to the three agencies that currently oversee HMOs, I believe these three agencies should first undertake their own effort to perform administratively the functions of the Advisory Committee. Consequently, I will direct HCACC to include in its "report card" all the information which the Advisory Committee would have been charged with gathering. Furthermore, I will expect that HCACC will work with the public information officers at DHMH and MIA to ensure that the public is aware of and has easy access to the report card. I expect this effort to be successful, but if we find the public is still not served by the current regulatory structure, I will consider supporting legislation to establish an advisory committee in the future.

The work of the Advisory Committee is also likely to duplicate the functions of MIA as it relates to receiving and facilitating the investigation of complaints by health care providers. Under the Patient Access Act passed last year, an HMO is required to maintain a specified procedure for the selection and termination of providers on the HMO's panel of providers. Any complaints alleging a violation of this procedure fall under the jurisdiction of the Insurance Commissioner. Regulations outlining this procedure have been proposed by HCACC and are expected to take effect in June.

The bill empowers the Committee to also receive such complaints, and empowers the Committee to facilitate the investigation of complaints, presumably meaning investigations by MIA. This overlapping authority creates the potential for confusion and inconsistent outcomes. I am mindful, however, that one of the driving forces behind this aspect of the bill is the ongoing tension between HMOs and health care providers, including minority providers, who can be aggrieved by adverse actions and decisions by HMOs. Providers must have access to a meaningful grievance mechanism. This is particularly true as more and more Marylanders opt to receive their health insurance through HMOs. The passage of Senate Bill 750, which authorizes the enrollment of Medicaid patients in "managed care organizations" which are not necessarily HMOs, also highlights the general shift toward managed care.

On May 14, 1996, I signed the Health Care Payor and Provider Act of 1996, House Bill 1374. That bill, among other things, established a temporary Task Force to Study Patient and Provider Appeal and Grievance Mechanisms. The Task Force is charged with evaluating the effectiveness of patient and provider grievance mechanisms used to appeal decisions of HMOs. The Task Force is to report any recommendations for changes by October 15, 1996. Before creating a separate and permanent advisory committee to consider complaints by providers, it would seem worthwhile to await the findings and recommendations of the Task Force.

In summary, the purposes of this bill are laudable and I support them in concept. If administrative efforts to improve the coordination of HMO activities prove less than satisfactory, or the Task Force, under House Bill 1374, confirms the need for changes to the recently enacted law relating to provider complaints, I will look forward to working with the sponsors of this legislation on a bill for next year.

For these reasons, I have vetoed Senate Bill 642.

Sincerely,
Parris N. Glendening
Governor