. 1753.45)

To permit an enrollee to file a timely complaint, the bill requires that a health care plan contact an enrollee within 72 hours after the enrollee makes a request for health care services if the plan is denying coverage for the services or placing limitations on the coverage. Contact may be by telephone or any other means. Within five days after making contact with an enrollee, the plan must mail a written notice of denial of health care services to the enrollee. The notice must include (1) a reason for the denial of health care services, (2) the name and telephone number of a person to call for information and assistance regarding the denial, (3) a summary of the health care plan's complaint procedure, and (4) notification of the right to continue to receive health care services currently being provided to the enrollee pending resolution of the complaint.²

If a health care plan intends to terminate or reduce coverage for health care services currently covered by the plan or to place limitations on the coverage, the plan must notify its enrollees of this intent at least 72 hours prior to the

¹ *The bill defines a "complaint" as a complaint made by or on behalf of an enrollee regarding (1) a health care plan's denial of health care services, (2) the availability, delivery, or quality of a health care plan's health care services, (3) a health care plan's handling of a payment or reimbursement for covered health care services, or (4) violations of the policy, contract, or agreement between a health insuring corporation and the enrollee (sec. 1753.31).*

² *The bill defines "resolution of the complaint" to mean an enrollee's written notice to a health care plan that the enrollee does not intend to pursue the complaint any further, or, if a complaint is pending, the delivery of a second-level review decision to an enrollee (sec. 1753.31).*

termination, reduction, or limitation of out-patient health care services, and 24 hours prior to the termination, reduction, or limitation of inpatient care.

Complaint procedure

(secs. 1753.34 and 1753.35)

Current law requires a health insuring corporation to establish and maintain a complaint system approved by the Superintendent of Insurance. The system must provide adequate and reasonable procedures for the expeditious resolution of written complaints initiated by enrollees concerning matters related to services provided by the health insuring corporation (sec. 1751.19, not in the bill). Health insuring corporations must also establish and maintain a procedure to accept complaints over the telephone or in person.

A health insuring corporation must provide a timely written response to each written complaint it receives. If the complaint concerns the quality or appropriateness of care, it must include a statement informing the complainant in detail of any right to submit the complaint to a professional peer review organization or health insuring corporation peer review committee. The statement must include the name of the organization or committee, its address and telephone number, and any other pertinent data that would enable the complainant to seek further independent review of the complaint. An appeal may not be made until the complaint system of the health insuring corporation has been exhausted.

Copies of complaints and responses, including medical records related to those complaints, must be available to the Superintendent of Insurance and the Director of Health for inspection for three years. Information that contains a medical record is confidential and is not a public record.

The bill repeals the existing law regarding complaint systems and replaces it with new procedures. Each health care plan is required to develop and maintain a written complaint procedure for receiving and resolving complaints and to develop standardized forms to be used in processing complaints. Each plan must file a copy of its procedure and standardized forms with the Office of the Managed Care Patient Advocate. The copy must be amended immediately following any subsequent material modification of the complaint procedure, and the plan may not use a form until it has been filed. Filings may be made by regular mail. Each written complaint procedure must be reviewed by the Director of Health. In addition, the bill requires health insuring corporations to annually file with the Office of the Managed Care Patient Advocate a statement that each of its health care plans has established and maintains a written complaint procedure that

conforms with the requirements of the bill and all rules adopted by the Director of Health.

A health care plan's written complaint procedure must provide for the following:

(1) A summary of the plan's complaint procedure must be given to each enrollee at the time of initial enrollment.

(2) The complaint procedure must permit the enrollee to initially file a complaint in person, by telephone, or in writing.

(3) The complaint procedure must require that each complainant be promptly provided with a notice that the enrollee may retain legal representation at the enrollee's own expense and that the health care plan is entitled to have an attorney present during second-level review meetings.

(4) The complaint procedure must require that each complainant be promptly notified of the right to contact the Office of the Managed Care Patient Advocate for assistance in the filing and handling of the complaint and provided with a mailing address and a toll-free telephone number for the Office of the Managed Care Patient Advocate.

A summary of a plan's complaint procedure must be posted in all offices and facilities operated by the plan, and it must provide a current summary of the complaint procedure to all persons on request. A plan must annually notify its enrollees of any material modification of the plan's complaint procedure.

Initiating a complaint

(secs. 1753.36 and 1753.39)

The bill provides that an enrollee may initiate a complaint in person, by telephone, or in writing. A complaint initiated in person or by telephone must be assigned a confirmation code at the time of the complaint. The health care plan's staff is required to reduce the complaint to writing and send a copy of the writing to the enrollee within 72 hours, together with a self-addressed stamped envelope and a form on which the enrollee may indicate the accuracy of the writing. The enrollee must return the completed form to the health care plan.

Within 24 hours after a complaint has been initiated, a health care plan must provide the following in writing to the enrollee:

(1) An explanation of the complaint procedure;

(2) The name, address, and toll-free telephone number of the person designated by the health care plan to respond to complaints;

(3) Notice of the enrollee's right to submit written information for first-level review, of the time limits for completion of a first-level review that the bill imposes on health care plans, that a failure to meet the time limits results in the complaint being deemed resolved in favor of the enrollee, that health care services already being provided will continue to be provided pending resolution of the complaint, of the enrollee's right to expedited review under certain circumstances and how expedited review may be requested, and that mediation and other informal mechanisms for resolution of the complaint are available.

Regardless of how the complaint is resolved, the bill provides that an enrollee is not financially liable, beyond copayments and deductibles, for health care services received while the enrollee's complaint is pending.

Availability of alternative methods of complaint resolution

(sec. 1753.43)

The bill requires a health care plan to make mediation and other informal mechanisms for resolving complaints available to its enrollees at the plan's expense. The use of mediation and other informal mechanisms, rather than the plan's regular complaint procedures, is at the discretion of the enrollee. A health care plan may, at the plan's expense, arrange for binding arbitration on the written request of an enrollee. If an enrollee elects binding arbitration and substantially prevails, the plan must pay the enrollee's reasonable attorney's fees and other costs related to the arbitration. If the enrollee does not substantially prevail, the enrollee may not be held liable for any costs incurred by the plan in the arbitration. An enrollee may terminate the use of arbitration, mediation, or other informal mechanisms of complaint resolution at any time and return to the regular complaint procedure. The time spent in arbitration, mediation, or another informal mechanism is not to be considered in calculating time limits for the review process.

Expedited review

(sec. 1753.40)

The bill requires that an expedited review be completed as rapidly as the enrollee's medical condition requires. A first-level review may be eliminated at the plan's option (see "**First-level review**" below). A second-level review decision must be completed within five working days from the date of the request, unless

the person requesting expedited review consents in writing to an extension (see "Second-level review" below). All requests, information, and decisions must be transmitted between the health care plan, the reviewer or review panel, and the enrollee by the most expeditious method available. An enrollee must be afforded a reasonable amount of time under the circumstances to gather and submit evidence and to prepare for any review meeting held.

The bill permits a health care plan to require the use of expedited review when the plan proposes to terminate or limit coverage of a health care service but is required to continue to provide health care services pending resolution of the complaint. Additionally, an enrollee must receive expedited review if a health care practitioner either requests it or expresses an opinion that adherence to the standard time limits of the complaint procedure would jeopardize the life or health of the enrollee or would jeopardize or unreasonably burden the enrollee's ability to regain maximum function.

An enrollee may request expedited review, verbally or in writing, at any time. On receiving such a request, the health care plan must immediately inform and send all relevant medical information in its possession to the Office of the Managed Care Patient Advocate. The Office is charged with deciding whether expedited review is appropriate, and must grant the request if it determines that the standard time limits would jeopardize the life or health of the enrollee or would jeopardize or unreasonably burden the enrollee's ability to regain maximum function.

First-level review

(sec. 1753.37)

For first-level review of a complaint, the bill requires that the complaint be reviewed by persons who were not involved in the determination or other action that is the subject of the complaint. If resolution of the complaint requires medical expertise, the health care plan must ensure that first-level review is conducted by a physician who was not involved in the initial determination or other action that is the subject of the complaint. The plan must continue to provide or pay for health care services currently being provided pending resolution of the complaint.

The enrollee is permitted to submit written materials for review, but does not have the right to a hearing. The plan must provide a verbal decision to the enrollee within 72 hours after the complaint is initiated and a written decision within five days of the verbal decision, if the complaint involves any of the following: health care services requested but not received by the enrollee; the possible termination of or a limit on health care services currently being provided

to the enrollee; or actions, policies, or practices of a health care plan that hinder an enrollee's receipt of covered health care services.³ In all other cases, a plan must notify the enrollee of its decision within ten days after the verbal decision is provided.⁴ If the plan fails to meet these time limits without obtaining written consent to an extension by the person who initiated the complaint, the bill requires that the complaint be deemed resolved in favor of the enrollee.

The plan's written decision must contain the following information:

- The names and titles of the person or persons participating in the review;
- A statement of the reviewers' understanding of the enrollee's complaint and the significant facts;
- The reviewers' decision, written in clear terms, and the contract basis or medical rationale for the decision, given in sufficient detail for the enrollee to respond further to the plan's position;
- If clinical practice guidelines were relied on by the reviewers, a copy of the relevant portions of the guidelines;
- A summary of the written and oral evidence that the reviewers relied on in reaching their decision;
- Notice of the complaint procedure governing second-level review, including time limits, the enrollee's right to a second-level review, and the requirement that services currently being provided to the enrollee continue to be provided pending resolution of the complaint.

Second-level review

(sec. 1753.38)

The bill requires that second-level review be requested in writing by the enrollee. The health care plan may provide the enrollee with a simple standardized form for use in making this request. Except in cases involving expedited review,

³ *If a health care practitioner ordered or requested the services in question or opposes the termination of or limitation on services, the bill requires that the practitioner be given the same notice as the enrollee.*

⁴ *It does not appear that the bill requires the health care plan to provide verbal notice in these circumstances.*

the completion of first-level review is a prerequisite to second-level review (see "*Expedited review*" above). The plan must continue to provide coverage for health care services currently being provided pending resolution of the complaint.

In cases not involving a disagreement about medical necessity or appropriateness, the plan must establish a review panel comprised of one member selected by the Managed Care Patient Advocate and two members selected by the plan. A person with an interest in the complaint may not be a member of the panel but may appear before the panel to present information or answer questions. The panel has the legal authority to bind the plan to the panel's decision. The panel must hold a second-level review meeting to review the complaint within 30 days after review is requested and provide a written decision within ten working days after the meeting. If the complaint involves a plan action or policy that hinders the receipt of covered services, the second-level review meeting must be held within 20 days after review is requested and the written decision provided within five working days after the meeting. If the plan fails to meet these time limits, without first obtaining written consent to an extension by the person who initiated the complaint, the complaint is deemed resolved in favor of the enrollee.

In cases that involve a disagreement about medical necessity or appropriateness, including whether a treatment is effective or experimental, the plan must establish a review panel comprised of health care practitioners: one selected by the plan and two selected by the Director of Health. The plan must select its member and request the assignment of the other review panel members immediately on receiving a request for second-level review and must send any information necessary to make the assignment. The members selected must have training and expertise relevant to the disagreement and may not have a financial interest in or be employed by the plan or any subsidiary of the plan or be associated with the plan in any other way. The plan must promptly submit all the relevant information about the case to the review panel. If the panel determines that it needs more information, the plan, at the panel's direction, is required to provide or pay for the tests, examinations, or procedures needed to obtain that information. The bill provides that the rights of the enrollee also apply to the health care plan with respect to these types of complaints.

When an enrollee has not yet received the health care services in question, or is faced with termination or a limit on services currently being provided, the second-level review meeting must be held within 20 days after review is requested, except in the case of expedited review (see "*Expedited review*" above). Within five working days after the meeting, the review panel must provide a written decision. In other cases, the meeting must be held within 30 days after review is requested and the decision provided within ten working days after the meeting. A

decision of the majority of the panel constitutes the decision of the panel and is binding on the plan. However, in cases where an enrollee's treating health care practitioner has recommended the services in question and the plan has denied coverage in whole or in part, if any of the panel members concurs in the practitioner's recommendation, the decision of the panel must be in favor of the enrollee.

Regardless of whether the case involves a disagreement about medical necessity or appropriateness, the second-level review meeting must be held at a time and location reasonably accessible to the enrollee. The enrollee must be notified immediately of the time and place for the meeting, and the plan may not deny an enrollee's reasonable request that the meeting be postponed. The bill requires that the enrollee be afforded the opportunity to appear in person at the second-level review meeting or to communicate with the panel at the plan's expense by conference call, videoconferencing, or other appropriate technology. However, the enrollee's right to a fair review is not conditional on the enrollee's appearance at the meeting.

If the health care plan intends to have an attorney present to represent its interests, it must notify the enrollee at least 15 working days in advance of the second-level review meeting that an attorney will be present and the enrollee may wish to obtain legal representation. On request of the enrollee, a plan must provide the enrollee all relevant information that is not confidential or privileged. The bill provides that the enrollee has the right to (1) attend a second-level review meeting, (2) present the enrollee's case to the review panel, (3) submit supporting material before, during, and after the meeting, (4) be assisted or represented by a person of the enrollee's choice, and (5) call and cross-examine witnesses at the meeting.

The panel's decision must include the following information:

- The names and titles of the members of the panel;
- A statement of the panel's understanding of the complaint and of the significant facts related to the complaint;
- The decision of the panel written in clear terms, including a contractual basis for the decision;
- A summary of the written and oral evidence the panel relied on in reaching its decision;

- Notice of the enrollee's right to appeal to the Director of Health and how to make such an appeal and of the right to reimbursement for witness and attorney's fees when applicable.

If a medical issue was involved, the decision must include the findings of the individual members of the panel and a copy of relevant portions of any clinical practice guidelines relied on by the panel. An enrollee is not responsible for any costs associated with the panel, and if the enrollee substantially prevails at second-level review, the health care plan is required to pay the enrollee's reasonable attorney's fees and expert witness fees.

Administrative appeal

(sec. 1753.41)

The bill permits an enrollee who has received a second-level review decision and is not satisfied to appeal the decision through the Office of the Managed Care Patient Advocate. If the decision involves a plan's denial of health care services, it must be reviewed in an administrative hearing. In all other cases, the Managed Care Patient Advocate must review the second-level review decision and decide whether to refer the decision for an administrative hearing. The Managed Care Patient Advocate must notify the enrollee within five days if the decision is to decline to refer the matter for an administrative hearing. The Advocate's decision must be consistent with the understanding that the appeal is a critical safeguard for individuals whose health and well-being are at stake. The bill provides that denial of an administrative hearing does not preclude other forms of intervention or appeal. The health care plan must continue to provide or pay for health care services currently being provided pending resolution of the appeal. If the appeal is decided in favor of the plan, the Director of Health may order the enrollee to pay for all or a part of the cost of those services.⁵ The enrollee must be notified of this possibility at the time the appeal is initiated.

The administrative hearing must be conducted by the Director of Health or the Director's designee and must include a de novo review of all relevant facts and arguments, including the evidence and decisions provided by the health care plan complaint procedure.⁶ The enrollee must be permitted to present evidence, call

⁵ *This provision appears to be in conflict with sec. 1753.39, which states that an enrollee is not financially liable, beyond copayments and deductibles, for health care services received while the complaint is pending.*

⁶ *A hearing "de novo" is one in which the issues are considered anew, as though no prior hearings had been held (Black's Law Dictionary, 6th Ed., 1990).*

and cross-examine witnesses, and to be assisted or represented by a person of the enrollee's choice. When the Director of Health determines that additional medical evidence is necessary for fair resolution of the issues or for development of the record, the hearing must include the presentation of such evidence by an independent medical expert provided at the health care plan's expense. In order to prevail, the plan must produce sufficient evidence to justify its decision denying, reducing, or terminating the services in question or the payment for such services.

The hearing results in a decision that is binding on the plan. The decision must be in writing and set out the Director's or designee's findings of fact and conclusions of law. If the enrollee has not received the services in question or is faced with the termination of or a limit on services currently being received, or the complaint involves a plan action, policy, or practice that hinders or delays receipt of health care services, the hearing must be held within 20 days after the appeal is received and a written decision provided within five days after the hearing is completed. In other cases, the hearing must be held within 30 days after the appeal is received and a written decision provided within ten days after the hearing is completed. If an enrollee prevails in an administrative appeal, the plan is required to pay the enrollee's reasonable attorney's fees and expert witness fees.

An expedited appeal must be made available when the Director of Health determines that adherence to the time limits would jeopardize the enrollee's life, health, or ability to regain maximum function. The Director may also provide for an expedited appeal in cases where the continuation of health care services or payment for services is required and the expedited procedures would be fair to all parties. In an expedited appeal, the hearing must be completed and the decision communicated to the enrollee as rapidly as the situation requires.

Appeal to a court

(sec. 1753.42)

The bill permits an enrollee to appeal a decision of the Director of Health to the common pleas court of Franklin County. If the enrollee prevails in this action, the health care plan must pay the enrollee's reasonable attorney's fees and expert witness fees, as well as other reasonable costs relating to the action. If the plan prevails, the enrollee may not be held liable for costs incurred in the health care plan's defense.

Recordkeeping and reporting requirements

(sec. 1753.44)

The bill requires a health care plan to maintain a written record of all complaints initiated during the past five years that includes the following information:

- (1) The name of the enrollee who initiated the complaint or on whose behalf the complaint was initiated;
- (2) A description of the reason for the complaint;
- (3) The dates when first- and second-level reviews were requested, and, if applicable, when those reviews were completed;
- (4) A copy of the written decision rendered at each level of review;
- (5) If time limits were exceeded, an explanation of why they were exceeded and a copy of the enrollee's consent to the extension of time;
- (6) A note as to whether expedited review was requested and the response to the request;
- (7) If binding arbitration was used, a copy of the enrollee's request for binding arbitration and the decision;
- (8) If an appeal to the common pleas court of Franklin County was made, a note of that appeal and its outcome, if available;
- (9) A note as to whether the complaint resulted in litigation and the result of the litigation.

A plan must annually submit an updated copy of this record to the Department of Health. The copy in the possession of the Department is a public record, and the written record must at all times be available for review by the Director of Health.

A plan must submit an annual report to the Department concerning the complaints that the plan has received during the year. The report must list the following:

- The total number of complaints initiated during the year by the plan's enrollees and the total number of enrollees in the plan;

- The number of complaints involving the denial of inpatient hospital services;
- The number of complaints involving the denial of a health care service by a plan due to questions of medical necessity or appropriateness;
- The number of complaints involving a denial of nursing facility or other institutional care;
- The total number of complaints involving any denial of health care services;
- The number of complaints involving a denial of health care services where the enrollee had not received the services at the time that the complaint was initiated;
- The number of complaints involving a denial of health care services that the enrollee had already received at the time the complaint was initiated;
- The number of complaints resolved at the first level of review and the number of complaints resolved at the second level of review and a description of how each such complaint was resolved;
- The number of complaints for which expedited review was provided because adherence to regular time limits would have jeopardized the enrollee's life, health, or ability to regain maximum function;
- The number of complaints for which expedited review was provided because the health care plan was required to continue services pending resolution of the complaint;
- The number of complaints that were appealed to the common pleas court and a description of the outcome of each of those appeals;
- The number of complaints that resulted in litigation, including a description of the outcome of the litigation.

Rulemaking authority

(sec. 1753.46)

The Department of Health must adopt rules under the Administrative Procedure Act to implement the complaint procedures described in the bill. The rules must establish fines to be imposed on health care plans for violations of its

rules. The following criteria must be considered by the Department in establishing the amount of the fines:

- The number of enrollees affected by the violation;
- The effect of the violation on an enrollee's health and access to health care services;
- Whether the violation is an isolated incident or part of a pattern of violations;
- The economic benefit derived from the violation by the health care plan or a participating health care practitioner.

The bill does not restrict the Department from considering other criteria in establishing fines. All fines collected by the Department of Health must be paid into the State Treasury to the credit of the General Revenue Fund.

ADMINISTRATION OF HEALTH INSURING CORPORATIONS

Selection of obstetrician/gynecologist as primary care provider

(sec. 1753.15)

Under the bill, if an individual or group health insuring corporation policy, contract, or agreement providing basic health care services either designates or provides for the designation of a primary care provider, the corporation must permit a female enrollee to designate as her primary care provider a physician who specializes in obstetrics and gynecology. The bill specifies that the physician selected must be a participating provider in the enrollee's health care plan.

Medical director

(sec. 1753.02)

The bill requires each health insuring corporation to name a doctor of medicine or osteopathic medicine to act as the corporation's medical director.

COMMENT

Am. Sub. H.B. 361 (referred to as the Physician-Health Partnership Act) was enacted by the 122nd General Assembly and goes into effect on October 1, 1998. The act contains provisions pertaining to the appeal of adverse coverage decisions of a health insuring corporation that are not amended by the bill. The

act's utilization review provisions, R.C. §§ 1751.77 to 1751.86, apply to any health insuring corporation that provides or performs utilization review in connection with its policies, contracts, and agreements providing basic health care services. While utilization review may be used by a health insuring corporation as a cost-control mechanism, the act includes under the scope of its utilization review provisions the review of adverse determinations regarding coverage rendered to individual enrollees.

The bill's and the act's provisions regulating an enrollee's appeal of a health insuring corporation's denial of health care coverage cover many of the same issues. Both set time limits for review decisions, provide for expedited review when an enrollee's medical condition warrants, require review by health care practitioners with relevant training, require the establishment of a toll-free telephone number for enrollees' use, require health insuring corporations to place review procedures in writing, and require complainants to be notified of the reasons for a denial of health care coverage and the procedures for initiating an appeal.

Despite similarities, there are also many differences in the scope and structure of the bill's and the act's appeal procedures. The bill's complaint procedure covers not only complaints about a health insuring corporation's denial of health care coverage, but also about the availability, delivery, or quality of health care services. The act specifies somewhat different procedures depending on whether a review is prospective, concurrent, or retrospective. The act's utilization review procedures regulate not only an enrollee's appeal of a denial of health care coverage, but also a health insuring corporation's overall review of its use of, and of the appropriateness of, a health care service, procedure, or setting. Because both the bill and the act regulate enrollee appeals of a health insuring corporation's denial of coverage, and address many of the same topics, the enactment of the bill could create conflicts with the similar provisions enacted in Am. Sub. H.B. 361.

HISTORY

ACTION	DATE	JOURNAL ENTRY
Introduced	01-20-99	p. 26

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