

ALASKA LEGISLATURE COMMITTEE FILES 1999-2000 8672

9941 HOUSE LABOR & COMMERCE

Broad-based criteria used by health plans and insurers are objective, measurable decision-making criteria based on sound clinical evidence, consistent with the plan's clinical practice guidelines, based on "best practices" that reflect up-to-date scientific research. These guidelines—optimal clinical benchmarks for a given condition with no complications—are reviewed by the health plan's quality committee whose members include network physicians practicing in the area. The use of guidelines in medical decision making is not new. The medical community has traditionally used guidelines. In making prior authorization determinations, health plan medical professionals apply plan guidelines on a case-by-case basis.

The proposed legislation could "lower the bar" for physicians by permitting merely the "generally accepted" standard to prevail. In effect, it would allow an individual provider to ignore decisions made by professional peers and adopted by a health plan as part of its utilization process.

2. Concerns about the Use of Risky Medical Procedures

Because Section 151 would give providers virtually unlimited autonomy with regard to the "manner" or "setting" in which care was delivered, it could subject patients to harm by leading to unnecessary hospital stays and/or possible over- or under-utilization of services. To the extent that treating physicians rather than health plans and insurers would be decision makers regarding plan coverage determinations, the Patients' Bill of Rights Act would increase health plans' exposure to civil lawsuits for punitive and other non-compensatory damages resulting in injury or wrongful death.⁵⁸

The following are examples of problems related to inappropriate treatment involving both overtreatment and undertreatment typical of those that health plan utilization management currently addresses:

- A study done by HCLIA with William Mercer found that if all hospitals performed at the benchmark levels of the top 100 hospitals, inpatient mortality and complication rates would drop 22 percent, and the average length of stay would be cut by about half a day.⁵⁹
- A study published in the Journal of the American Medical Association (JAMA) in 1993 found that 16 percent of hysterectomies performed were inappropriate.⁶⁰
- Twenty percent of cardiac pacemakers were found to have been inserted for clearly inappropriate reasons, according to a study published in the New England Journal of Medicine in 1988.⁶¹
- Twenty-three percent of children proposed for tympanostomy tube insertion (the most common surgical procedure in childhood) had been recommended for inappropriate reasons according to a study published in JAMA in 1994 and referred to in 1998.⁶²
- Two 1992 studies of ambulatory adults and children, published in JAMA in 1997 and 1998, found that 21 percent of all antibiotic prescriptions (a total of 23.8

million prescriptions) were used to treat colds, other upper respiratory tract infections, or bronchitis—conditions for which antibiotics are ineffective and pose the risk of life-threatening adverse drug reactions and an increase in antibiotic resistance.⁶³

- A study by the University of Maryland Medical School showed that cholesterol-lowering drugs are given to only 35 percent of the women and 54 percent of men diagnosed as at risk of having a heart attack.⁶⁴
- Approximately one-third of the heart attack victims who could benefit from the use of beta blockers, the widely accepted drug for secondary prevention after acute myocardial infarction, are not prescribed the drug, resulting in about 18,000 deaths a year.⁶⁵
- The use of beta blockers varies significantly across the country, from a low of 30.3 percent of the appropriate subject population to a high of 77.1 percent. Beta blockers are associated with a 14 percent lower risk of mortality one year after hospital discharge.⁶⁶
- A study conducted by Yale University found that only about 38 percent of the people who could benefit from taking Warfarin, a drug that prevents up to 80 percent of strokes in people with atrial fibrillation, receive prescriptions for it.⁶⁷

D. Concerns About Abrogation of Contracts

1. Insurers' Fundamental Fiduciary Duty Would Be Abolished

Health insurance policies are private contracts that spell out the rights and responsibilities of both consumers and issuers or providers of the coverage. These contracts establish the details of the relations between insurers and the insured, health plans and administrators, and health plans and networks of providers. Moreover, standards for private health insurance contracts also appear in state laws, including general contract law, common law, and insurance laws and regulations.⁶⁸ Government health care programs, including Medicare and FEHBP, also rely on similar "contractual" terms to delineate eligibility, coverage obligations, and various other matters.⁶⁹ In the case of publicly financed health care, the statutes and regulations that govern both state and federal programs function as contract terms, and adherence to these terms is enforceable.

By defining medical necessity, and mandating that only the treating physician may determine whether particular services are "medically necessary or appropriate," the proposed law would both undermine the ability of the health plan or insurer to define "medical necessity" and to determine whether, for purposes of coverage and reimbursement, particular services are "medically necessary." Accordingly, the proposed law would remove the cornerstone of the private contract, leaving only eligibility and payment rates as subjects for contractual agreement. While the law would permit a general outline of benefits, the treating physician would decide which particular services are required for treatment, how those services are provided, in what setting, and for how long.

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In doing so, the law would abrogate the central tenet of insurance contracts, which are in fact agreements in which the insurer pledges to maximize the pooled resources of the many to the advantage of all beneficiaries. This obligation to make the best use of pooled resources is fundamental to all forms of insurance. With health coverage, insurers fulfill this responsibility to those who have paid premiums by agreeing to pay only for "covered" items and services determined to be medically necessary and appropriate. By contract, then, the employer or the sponsor of a group health insurance plan has obligated the health plan or insurer to reserve coverage and payment for only medically necessary care. Similarly, an individual purchasing individual coverage has entered into the same type of contract with the health plan or insurer. Indeed, the insurer is legally obligated to exclude items and services "not reasonable and necessary" for the diagnosis or treatment of illness or injury. This is true of all health care contracts, be they for a managed care arrangement or for fee-for-service coverage.⁷⁰

2. Fiduciary Deference Under ERISA Would Be Abolished

In addition, the proposed legislation would also play havoc with claims administration of employer-provided benefit plans. This is because the new law would amend ERISA, which was in part passed to foster uniformity and predictability in the administration and structure of benefits. Subjecting coverage and payment decisions to each provider's medical necessity determination breaches ERISA's long-standing principle of uniform claims administration and subjects employers to covering many different procedures. Thus, it would impede employer-sponsored group health plans from granting fiduciaries discretion to interpret established contractual terms and conditions for determining coverage provided by employee plans, and would prevent performance of the duty owed to the plan by that fiduciary.

Under current law, where ERISA plans provide discretionary authority to administrators to interpret the plan's terms and conditions, judicial review of a denial of a benefit is based on an "arbitrary and capricious" standard. This developed under the trust-law model of ERISA, and deference is provided to the fiduciary who is empowered to exercise discretionary authority over benefit claims.⁷¹ The proposed legislation would instead give deference to the treating physician, overturning years of judicial precedent. ERISA common law has developed important safeguards, ensuring that decisions by administrators of ERISA group health plans are properly made solely in the interest of participants and beneficiaries. Courts have established a much more narrow deference to such decisions where the financial interests of a fiduciary come into play. A significant line of case law requires that plan administrators carefully review issues of medical necessity including adherence to the plan's precise definition, review of all medical evidence, and consultation with treating physicians.⁷²

The proposed law also would change the nature of the fiduciary duty owed by plan administrators. Currently, ERISA imposes strict fiduciary obligations on employer plans, requiring administrators to act solely in the interest of the beneficiary and to pay valid claims. A fiduciary can be held personally liable for a breach of that duty.⁷³ The bill appears to alter

one of the principles fundamental to this body of law: changing the concept of fiduciary duty from "prudent management of the plan assets for the use of all beneficiaries" to "ensuring that the treating physician of each single beneficiary is paid for services rendered."⁷⁴ Accordingly, a fiduciary's duty is narrowed significantly, with a greater duty of deference owed to the physician treating an individual covered under the group health plan.

E. Concerns About Conflict with Public Programs

1. Separate Standard Continued for Public Programs

"Medical necessity" is common to private health insurance contracts and governmental health insurance programs, a touchstone of "contractual" obligation for determining coverage and payment of medical items and services. Public health insurance programs, including Medicare and FEHBP, premise payment on "medical necessity" in order to maximize resources and to protect health care consumers. Medicare, for example, excludes coverage for items and services "not reasonable and necessary."⁷⁵ The Health Care Financing Administration (HCFA) has issued regulations and circular letters instructing medical intermediaries to adopt claims payment practices based on determination of medical necessity. Medicare may refuse reimbursement for certain kinds of services and prohibit payment of benefits for experimental, investigational, or unproven treatments.

Federal courts have distinguished this coverage determination from medical decisions and have opined that Medicare's denial of payment for services "not medically necessary" does not constitute the practice of medicine.⁷⁶ Indeed, in one key case, a court held that while excluding coverage for services determined "not reasonable or necessary" may certainly influence medical decisions, without such an exclusion the Secretary of Health and Human Services would scarcely be able to regulate the Medicare program at all.⁷⁷ The court further declared that the provision does not direct or prohibit any kind of treatment, but only determines its subsequent reimbursement.⁷⁸

The federal Medicaid program uses medical necessity as a standard of coverage and payment.⁷⁹ As a consequence, states have conditioned benefits upon medical necessity.⁸⁰ For example, troubled by reports of significant numbers of unnecessary surgeries performed in the United States, in 1974 the State of New York formulated more restrictive guidelines and controls for authorized surgical procedures in hopes of saving up to \$65 million in Medicaid costs. The state defined its "medical assistance" to mean payment for medically necessary care. Similarly, Massachusetts restricts the amount, duration, and scope of Medicaid benefits based upon such criteria as "medical necessity."

The Military Health Services System, the Civilian Health and Medical Program of the Uniformed Services ("CHAMPUS"), which provides benefits to active duty dependents, retirees, and retirees' dependents, employs a medical necessity standard.⁸¹ For example, in defining the scope of benefits for the program, the statute specifies that coverage is not provided for any service that is not medically necessary.

2. Public Program Principles Apply to Private Contracts

These same key principles are applicable to private contracts for health care coverage, including managed care arrangements under which coverage and payment determinations may occur before services are rendered.²² Some treatments have been determined not to be medically necessary because they were not reimbursable by Medicare under the terms of the program and occurred in connection with medical research.²³ However, the Patients' Bill of Rights legislation would alter this result because such standards become irrelevant in the face of the treating physician's determination. Because every service would in fact be deemed covered (unless the insurer can prove otherwise), public and private insurance would be running on two different tracks. The congruence between private and public insurance would be destroyed. Hundreds of private contracts referencing the Medicare standard, for example, would need to be amended, causing many controversies and making any reliance on this standard uncertain at best.

IV. CONCLUSION

The proposed legislation would fundamentally alter the health care market by relegating plans and insurers to the role of writing "blank checks" to the medical community. Key coverage and reimbursement decisions would in fact be made by physicians, who would have both economic and noneconomic incentives to overtreat, thereby driving up costs and lowering the quality of care.

Eliminating medical necessity determinations by plans and insurers also changes the nature of the health insurance contract. It disables the private contract structure for insurers and policyholders, leaving the provider community in command of interpreting essential terms and conditions of contracts to which they often are not parties. It also radically changes the nature of fiduciary responsibilities, especially for ERISA plans. Additional confusion would arise because the law would not apply to government health insurance programs, which would continue to use this mechanism to assure beneficiaries of appropriate health care and proper expenditure of scarce health care dollars.

In sum, this legislation is not an effort to protect patients but to reintroduce fee-for-service reimbursement to the private marketplace, wrest control of coverage determinations from insurers, and maximize provider incomes. It undermines all health care delivery models, including managed care which has served as a protective mechanism for consumers and for society as a whole. It would return our health care system to an unconstrained fee-for-service environment. By turning medical necessity determinations over to providers, the legislation threatens to undermine the considerable progress made with respect to quality and cost. This result would be contrary to sound public policy.

Endnotes

- ¹ See, for example, S. 2529, 105th Cong., 2d Sess., § 151 (a) (1998); S. 6/H.R. 358, 106th Cong., 1 Sess., § 151 (1999) (hereinafter "PBOR").
- ² Remler, Dahlia K., Karen Donelan, Robert J. Blendon, George D. Lundberg, M.D., David R. Calkins, M.D., Lucian L. Leape, M.D., Katherine Binns, and Joseph P. Newhouse. "What Do Managed Care Plans Do to Affect Care? Results from a Survey of Physicians," *Inquiry* 34:196-204 (Fall 1997). See also Anderson, Gerard, Mark A. Hall, Teresa R. Smith. "When Courts Review Medical Appropriateness," 36 *Med. Care* 1295 (1998).
- ³ HIAA Legislative Summary, S. 6/H.R. 358, The Democrats' Patients' Bill of Rights Act of 1999.
- ⁴ See PBOR § 151, (a) (1).
- ⁵ See PBOR § 151, (a) (1).
- ⁶ Remler et al. (Fall 1997). See also Anderson et al. (1998).
- ⁷ See the Public Health Service Act (PHSA) § 2791 (b) (1).
- ⁸ See PHSA § 2791 (b) (1).
- ⁹ See PHSA § 2791 (b) (1).
- ¹⁰ See PHSA § 2791 (b) (1).
- ¹¹ See PHSA § 2791 (b) (1).
- ¹² See PHSA § 2791 (b) (1).
- ¹³ See PBOR § 151 (a) (1).
- ¹⁴ P.L. 104-191.
- ¹⁵ See PHSA § 2791 (a) (1).
- ¹⁶ See PHSA § 2791 (b) (1).
- ¹⁷ See PBOR § 201.
- ¹⁸ See PBOR § 202.
- ¹⁹ See PBOR § 301.
- ²⁰ See PBOR § 151 (a) (1).
- ²¹ See Furrow, Barry R. et al. *Health Law* § 11-2 at 8 (1995).
- ²² See Furrow, Barry R. et al. *Health Law* § 11-2 at 12 (1995).
- ²³ See e.g., *Duncan v. Travelers Ins. Co.*, 480 P.2d 418 (1971); *Cullop v. Rogue Valley Physicians' Service, Inc.*, 503 P.2d 699 (1972); *Trine v. Prudential Ins. Co.*, 645 F.2d 39 (1981 C.A. 10 Colo.); *Hanson v. Prudential Ins. Co.*, 783 F.2d 762 (1985 CA9 Cal.); *Kravitz v. Equitable Life Assur. SOC.*, 453 F. Supp. 381 (1978, DC Pa.)
- ²⁴ See PBOR § 151 (a) (1) and (3).
- ²⁵ See *Blacks Law Dictionary* at 104-105 (6th Ed. 1990).
- ²⁶ July 16, 1998, CBO cost estimate for H.R. 3605/S. 1890, the Patients' Bill of Rights Act of 1998, 15. (Emphasis added.)
- ²⁷ *Fraud: The Hidden Cost of Health Care*. Health Insurance Association of America, Washington, DC: 1996, 15-48.
- ²⁸ *Vulnerable Payers Lose Billions to Fraud and Abuse*. Washington, DC: Government Accounting Office, 1992.
- ²⁹ Health Care Financing Administration, Office of the Actuary, 1998 projections.
- ³⁰ Testimony of Charles L. Owens, Chief, Financial Crimes Section, Federal Bureau of Investigation, before the House Ways and Means Health Subcommittee, October 9, 1997, serial 105-33.
- ³¹ Testimony of Charles L. Owens, Chief, Financial Crimes Section, Federal Bureau of Investigation, before the Permanent Subcommittee on Investigations of the Senate Committee on Government Affairs, June 26, 1997, S. Hrg. 105-154, 20.
- ³² *Health Insurers Anti-Fraud Programs*. Washington, DC: Health Insurance Association of America, June 1997.
- ³³ P.L. 104-191, §§ 211-217.
- ³⁴ P.L. 105-33.
- ³⁵ "A Comprehensive Strategy to Fight Health Care Waste, Fraud and Abuse," HHS Fact Sheet, February 10, 1999. See also Pear, Robert, "Improper Medicare Payments Fall but Still Cost \$12 Billion," *The New York Times*, February 10, 1999, A17.

²⁴ Fraud: The Hidden Cost of Health Care, Washington, DC: Health Insurance Association of America, 1996, 223.

²⁷ Ibid., 223.

²⁸ Ibid., 225.

²⁹ Ibid., 226.

³⁰ Ibid., 227.

³¹ Ibid., 229.

³² See Endnote 31.

³³ See Endnote 31.

³⁴ See Dallis v. Aetna Life Ins. Co., 768 F.2d 1303 (1985). But see Trustees of the Northwest Laundry and Dry Cleaners Health and Welfare Fund v. Burzynski, 27 F.3d 153 (5th Cir. 1994) (denying coverage of unorthodox cancer treatments determined "medically necessary" by treating physicians).

³⁵ See Marker v. Union Fidelity Life Ins. Co., 907 F.2d 1138 (4th Cir. 1990) (awarding summary judgment to the patient for his appendectomy done for purely preventive, exploratory reasons and asserting that "the determination of what was reasonable and necessary was for the licensed, treating physician").

³⁶ See Van Vactor v. Blue Cross Association, 365 N.E.2d 638, 643 (Ill. App. Ct. 1977) (stating that where patient was hospitalized to remove impacted teeth, "there was sufficient evidence . . . that the insured was justified in relying on the good faith judgment of his treating physician as to the medical necessity of services prescribed"); Carrao v. Health Care Serv. Corp., 454 N.E.2d 781, 788 (Ill. App. Ct. 1983) (stating that Van Vactor remains good law in the absence of an explicit contractual provision to the contrary).

³⁷ See Taylor v. Prudential Ins. Co., 388 So. 2d 470 (1980).

³⁸ See Duncan v. J.C. Penny Life Ins. Co., 388 So. 2d 470 (1980).

³⁹ See "Managed Care Savings for Employers and Households: 1990 through 2000," a study conducted by The Lewin Group for the American Association of Health Plans, June 1997. According to the study, "without managed care, average health spending for non-aged families in 1996 would have been higher by an average of \$406 under a high-range scenario and an average of \$304 under a low-range scenario."

⁴⁰ See Social Security Act § 1862 (a) (1), 1901. See also Hall, Mark A., and Gerard F. Anderson, "Health Insurers' Assessment of Medical Necessity," 140 Penn.L.Rev. 1637, 1647 (1992).

⁴¹ See PBOR § 151 (c).

⁴² See Rosenblatt, Rand E., et al., Law and the American Health Care System (1997) at 212-213.

⁴³ See Sharpe, Virginia A, Faden, Alan L, "Appropriateness in Patient Care: A New Conceptual Framework," The Milbank Quarterly, 74:115 (March 22, 1996).

⁴⁴ See Rodwin, Marc A. Medicine, Money, and Morals: Physicians Conflict of Interest, Oxford University Press.

⁴⁵ Beeman, Douglas E., "When Mistakes Are Fatal: A Medical Researcher Says Doctors' Errors May Cause Up to 120,000 Deaths and 1 Million Injuries Each Year," The Press-Enterprise, Riverside, California, October 14, 1996.

⁴⁶ The Journal of the American Medical Association (JAMA) 9/16/98.

⁴⁷ JAMA, 9/16/98.

⁴⁸ See PBOR, § 302.

⁴⁹ Managed Healthcare, 1/98.

⁵⁰ JAMA, 9/16/98.

⁵¹ Ibid.

⁵² Ibid.

⁵³ Ibid.

⁵⁴ USA Today, 6/19/98.

⁵⁵ USA Today, 6/17/98.

⁵⁶ JAMA, 8/19/98.

⁵⁷ USA Today, 6/17/98.

⁵⁸ See Furrow, Barry R., et al., Health Law § 11-1 at 4 (1995).

⁵⁹ See Social Security Act § 1862 (a) (1) (A); and 5 U.S.C. § 8902 (n). See also 42 C.F.R. § 411.15 (k) (1997); and 5 C.F.R. § 890.105(a), (b) (1998).

⁷⁰ See Havinghurst, Clark C., Health Care Choices: Private Contracts as Instruments of Health Reform at 15 (1995).

⁷¹ See Firestone Tire & Rubber Co. v. Bruch 489 U.S. 101 (1989).

⁷² See Bedrick v. Travelers Ins. Co., 93 F.3d 149 (4th Cir. 1996); McGraw v. Prudential Ins. Co. of Amer. (10th Cir. 1998); Friends Hospital v. MeritHealth Serv. Corp., 9 F. Supp. 2d 528 (E.D. Pa. 1998); Dowden v. Blue Cross & Blue Shield of Tex., Inc., 126 F. 3d 641 (5th Cir. 1997).

⁷³ See ERISA § 409 (a)

⁷⁴ See Brown v. Blue Cross & Blue Shield, 898 F.2d 1556 (11th Cir. 1990).

⁷⁵ See Social Security Act § 1862 (a) (1).

⁷⁶ See Goodman v. Sullivan, 891, F.2d 449 (2nd Cir. 1989). See also State of New York on Behalf of Bodnar v. Sec. Of Health and Human Services, 903 F.2d 122 (1990); Wilkins v. Sullivan, 889 F.2d 135 (1989); Vorster v. Bowen, 709 F. Supp. 934 (1989); Bedford County General Hosp. v. Heckler, 574 F. Supp. 943 (D.C. Tenn. 1983); Tophy v. Weinberger, 384 F. Supp. 1117 (D.C. Wisc. 1974).

⁷⁷ See Goodman v. Sullivan, 891 F.2d 449, 451.

⁷⁸ See Goodman v. Sullivan, 891 F.2d 499, 451.

⁷⁹ See Social Security Act § 1901 (limiting appropriations to cover "necessary" medical services); and Social Security Act § 1902 (a) (30) (A) (requiring state plans to provide for procedures "necessary to safeguard against unnecessary utilization of care and services"). See also 42 C.F.R. § 440.230 (d) (authorizing states to limit services based upon "medical necessity" or utilization control).

⁸⁰ See e.g. Calif. Welf. & Inst. Code §§ 14059.5, 14137.8; Ann L. Mass. Chap. 118E § 15; Mich. C.L. Ann. §§ 400.111a (3) (b), (7) (e), (8); and N.Y. Social Services Law § 365-a (2).

⁸¹ See 10 U.S.C. § 1079 (a) (13) (excluding coverage for any service or supply which is not "medically necessary"). See also 32 C.F.R. §§ 199.2 (defining "medically necessary"); 199.4 (a) (1) (I) (limiting the scope of benefits paid for to those "medically necessary"); 199.4 (a) (1) (I) (limiting the scope of benefits paid for to those "medically necessary"); 199.17 (h) (authorizing review for "medical necessity" under TRICARE).

⁸² See, e.g., Trustees of the Northwest Laundry and Dry Cleaners Health & Welfare Trust Fund v. Burzynski, 27 F.3d 153 (5th Cir. 1994), cert. denied, 115 S.Ct. 1110 (1995) (physician's "antineoplastons cancer treatments" were not medically necessary" and physician was not entitled to reimbursement); Farley v. Benefit Trust Life Ins. Co., 979 F.2d 653 (8th Cir. 1992) (insured's high-dose chemotherapy treatment accompanied by autologous bone marrow transplant procedure was not "medically necessary").

⁸³ Compare Grethe v. Trustmark Ins. Co., 881 F. Supp. 1160 (N.D. Ill 1995) (50-year-old person suffering from inoperable, terminal breast cancer is not entitled to preliminary injunction requiring insurer to pay for HDCT/ABMT or peripheral stem cell rescue, such treatment is not "medically necessary" because it is not reimbursable by Medicare and is administered in connection with medical research).

STATE OF ALASKA

DEPARTMENT OF COMMERCE AND ECONOMIC DEVELOPMENT

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May 7, 1999

The Honorable Norman Rokeberg
House of Representatives
State Capitol, Room 24
Juneau, AK 99801-1182

MAY 07 1999

Dear Representative Rokeberg:

Re: Alaska Patients Bill of Rights – House Bill 211

We appreciate having had the opportunity to review and comment on this legislation's early drafts. Most of the changes made are positive. Several of the problems that we previously identified, from our perspective, still need to be resolved.

The vast majority of Alaska residents are covered under self-funded employer health plans and government plans that under federal laws and court decisions are beyond the reach of state *insurance* regulation. However, we believe that strong arguments can be made for the State of Alaska to exercise its police powers to protect its citizens from inappropriate health care by enacting appropriate legislation that addresses legitimate health care concerns.

Consistent with your desire to improve protections for consumers through a Patient's Bill of Rights, we believe there are important issues that still must be addressed in order to fulfill the bill's promise.

Toward that end, we continue to recommend that:

1. addition of a purpose section that clearly states the legislative intent to protect its citizens from inappropriate health care (not to regulate health care plans of self-funded private and government employers) to avoid confusion that the legislation intrudes into areas prohibited by ERISA
2. protections proposed by this legislation be also applicable to individual health insurance policy purchasers
3. "health care treatment decision" should be redefined in Section 2 to explicitly include prospective and concurrent review of proposed treatment;
4. "managed care entity" should be redefined as "any person who controls or has a financial interest in the health care treatment decisions of a medical care provider and the provider's patient"
5. [N.B. The current definitions of managed care entity and group managed care plan remain circular.]
6. "ordinary care" should be redefined in Sec. 2 to recognize the diversity of quality and sometimes-limited availability of care in different areas of Alaska and to recognize that treatment locations may differ from the area (and perhaps the State) in which a person resides

7. **Section 3** be moved to a title that directly focuses on the state's exercise of its police powers to protect its citizens from inappropriate health care (this is particularly important with respect to **Sections 21.07.010, 21.07.040, and 21.07.050**)
8. references to "insurance" within **Section 3** be deleted
9. **Sec 21.07.010** in **Sec. 3** be rewritten to prohibit health care providers from entering into a contract *with any person* that includes inappropriate provisions [i.e., subsections **(b)** and **(c)**] or fails to include appropriate provisions [i.e., subsection **(a)**].
10. **Sec 21.07.010 (a)(6)(F)** be redrafted to follow the approach that the legislature has applied to arbitration involving insurance issues [refer to AS 21.89.020(f)(1) and AS 21.89.035]
11. **Sec 21.07.010 (a)(6)(F)** be redrafted to require that arbitrators and mediators are knowledgeable – that they have knowledge of Alaska law and business practices or the requisite medical background to understand and make decisions concerning the issues in dispute
[Consideration should be giving to limiting the costs that may be assessed against the health care provider and ultimately borne by the consumer.]
12. the availability standard in subsection **Sec. 21.07.020(a)(4)** should be more clearly defined
[Reasonable availability has two major components – distance or travel time to reach a health care provider, and wait times to be seen by a health care provider.]
13. the **Sec. 21.07.020(a)(4)** definition for "standard of care" for a community should be more clearly defined to assure enforceability
[A focus on the community where the patient resides may present compliance difficulties for the managed care entity. They may not know where a group's members live, and membership in a group may change. An alternative approach may be to focus on service areas and require that out of area service be reimbursed on the same basis as inside the service area.]
14. A focus on the community may also inadvertently reduce consumer choice. A person who lives some distance from an urban center might be denied the opportunity to select a managed care plan because all health services were not available in the community where the person resided. For many employers, the requirement that health care services be available in the community where a covered person resides may reduce choice. Many employers have employees that commute or employees that are not all located in an urban area.]
15. **Section 21.07.020(a)(5)** be amended to require all utilization review decisions to be made as soon as practicable within maximum time limits.
16. "Working days", **Sec. 21.07.250(15)**, should be amended to define the holidays that are not working days.
17. **Section 21.07.020(a)(6)** establish minimum standards for an internal appeal mechanism.

May 7, 1999

[A managed care entity should be required to provide information and access for the patient or the patient's representative and health care provider to present information. How is the patient to know what should be presented? Who may perform the review (a person not involved in the original decision to provide a fresh review of the information)? What weight is to be given to the individual patient's symptoms, test results, and diagnosis versus the managed care entity's predetermined protocols? These questions should all be answered or the division should be specifically granted authority to establish appropriate regulations.]

18. Sec. 21.070.050(b)(4) be modified to remove its economic disincentives for appeals
19. the conflict between Sec. 21.070.050(b)(4) and Sec. 21.070.050(b)(5) be eliminated
20. the definition of "managed care" in Sec. 21.07.250 be modified to focus on utilization review rather than networks.

[A managed care organization may not have a network, but treatment pre-approval and concurrent and retrospective utilization review requirements may still be abusive or abused.]

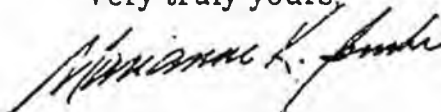
21. the intent of Section 21.42.390 be clarified and
22. Sec. 21.42.390(b) be modified to provide that medical necessity and utilization review protocols and guidelines be developed with the participation and perhaps approval of Alaska health care providers.

Version D contains a new provision on lines 9 and 10 of page 2 [Sec. 09.65.175(c)(2)] that exempts employers and employer associations from the section. The exception is not granted to labor organizations or other potential plan sponsors. Though the exception is limited to entities that do not make health care treatment decisions, it would also appear to apply to entities that use unqualified surrogates in an attempt to avoid responsibility. Both with respect to this new section, our final recommendations are that:

- labor and other non-insurance groups that sponsor plans (as opposed to plan operators or managers) be included within the exception and
- the loophole for surrogate use be eliminated.

Again, thank you for the opportunity to share our knowledge and experience. If we can help you in any way, please feel free to call on us.

Very truly yours,



Marianne K. Burke
Director

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PRACTICE LIMITED TO GENERAL SURGERY

BY APPOINTMENT ONLY

April 30, 1999

The Honorable Norm Rokeberg
State of Alaska House of Representatives
Chairman, House of Labor & Commerce Committee
State Capitol
Juneau, AK 99801

Re: House Bill HB211-Regulation of Managed Care Insurance
Plan

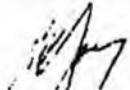
Dear Representative Rokeberg:

I am a private practicing general surgeon in Anchorage who has been in Alaska for 25 years. I am writing this letter in support of House Bill HB211 as an advocate of all patients and health care consumers in the state of Alaska.

I feel HB211 should be passed in order to provide for fair and equitable treatment of Alaskans by managed care insurance companies. It is my understanding this bill provides for appropriate freedom of choice of physicians as well as a mechanism for neutral review of claims denied or reduced by the insurance companies' unilateral determination concerning medical necessity. It would provide for more equitable negotiation in contractual arrangements between Alaska physicians and managed care insurance companies. Finally, and perhaps most importantly, it would hold managed care insurance companies accountable for their negligent health care decisions which would put the liability where it belongs when patients are denied care.

Thank you very much in advance for consideration of this bill.

Sincerely,


Roland E Gower, MD

REG/ks

American Medical Association

Physicians dedicated to the health of America



Margaret H. Draper, JD 515 North State Street 312 464-5020
Senior Legislative Attorney Chicago, Illinois 60610 312 464-4061 Fax
Division of State Legislation

May 6, 1999

Jim Jordan
Executive Director
Alaska State Medical Association
4107 Laurel Street
Anchorage, AK 99508

Dear Jim:

On behalf of the American Medical Association (AMA), I have had an opportunity to read and analyze Alaska House Bill 211, relating to managed health care and patient rights. As you know, the AMA strongly supports patient protection initiatives which help ensure that high quality health care services are delivered to patients, while balancing the needs of physicians and health insurance companies in a commercially reasonable manner. HB 211 contains several key provisions which, if enacted, would address problems that exist in the managed care marketplace which can inhibit patients' ability to receive quality care.

The AMA believes any managed care health plan that makes medical determinations should be held accountable for negligent decision-making that results in harm to a patient. Physicians and other health care providers may be held liable for their negligence, and health plans should be no exception to this rule. HB 211 addresses this inequity by creating a cause of action for patients or their representatives against health plans for negligent decision-making, and by prohibiting hold harmless clauses.

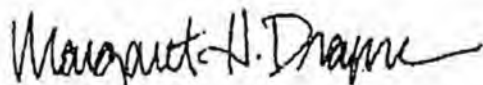
Many managed care enrollees are being denied important care that health plans are deciding is not "medically necessary" through utilization review procedures. These determinations occur after a patient's treating provider, using professional judgment, has determined that a covered treatment or service *is or was necessary* for the health of the patient. The AMA believes that all health plans conducting utilization review should establish an external appeals process whereby physicians, other health care providers, and patients can have coverage denials reviewed by physicians who are not affiliated with the health plan. HB 211 contains a provision whereby patients, providers, or representatives may appeal adverse medical necessity determinations and have their decision reviewed by an entity whose members are not affiliated with the health plan. This decision would be binding but would allow patients to pursue judicial review.

Critical to an effective external appeals process is a fair statutory definition of "medical necessity". Many health plans are defining "medical necessity" as the shortest, least expensive treatment or service as determined by the health plan, or in other ambiguous manners. This type of definition clearly raises the question as to whether some plans are basing their determinations not on what's best for the patient, but what will most help the plan's bottom line. HB 211 contains a solid definition of "medical necessity", basing the determination on what a prudent physician would provide to a patient, consistent with generally accepted standards of medical practice.

Also noteworthy are HB 211's provisions on network adequacy, gag clauses, emergency care and the "prudent layperson" standard, and disclosure requirements for health plans. These initiatives are critical in ensuring patients receive the highest possible quality of care in today's managed care marketplace.

Thank you for the opportunity to review and comment of various provisions of HB 211. We look forward to hearing about the passage of this legislation. Please let us know if we may be of assistance to you with this or any other legislative effort.

Sincerely,



Margaret H. Draper, JD
Senior Legislative Attorney

ALASKA STATE LEGISLATURE

House of Representatives

COMMITTEE ASSIGNMENTS.

LABOR & COMMERCE COMMITTEE, CHAIRMAN
JUDICIARY COMMITTEE, MEMBER
LEGISLATIVE COUNCIL, MEMBER
SPECIAL COMMITTEE ON UTILITY RESTRUCTURING, MEMBER
SPECIAL COMMITTEE ON ECONOMIC DEVELOPMENT &
TOURISM, MEMBER

e-mail: Representative_Norman_Rokeberg@legis.state.ak.us



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716 WEST 4TH AVENUE, SUITE 640
ANCHORAGE, AK 99501
PHONE (907) 269-0117
FAX (907) 269-0119

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ALASKA STATE CAPITOL
JUNEAU, AK 99801-1182
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FAX (907) 465-2040

Representative Norman Rokeberg

Sponsor Statement HB211

Alaska Patients Bill of Rights

Patients need assurance the quality of their health care will not be compromised as managed care expands. HB211 requires managed care entities to provide a reasonable standard of health care, and holds them civilly liable if they do not. It also establishes requirements for contracts between managed care entities and their health care providers, patients and their group managed care plans, and health care insurers and their insureds, providing patients with the following:

- access to emergency room services
- uniform copayments among health care providers
- local availability of medical services
- full disclosure of treatment options
- choice of health care providers, including specialists
- clear descriptions of covered items and services, benefits, procedures, compensation methods, availability (and exclusions) of prescription medications and the availability of translation or interpreter services
- a point-of-service plan option, allowing insureds to choose their own doctor without referral or prior authorization from their managed care entity
- follow-through of preapproved payment
- quick utilization review decisions
- opportunity for internal and external appeals of utilization review decisions
- added protection from denial, reduction, or termination of payment for health care services

In addition, this legislation gives health care providers the freedom to share all testing and treatment options with their patients, and lets them advocate for their patients without the risk of being penalized or terminated by the managed care entity they contract with. It also prohibits contracts between managed care entities and health care providers from including "hold harmless" clauses for the managed care entity or financial incentives for providers to withhold medically necessary services.

While it streamlines the health care system, managed care may also increase the vulnerability of patients and doctors, resulting in a lower quality of care. HB211 is necessary to ensure continued quality health care in the face of a growing managed care industry.

I urge you to support this legislation.

The Rokeberg Legislative Questionnaire



Sand Lake - Spenard - Taku/Campbell - Turnagain

April 1999

Dear Friends and Neighbors,

Thank you for taking the time to complete my 1999 Legislative Questionnaire. I always enjoy knowing your thoughts and ideas -- it's important to me.

The Legislature has much to do during the next few weeks. Please continue to keep me advised through letters, phone calls, public opinion messages, and e-mail.

Gayle and I look forward to returning home and seeing many of you during the summer and fall.

Of the 4,157 mailed, 314 or 7.5% were returned to my office prior to April 14, 1999.

Best regards,

Norman Rokeberg

SURVEY RESULTS - DO NOT RETURN

1. How many voters are in your household? 546
(If you wish, you may copy this questionnaire or indicate a difference of opinion on a particular answer in the margin.)
2. A June 1999 deadline has been established for the start of federal takeover of Alaska's subsistence fishery. Senators Murkowski and Stevens say there will be no more moratoriums.
 - a. Do you support a constitutional amendment treating "rural" subsistence users differently than "urban" subsistence users? Yes 118 No 162
 - b. Would you support a constitutional amendment establishing subsistence "uses" as the highest and best use of fish and game in times of shortage? Yes 171 No 94
 - c. Do you believe that the ANILCA legislation (federal law) should be changed to agree with Alaska's Constitution rather than changing our Constitution to accommodate federal law? (Please select one)
Change ANILCA 209
Change Alaska Constitution 63
 - d. Would you support a constitutional amendment establishing a rural subsistence priority in times of shortage to stop federal control of fish and game? Yes 197 No 88
3. Should legislative sessions be held in Anchorage rather than Juneau? Yes 243 No 61
4. Should Alaskan businesses, who exercise due diligence and good faith in fixing their Y2K problems, be immune from Y2K lawsuits? Yes 197 No 91
5. Do you think Alaskans and Alaska's economy will suffer because of Y2K? Yes 48 No 241
6. I am working on a patients' bill of rights addressing some managed care issues. Do you think that individuals should have the option of selecting their own doctor? Yes 299 No 5
7. Would you be willing to pay a higher insurance premium or co-payment in order to be able to select your own health care provider? Yes 173 No 125
8. When a home inspector issues a report on your home prior to a sale, should that inspector have any liability for the report above the cost of the report itself? Yes 221 No 60

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101


130 Seward Street, Suite 409
Juneau, Alaska 99801-2105

MEMORANDUM

April 30, 1999

SUBJECT: Sectional Summary of HB 211.

TO: Representative Norman Rokeberg
Attn: Tracy

FROM: Michael F. Ford 
Legislative Counsel

You have requested a sectional summary of the above-described bill.

As a preliminary matter, note that a sectional summary of a bill should not be considered an authoritative interpretation of the bill and the bill itself is the best statement of its contents. If you would like an interpretation of the bill as it may apply to a particular set of circumstances, please advise.

Section 1. Short title for section 3.

Section 2. Imposes civil liability on managed care entities for certain health care acts. Creates a defense to the civil action and certain exclusions to liability.

Section 3. Imposes certain provisions that must be included in a contract between a health care provider and a managed care entity. Specifies that certain provisions cannot be included in a contract between a health care provider and a managed care entity. Prohibits an indemnification clause in a contract between a provider and a managed care entity. Requires contract provisions be filed with and approved by the director of the division of insurance. Requires that group managed care plans include certain contract provisions. Imposes certain requirements regarding a covered persons choice of a health care provider, including a point-of-service option, continuing treatment by a health care provider whose contract is terminated, and notification when a provider contract is terminated for cause. Specifies that medical and financial information concerning a covered person or applicant is confidential. Establishes an external appeals mechanism for covered persons.

Section 4. Prohibits a health care insurer from limiting a covered persons choice of a health care provider or limiting information on care or treatment. Requires that treatment decisions be made by a licensed health care provider trained in the area in question and that denial of coverage occur only after consultation with the treating provider. Establishes a private cause of action for enforcement of rights created under this section.

Representative Norman Rokeberg
April 30, 1999
Page 2

Section 5. Repeals a duplicative provision of law.

Section 6. Effective date.

MFF:glc
99-221.glc

ASPI ALASKA
SPINE
INSTITUTE

Fellow American Academy of Physical Medicine & Rehabilitation

Nerve Blocks
Electrodiagnosis
Pain Management

Glenn A. Ferris, M.D.

Transmitted by Facsimile

May 3, 1999

Honorable Norm Rokeberg
State of Alaska
House of Representatives
Chairman, House Labor and Commerce Committee
State Capitol
Juneau, AK 99801-1182

Re: HB 211 - Regulation of Managed Care Insurance Plan

Dear Representative Rokeberg:

I am a private practice specialist physician practicing in Anchorage, Alaska. I write to you today as an advocate for Alaska's patients.

I strongly favor key elements of HB 211. These include the following:

1. Provide for fair and equitable treatment of Alaska's patients by the managed care insurance companies by providing for the appropriate freedom of choice of their treating physicians, the reasonable continuation of care by the patient's physician of choice, and for a meaningful external, neutral review of claims denied or reduced based on an insurance company's determination of the lack of medical necessity. (Other states who have not maintained this protection of patient's rights are now regretting their mistakes);
2. Provide for a more "level playing field" in the contractual arrangements between Alaska's physicians and the large managed care health insurance companies; and
3. Holds managed care health insurance companies accountable for negligent health care decisions that they might make. (This has clearly been found reasonable in other states such as Texas.)

Thank you for your consideration.

Sincerely,



Glenn A. Ferris MD

DAVID G. ALEXANDER, M.D.
 3240 PROVIDENCE DRIVE - SUITE 400
 ANCHORAGE, ALASKA 99508-4604

PHONE (907) 562-2423

30 Apr 99

Honorable Norm Rokeberg
 State of Alaska
 House of Representatives
 Chairman, House Labor and Commerce Committee
 State Capitol
 Juneau, AK 99801-1182

Re: HB 211 - Regulation of Managed Care Insurance Plan

Dear Representative Rokeberg:

I am a pediatrician in private practice in Anchorage Alaska. This letter is written today in my role of advocate for my pediatric patients.

With Managed Health Care knocking on our door and with all the complaints reverberating around the lower 48 where managed care has become so firmly entrenched it is obvious that now is the time to take a close look at the programs and all they entail. Now is the time to decide where and what we in Alaska ought to have in place to have some controls and some oversight.

I urge you to favorably consider those elements of HB 211 that:

- a) Allow patients reasonable choice in deciding on their own physician providing continuity of care. Allowing choice as to the most appropriate sub-specialist (e.g.: allowing the choice of a pediatric ophthalmologist to care for a child's eye problems). Requiring claims to be reviewed by physicians or providers in the same area of practice before that claim can be denied, and that the reason for the denial must be stated. (Medical necessity is really specialty specific).
- b) Any program must allow a level playing field in contractual arrangement activities between the physicians and the large health care organizations.
- c) Managed health care organizations must be legally and financially responsible for their decisions.
- d) Gag clauses must be forbidden since they clearly preclude patients from being told "the whole picture."

Thank you for your consideration.

Sincerely,

David G. Alexander MD

Adam A. Arita, M.D.
15612 Bridgeview Drive
Anchorage, AK 99516
Home: (907) 349-7850
Fax: (907) 349-7820
E-Mail: aaarita@alaska.net

30 April 1999

Honorable Norm Rokeberg
State of Alaska
House of Representatives
Chairman, House Labor and Commerce Committee
State Capitol
Juneau, AK 99801-1182

Re: HB 211—Regulation of Managed Care Insurance Plan

Dear Representative Rokeberg:

I am a private practice physician, specializing in anesthesiology and pain management. I practice in Anchorage, AK at the Providence Hospital. I am writing to ask for your support in advocating the following aspects of HB 211.

1. Require managed care insurance companies to allow Alaska's patients to choose their treating physicians, reasonable continuation of care by the patient's physician, and for a meaningful external, neutral review of claims denied or reduced based on a insurance company's determination of the lack of "medical necessity".
2. Provide a more "level playing field" in the contractual arrangements between Alaska's physicians and the large managed care health insurance companies.
3. Hold managed care health insurance companies accountable for the negligent health care decisions they might make.

Sincerely yours,



Adam A. Arita, M.D.
Diplomate of the American Board of Anesthesiology (ABA)
Subspecialty Certification in Pain Management (ABA)
Diplomate of the American Board of Pain Medicine (ABPM)

May 5, 1999

Honorable Norm Rokeberg
State of Alaska
House of Representatives
Chairman, House Labor and Commerce Committee
State Capitol
Juneau, AK 99801-1182


RE: HB 211 - Regulation for Managed Care Insurance Plan

Dear Representative Rokeberg,

I am an Alaskan anesthesiologist in private practice at Providence Alaska Medical Center in Anchorage. Naturally I wish that you favorably consider HB 211. The present state of managed care favors very few people. It doesn't favor the vast majority of physicians and it definitely doesn't favor patients. It may sound good to the tax payer and the politician, but remember that someday they will probably be a patient too. If you were a patient with a serious illness I think that you would want your physician to be controlling your care and not some non-medical administrator. Your care definitely would be affected if the physician had to run a gauntlet of "red tape" and obstacles in trying to provide you with optimal medical care. What is most scary is that the "obstacles" aren't even liable for unnecessary pain and suffering you endure in the process. Hopefully you will never be in this situation, but many people nationwide are already.

HB 211 will make positive steps in controlling the activities of Managed Care Entities and put things in proper perspective. In the end result, the only group that truly benefits from present managed care medicine are the Managed Care Entities themselves. Thank you, for your consideration.

Sincerely,



Mark R. Barnett, MD

Sherman Beacham, M.D.
1200 Airport Heights Drive, Suite 210
Anchorage, Alaska 99508
(907) 264-2030/FAX (907) 276-0366

April 30, 1999

The Honorable Norm Rokeberg
State of Alaska
House of Representatives
Chairman, House Labor and Commerce Committee
State Capitol
Juneau, AK 99801-1182

Re: HB 211—Regulation of Managed Care Insurance Plan

Dear Representative Rokeberg:

I am a private-practice physician, specializing in Internal Medicine, in Anchorage, Alaska. I am writing to you today as an advocate for Alaska's patients.

I urge you to favorably consider those elements of HB 211 that:

1. Provide for fair and equitable treatment of Alaska's patients by the managed care insurance companies by providing for the appropriate freedom of choice of their treating physicians, the reasonable continuation of care by the patient's physician of choice, and for a meaningful external, neutral review of claims denied or reduced based on an insurance company's determination of the lack of medical necessity;
2. Provide for a more "level playing field" in the contractual arrangements between Alaska's physicians and the large managed care health insurance companies; and
3. Holds managed care health insurance companies accountable for negligent health care decisions which they might make.

Thank you for your consideration.

Sincerely,



Sherman Beacham, MD



Fairbanks Clinic

Quality Care Since 1932

May 05, 1909

Honorable Norm Rokeberg
State of Alaska
House of Representatives
Chairman, House Labor and Commerce Committee
State Capitol
Juneau, AK 99801-1182

RE: HB 211 - Regulation of Managed Care Insurance Plans

Dear Representative Rokeberg:

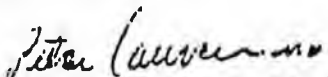
I am a private practice physician, practicing Obstetrics and Gynecology in Fairbanks, Alaska. I write to you today as an advocate for Alaska's patients.

I urge you to favorably consider those elements of HB 211 that:

1. Provide for fair and equitable treatment of the Alaska's patients by the managed care insurance companies by providing for the appropriate freedom of choice of their treating physicians, the reasonable continuation of care by the patient's physician of choice, and for a meaningful external, neutral review of claims denied or reduced based on a insurance company's determination of the lack of medical necessity.
2. Provide for a more "level playing field" in the contractual arrangements between Alaska's physicians and the large managed care health insurance companies, and
3. Holds managed care health insurance companies accountable for negligent health care decisions which they might make.

Thank you, for your consideration.

Sincerely,


Peter Lawrason, MD, FACOG
OB/GYN
PL:ska

May 4, 1999

Honorable Norm Rokeberg
State of Alaska
House of Representatives
Chairman, House Labor and Commerce Committee
State Capitol
Juneau, AK. 99801-1182

MAY 06 1999

RE: HB 211 Regulation of Managed Care Insurance Plan

Dear Representative Rokeberg:

I am a private practice physician, anesthesiologist, in Anchorage Alaska. I write to you today as an advocate for Alaska's patients.

I urge you to favorably consider those elements of HB211 that:

1. Provide for fair and equitable treatment of Alaska's patient's by the managed care insurance companies by providing for the appropriate freedom of choice of their treating physicians, the reasonable continuation of care by the patient's physician of choice, and for a meaningful external, neutral review of claims denied or reduced based on an insurance company's determination of the lack of medical necessity.
2. Provide for a more "level playing field" in the contractual arrangements between Alaska's physicians and the large managed care health insurance companies: and
3. Holds Managed care health insurance companies accountable for negligent health care decisions which they might make.

Thank you for your consideration.

Sincerely,



Richard F. Farah MD

PO Box 230269
Anchorage, AK 99523

MICHAEL D. MANUEL, M.D.

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April 29, 1999

Honorable Norm Rokeberg
State of Alaska House of Representatives
Chairman's House Labor and Commerce Committee
State Capitol
Juneau, AK 99801-1182

RE: HB-211
Regulation of Managed Care Insurance Plan

Dear Representative Rokeberg,

Before you exists an opportunity to preserve the level of health care being delivered to the patients of Alaska as well as possibly lower costs to employers and private individuals.

I currently have over 9,000 patients that I have treated in the last 13 years and have developed significant professional as well as personal relationships with these patients. From the pediatric population with congenital deformities to women with breast cancer to the elderly with facial skin cancers, I provide a service wide ranging in scope to patients in all areas of Alaska, not just Anchorage. I believe that any limitations in the ability of patients to see me or other physicians that they are currently seeing, would significantly break this physician/patient relationship bond. This bond is extremely important to assure deliverance of professional and compassionate care.

The ability of physicians to negotiate directly with insurance companies or amongst themselves to determine the potential for group purchasing of supplies and delivering similar care, should not go impeded. This potential lowering of costs will necessitate an equalization of the ability to contract for care directly between physicians and employers and patients much as the large managed care health insurance companies are currently doing. By cutting out the middle man, we should have a theoretical possibility of lowering fees or eliminating the anticipated large increase when the middle man is paid a significant share to appease the stock holders of these large corporations. In addition, a method to review claims denied on the patients behalf is needed to assure that patients receive appropriate and timely care.



Member

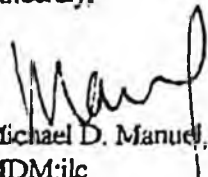
AMERICAN SOCIETY OF PLASTIC AND RECONSTRUCTIVE SURGEONS INC.

Page two
cont.

The last feature of House Bill 211 I would like to address would hold the managed care health insurance companies accountable for negligence or possible negligence related to care being withheld or if there is an untimely delivery of care secondary to a prolonged insurance review. It is important that a physician be allowed to make these decisions based on their patients needs and not on the corporate policy of some large private insurance company.

I appreciate your time in this matter and trust you will give it serious attention.

Sincerely,


Michael D. Manuel, M.D.
MDM:jlc

DAVID A. MCGUIRE, M.D.

Orthopedic Surgery

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OF ORTHOPAEDIC SURGERY

4048 LAUREL STREET
SUITE 202
ANCHORAGE, ALASKA 99508

PHONE 907-562-4142
FAX 907-563-8824

May 5, 1999

MAY 05 1999

Representative Norm Rokeberg
State of Alaska
House of Representatives
Chairman, House Labor and Commerce Committee
State Capitol, Room 24
Juneau, AK 99801-1182

Re: HB211 - Regulation of Managed Care Insurance Plan

Dear Representative ^{Norm}Rokeberg,

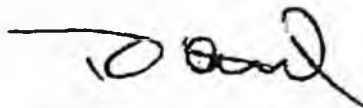
I am writing to you today as an advocate for Alaska's patients and requesting your support of HB211.

I am in favor of this bill to provide fair and equitable treatment of patients by the managed care insurance companies by providing for the appropriate freedom of choice in selection of a treating physician. This bill would allow reasonable continuation of care by the patient's physician of choice. This bill also requires the insurance companies to do an external, neutral review of claims denied or reduced based on an insurance company's determination of the lack of medical necessity.

In order to provide a more "level playing field" in the contractual arrangements between Alaskan physicians and the large managed care health insurance companies we need to hold managed care health insurance companies accountable for negligent health care decisions which they might make.

I appreciate your consideration.

Sincerely,



David A. McGuire, M.D.

DAM/rth

JOHN C. MUES, M.D., F.A.C.P.
INTERNAL MEDICINE

5-5-99

To: Honorable Norm Rokeberg
State of Alaska
House of Representatives
Chairman, House Labor and Commerce Committee
State Capitol
Juneau, Alaska 99801-1182

Re: HB 211—Regulation of Managed Care Insurance Plan

Dear Representative Rokeberg,

I am an Internal Medicine Physician in private practice in Anchorage. I write this note to you as a patient advocate

I urge you to consider favorably the elements of HB 211 which Control Managed Care in the State of Alaska:

Patient freedom of choice for treating Physician and continuity of care with that Physician must be maintained.

Claims denial should be fair- and denial should have a meaningful, external review process which is accessible and not an impossible administrative burden to Patients or Physicians.

Denial of Claims is often a denial of care and Managed Care Companies should be held accountable for the results of their decisions. Physicians should not carry the total burden of care that was not performed or delayed due to Bureaucratic reasons.

Contractual arrangements between Managed Care Companies and Alaskan Physicians should be fair and reasonable.

Removal from a plan should only be with a due process, external review.
Payment for services rendered should be timely and associated with a penalty for late payment.

Physicians should not be compelled to work without pay as many have had to do with Managed Care Companies Outside who are insolvent.

Sincerely,


John C. Mues, M.D.

Attachment: HB 211- Important Provisions

4120 Laurel St., Suite 204 Anchorage, Alaska 99508
Ph: 907-561-4362 Fax: 907-563-4498

HB 211—IMPORTANT PROVISIONS

- Patient Protections

- No "Gag Clauses"
- Reasonable Choice of Physician (Point of Service Option)
- Timely Internal Appeals of claims denials or reduction based on "Medical Necessity" determination
- Neutral External appeals of claims denials or reduction based on "Medical Necessity" determination
- "Prudent layperson" standard used for emergency room services coverage required
- "Medical Necessity" determinations must be made according to AMA definition which is based on the doctor making the care decisions

- Physician Protections in Physician Services Agreements:

- All terms required clearly to be defined
- Due process procedures for physician disputes with health insurance company
- Equitable discretionary termination provision required
- "All products" clauses prohibited
- "Most favored Nation" clauses prohibited
- "Stealth/hold harmless/Transfer of Liability clauses are prohibited and made void in existing contracts

- Managed Care Entity (MCE) Accountability:

- MCE's held accountable in state courts for negligent health care decisions made by them
- MCE's required to exercise ordinary care when making those treatment decisions

Richard L. Neubauer MD, FACP

1200 Airport Heights Suite 210

Anchorage, Alaska 99508

Telephone 907-264-2030

Fax 907-276-0366

April 30, 1999

The Honorable Norm Rokeberg
State of Alaska
House of Representatives
Chairman, House Labor and Commerce Committee
State Capitol
Juneau, AK 99801-1182

Re: HB 211—Regulation of Managed Care Insurance Plan

Dear Representative Rokeberg,

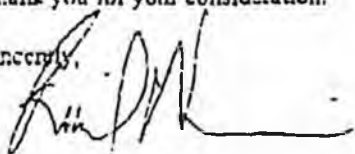
I am a private-practice physician, specializing in Internal Medicine, in Anchorage, Alaska. I am writing to you today as an advocate for Alaska's patients.

I urge you to favorably consider those elements of HB 211 that:

1. Provide for fair and equitable treatment of Alaska's patients by the managed care insurance companies by providing for the appropriate freedom of choice of their treating physicians, the reasonable continuation of care by the patient's physician of choice, and for a meaningful external, neutral review of claims denied or reduced based on an insurance company's determination of the lack of medical necessity;
2. Provide for a more "level playing field" in the contractual arrangements between Alaska's physicians and the large managed care health insurance companies; and
3. Holds managed care health insurance companies accountable for negligent health care decisions which they might make.

Thank you for your consideration.

Sincerely,



Richard Neubauer, MD

PATHOLOGY ASSOCIATES

P.O. BOX 111565
ANCHORAGE, ALASKA 99511
(907) 346-0004
FAX (907) 346-7763

STEVEN JAYICH, PH.D., M.D.
RANDY VAN ANTWERP, M.D.

May 1, 1999

Honorable Norm Rokeberg
State of Alaska
House of Representatives
Chairman, House Labor and Commerce Committee
State Capitol
Juneau, AK 99801-1182

RE: HB 211 -- Regulation of Managed Care Insurance Plan

Dear Representative Rokeberg:

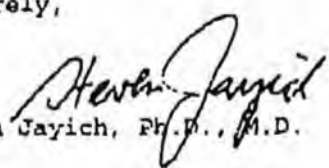
I am a practicing pathologist at Alaska Regional Hospital. I am writing you to urge your support of HB 211, especially those elements that:

1. Hold managed health insurance companies accountable for negligence regarding patient care;
2. Provide for a "level playing field" in contractual agreements between physicians and managed care health insurance companies; and,
3. Provide for equitable treatment of patients by managed care insurance companies by providing for freedom of choice of their treating physicians, reasonable continuation of care by the patient's physician of choice, and a fair mechanism for review of claims denied or reduced based on an insurance company's determination of the lack of medical necessity.

Also, I would urge you to add an "any willing provider" clause which would allow patients to choose to have care at the hospital of their choice if the hospital can offer care at a cost comparable to other hospital(s) that have a preferred contract arrangement with the patient's managed care insurance company.

Thank you for your consideration.

Sincerely,


Steven Jayich, Ph.D., M.D.

SAJ/alg

ANATOMIC - CLINICAL
PATHOLOGY

THOMAS P. SENTER M.D.
Diplomate American Academy of Dermatology
636 Barrow Street
Anchorage Alaska 99501
(907) 278-1315



MAY 04 1999

April 30, 1999

The Honorable Norm Rokeberg
State of Alaska
House of Representatives
Chairman, House Labor and Commerce Committee
State Capitol
Juneau, AK 99801-1182

Dear Representative Rokeberg:

I am writing in follow up to the telephone message I left in your office on Thursday, April 29, 1999, regarding House Bill 211, the Regulation of Managed Care Insurance Plan.

As I told your administrative assistant, I salute you for introducing this important piece of legislation. I feel it is very necessary to help protect Alaska patients from the worse excesses of the so-called managed care plans.

I speak from personal experience, having worked full-time for a managed care organization prior to coming to Alaska in 1981. I feel that my experience during that time would have been not as unpleasant for both my patients and myself if there had been a bill like yours around.

I therefore ask that you work as hard as you can to get this bill passed.

Thank you for your consideration. I will look forward to seeing both you and your wife in the near future in the office. Until then, I remain,

Sincerely yours,

Thomas P. Senter, M.D.

Tanana Valley Clinic

Family Medical Care
Since 1958

MAY 06 1999

May 3, 1999

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Jim Lynch, Assistant to the Controller
Wendylyn Tarnoff, Director of Human Resources

Honorable Norm Rokeberg
State of Alaska
House of Representatives
Chairman, House Labor and Commerce Committee
State Capital
Juneau, AK 99801-1182

RE: HB 211-Regulation of Managed Care Insurance Plan

Dear Representative Rokeberg:

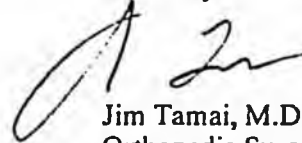
I am a private practice physician, Orthopedics, in Fairbanks, Alaska. I write to you today as an advocate for Alaska's patients.

I urge you to favorably consider those elements of HB 211 that:

1. Provide for fair and equitable treatment of Alaska's patients by the managed care insurance companies by providing for the appropriate freedom of choice of their treating physicians, the reasonable continuation of care by the patient's physician of choice, and for a meaningful external, neutral review of claims denied or reduced based on an insurance company's determination of the lack of medical necessity.
2. Provide for more "level playing field" in the contractual arrangements between Alaska's physicians and the large managed care health insurance companies.
3. Hold managed care health insurance companies accountable for negligent health care decisions which they might make.

Thank you for your consideration.

Sincerely,



Jim Tamai, M.D.
Orthopedic Surgeon

JT/dr



Norman J. Wilder, MD
 Pulmonary Disease & Aviation Medicine

Fellow, American College of Physicians (FACP)
 Fellow, American College of Chest Physicians (FCCP)
 Diplomate, American Board of Internal Medicine in
 Internal Medicine and Pulmonary Disease

1200 Airport Heights Drive, Suite 210
 Anchorage, AK 99508-2952
 Tel: (907) 264-2030 Fax: 276-0366
 E-mail: wilder@alaska.net

April 30, 1999

The Honorable Norm Rokeberg
 State of Alaska
 House of Representatives
 Chairman, House Labor and Commerce Committee
 State Capitol
 Juneau, AK 99801-1182

Re: HB 211—Regulation of Managed Care Insurance Plan

Dear Representative Rokeberg:

I am a private-practice physician, specializing in Pulmonology, in Anchorage, Alaska. I am writing to you today as an advocate for Alaska's patients.

I urge you to favorably consider those elements of HB 211 that:

1. Provide for fair and equitable treatment of Alaska's patients by the managed care insurance companies by providing for the appropriate freedom of choice of their treating physicians, the reasonable continuation of care by the patient's physician of choice, and for a meaningful external, neutral review of claims denied or reduced based on an insurance company's determination of the lack of medical necessity;
2. Provide for a more "level playing field" in the contractual arrangements between Alaska's physicians and the large managed care health insurance companies; and
3. Hold managed care health insurance companies accountable for negligent health care decisions which they might make.

Thank you for your consideration.

Sincerely,

Norman J. Wilder, MD

PAUL M. WORRELL, M.D.
INTERNAL MEDICINE
UNIVERSITY PROFESSIONAL CENTER
3850 LAKE OTIS PARKWAY
ANCHORAGE, ALASKA 99508
581-4402

May 4, 1999

Honorable Norm Rokeberg
State of Alaska
House of Representatives
Chairman, House Labor and Commerce Committee
State Capitol
Juneau, Alaska 99801-1182

RE: HE 211 Population of Managed Care Insurance Plan

Dear Representative Rokeberg:

I am a private practicing physician, Internal Medicine, in Anchorage, Alaska. I write to you today as an advocate for Alaska's patients.

I urge you to favorably consider those elements of HB 211 that:

1. Provide for fair and equitable treatment of the Alaska's patients by the managed care insurance companies by providing for the appropriate freedom of choice of their treating physicians, the reasonable continuation of care by the patient's physician of choice, and for a meaningful external neutral review of claims denied or reduced based on a insurance company's determination of the lack of medical necessity.
2. Provide for a more "level playing field" in the contractual arrangements between Alaska's physicians and the large managed care health insurance companies; and
3. Holds managed care health insurance companies accountable for negligent health care decisions, which they might make.

Thank you, for your consideration.

Sincerely,



Paul M. Worrell, M.D.

Medicine MANAGED CARE WHERE DO

Children

Medicare

Specialists

Hospitals

Medicaid

Drugs



FROM HERE?

Liability

PPOs

In 10 years, managed care has changed the landscape of American health care, saving money, simplifying paperwork and engendering lots of new legislation — but all the problems haven't been solved.

By Richard Cauchi

When Helen Hunt's character in the movie "As Good as It Gets" blasted her managed care plan for not giving her asthmatic son the help he needed, audiences cheered.

Is dissatisfaction with managed care organizations as widespread as headlines lead us to believe? Or are we in danger of "over-managing" managed care, defeating its purpose with micro-oversight of health care decisions?

Certainly the 1998 congressional debate about patient protection legislation caught the public's ear. Meanwhile, the real action has been in state legislatures. Between 1994 and 1998, 39 states approved "patient protection acts" or "comprehensive consumer bills of rights" affecting managed care. Eleven of those were adopted in 1998. The remaining 11 states have considered similar legislation.

Much legislative activity is driven by consumer complaints. For example, legislators heard about women being released from hospitals less than 24 hours after delivering babies because man-

aged care plans wouldn't pay for longer stays. Under this so-called "drive-through delivery" practice, most women and babies did fine, but some had serious problems. In the first year after this issue made headlines, 27 states enacted laws requiring coverage for longer stays, typically 48 hours.

In Colorado, a personal story came from a mother who also happened to be a legislator and chair of a legislative health committee. During a 1998 managed care hearing, she told of her daughter, "Marcia," who was diagnosed with uterine cancer at age 30. Marcia's older sister also had the disease at a young age, resulting in a hysterectomy several years previously. With Marcia's diagnosis and family history, her doctor recommended

a full hysterectomy. But her health maintenance organization (HMO) said "no, it would pay only for a partial procedure." and continue to monitor her condition.

Richard Cauchi covers health insurance for NCSL at the Denver office. NCSL staff Mollie Stauffer, Marla Kothouse and Joe Johnson Wilson contributed material used in this article.

MANAGED CARE FACTS AT A GLANCE

- ◆ HMO enrollment reached 83.7 million in 1997.
- ◆ Enrollment in preferred provider organizations (PPOs) reached 89.7 million in 1997.
- ◆ Insurance companies own 60.4 percent of PPOs.
- ◆ Fifteen of the top 25 HMO plans are nonprofits.
- ◆ There were 757 licensed HMOs and 1,035 PPOs operating in the United States in 1997.
- ◆ Managed care enrolled 46.7 percent of the Medicaid population at the end of 1997 (14.6 million people).
- ◆ HMOs enrolled 14.9 percent of the Medicare population in 1997 (5.6 million people).
- ◆ After actually decreasing 1.3 percent in 1997 (from \$434 to \$429 for family coverage), health maintenance organizations' (HMOs) average monthly premiums are rising to an estimated \$460 in 1999.

SELECTED STATE LAWS ON MANAGED CARE / HMOs

| STATE | Comprehensive consumer law (year) | Ban on financial incentives | Ban on gag clauses | Direct Access to ob/gyn | Continuity of Care | HMO Medical Director | Emergency Prudent layperson | Insurer Liability | Independent Review |
|-------------------|-----------------------------------|-----------------------------|--------------------|-------------------------|--------------------|----------------------|-----------------------------|-------------------|--------------------|
| Alabama | | | | ■ | | ■ | | | |
| Alaska | 1998 | ■ | ■ | ** | | | | | |
| Arizona | | | ■ | | | | | | ■ |
| Arkansas | 1997 | | ■ | ■** | ■ | ■ | ■ | | |
| California | 1994, '95 | ■ | ■ | ■ | ■ | ■ | | | exp |
| Colorado | 1997 | | ■ | ■ | ■ | | ■ | | ■ |
| Connecticut | 1997 | | ■ | ■** | | | ■ | hh | ■ |
| Delaware | Regulations | ■ | ■ | ■ | ■ | ■ | ■ | | ■ |
| Florida | 1997 | ■ | ■ | ■** | ■ | ■ | | | ■ |
| Georgia | 1996 | ■ | ■ | ■** | | | ■ | | |
| Hawaii | 1998 | | ■ | | | | ■ | | ■ |
| Idaho | 1997 | ■ | ■ | ■ | | | ■ | hh | |
| Illinois | | | | ■ | | | | | |
| Indiana | 1998 | | ■ | ■ | ■ | ■ | ■ | | |
| Iowa | Voluntary | | ■ | | | | ■ | | |
| Kansas | 1997 | ■ | ■ | | ■ | | ■ | | |
| Kentucky | 1998 | | ■ | ** | | ■ | ■ | | |
| Louisiana | 1997 | ■ | ■ | | | | ■ | hh | |
| Maine | 1996 | | ■ | ■** | | | ■ | hh | |
| Maryland | 1995 | ■ | ■ | ■ | ■ | ■ | ■ | hh | ■ |
| Massachusetts | | | ■ | | | | | | |
| Michigan | | | ■ | | | | ■ | | ■ |
| Minnesota | 1997 | ■ | ■ | ■ | ■ | | ■ | | |
| Mississippi | 1995 | | | ■ | | | | | |
| Missouri | 1997 | ■ | ■ | ■ | ■ | ■ | ■ | hh | ■ |
| Montana | 1997 | ■ | ■ | ■** | | ■ | | | |
| Nebraska | 1998 | ■ | ■ | ■ | | | ■ | | |
| Nevada | 1997 | ■ | ■ | ■ | | ■ | ■ | | |
| New Hampshire | 1997 | | ■ | ■ | | | | hh | |
| New Jersey | 1997 | ■ | ■ | ■ | ■ | ■ | | | ■ |
| New Mexico | 1998 | ■ | ■ | ■ | | | ■ | | ■ |
| New York | 1996 | | ■ | ■ | ■ | | ■ | hh | ■ |
| North Carolina | Regulations | | ■ | ■ | | | ■ | | ■ |
| North Dakota | | | ■ | | | | | hh | |
| Ohio | 1997 | ■ | ■ | ■ | | ■ | ■ | | exp |
| Oklahoma | 1997 | | ■ | | | ■ | | | |
| Oregon | 1997 | | ■ | ■ | | | ■ | hh | |
| Pennsylvania | 1998 | ■ | ■ | ■ | ■ | | ■ | | ■ |
| Rhode Island | 1996 | ■ | ■ | ■ | | ■ | | hh | ■ |
| South Carolina | 1998 | | ■ | ■ | ■ | | ■ | hh | |
| South Dakota | | | | | | | | | |
| Tennessee | 1998 | | ■ | ■ | ■ | | | hh | ■ |
| Texas | 1997 | ■ | ■ | ■ | ■ | ■ | ■ | hh | ■ |
| Utah | | | ■ | ■ | | | | | |
| Vermont | 1996 | ■ | ■ | ■ | ■ | ■ | ■ | hh | ■ |
| Virginia | 1995, '98 | | ■ | ■ | ■ | | ■ | hh | ■ |
| Washington | 1996 | | ■ | ■ | | | ■ | | |
| West Virginia | | ■ | ■ | ■ | | | ■ | | |
| Wisconsin | 1998 | | ■ | ■ | ■ | ■ | ■ | | |
| Wyoming | | | ■ | | | | | | |
| Dist. of Columbia | 1998 | | ■ | ■ | ■ | | | | ■ |
| Puerto Rico | | | | | | | | | |
| TOTAL | 39 | 22 | 46 | 37 | 20 | 18 | 31 | 1 | 22 |

** Alaska and Kentucky have direct access only to chiropractors; Maine covers ob/gyn and chiropractors; Arkansas also covers optometrists; Colorado, Connecticut, and Montana also cover advance practice nurses or midwives and Florida and Georgia also cover dermatologists.

* State has adopted a variation of the prudent layperson standard
 hh = ban on health plan "hold harmless" clauses, which shift all liability to doctor or health facility
 exp = applies to experimental treatments
 Note: In some cases, state provisions are contained in regulations or administrative code.

Source: Health Policy Tracking Service, National Conference of State Legislatures.

THE
FOLLOWING
DOCUMENT(S)
ARE
POOR
ORIGINAL
COPIES

"I believe the HMO made its decision based on financial considerations and not on what was best for Marcia," asserts her influential mother. She believes legislators play an important oversight role to protect consumers.

Another issue making headlines concerns access to emergency services under managed care plans. When 2-year-old Michael Silver cracked his head open on Thanksgiving eve several years ago, his parents rushed him to the nearest emergency room, five minutes away. The child received three layers of stitches from a plastic surgeon, but the family's HMO refused to pay the \$360 bill because Michael's case didn't constitute an "emergency" under the plan. Nor had his parents contacted the HMO for prior permission to take him to a facility outside the network.

"My son was gushing blood. I was scared to death, and my hands were holding his head shut," reports Michael's mother. "It certainly was an emergency in my mind, and it never occurred to me to take him the 40-minute drive to our HMO's closest emergency center or to call them up. Getting my baby immediate help was all that was on my mind."

In response to similar cases, more than 30 states have implemented "prudent layperson" standards to make getting emergency care easier. Such laws require plans to cover emergency care if a "prudent layperson" believes that immediate treatment is needed.

Personal stories such as Marcia's, Michael's and others made managed care a top constituent issue for many state legislators in the 1990s. With lives, livelihoods and votes at stake, states acted decisively. Among the 50 states, nearly 900 laws passed that affect managed care, according to NCSL's Health Policy Tracking Service (HPTS).

PRO-CONSUMER LEGISLATION

State laws addressing these issues have not followed any single model act, although insurance regulators, physicians and consumer advocates have circulated several such examples. In fact not all were high visibility packages. Many of the 900 state laws addressed particular issues reported by consumers negotiating the managed care system, such as gaining access to a specialist, being fully informed of medical options, getting coverage for emergency room services, obtaining 48-hour hospital coverage following birth for maternity cases, receiving adequate hospital coverage for mastectomies, appealing a denial of coverage for a specific service or procedure, or even just knowing what is covered.

Along the way, legislatures also have addressed structural and financial issues not as visible to the individual enrollee. These include: requiring consumer "report cards," requiring all HMO medical directors to be licensed MDs, allowing more providers to join health plans, requiring advance notice when terminating doctors and other providers and requiring prompt payment for doctors or specialists.

Many of these recent laws expand state authority or mandate additional action or services. However, at the

SOME STANDARD FEATURES

After five years of state actions some clear trends have emerged for managed care. At least 20 states have enacted laws with these requirements:

◆ **Any willing provider:** In response to complaints that consumers want to use a local drug store, 22 states require that managed care organizations allow any pharmacy to be a provider to their enrollees; several states also include doctors or other providers.

◆ **Bans on gag clauses:** Forty-six states have laws prohibiting any agreement that limits doctors' ability to inform patients of treatment options, especially if some choices may cost the insurer more. A 1997 federal law now bans gag clauses for Medicaid and Medicare managed care.

◆ **Bans on financial incentives:** Twenty-two states prohibit a managed care plan from rewarding doctors for performing a less costly procedure or prescribing a less costly drug.

◆ **Direct access to women's health specialists:** Thirty-six states and the District of Columbia now allow women to see an obstetrician or gynecologist without first getting permission or a referral from a primary care provider.

◆ **Hospital stay after childbirth:** Forty-three states require reimbursement for (typically) at least a 48-hour maternity stay. A federal law requiring coverage for a 48-hour stay took effect in January 1998.

◆ **Independent review of denials:** Twenty-one states and the District of Columbia now require an independent panel to evaluate the validity of denied care. Once opposed as too costly by the managed care industry, this idea now is embraced as a "reasonable" alternative to court suits. In Texas, an HMO association actually urged a federal judge to retain that state's external appeals process. Aetna, the nation's largest managed care company, has announced it will voluntarily allow such appeals for enrollees in 30 states, as of June 30, 1999. In addition, all 50 states require some form of internal appeal for denials of care.

◆ **Prudent layperson standard for emergencies:** Thirty-one state laws specify automatic coverage for emergency medical conditions of sufficient severity, including severe pain, that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of medical attention to result in placing the person's health in jeopardy.

◆ **Financial standards and licensing:** All 50 states provide for structural regulation of managed care organizations, usually requiring a "certificate of authority" to operate, financial solvency standards, periodic reporting and filing of operational plans.

same time, the legislative sponsors generally made it clear that they did not intend to restrict enrollment or hurt the growth of managed care plans. In fact, some would say the pro-consumer regulations may well make HMOs more acceptable and ultimately more popular.

With all these laws in effect, has managed care finally been "managed?" For 1999, many legislators would answer, "No way!" An HPTS survey of legislators active in health issues conducted in December indicates that managed care in general is still a priority in all 50 states and D.C.

Others worry, however, that overregulation of managed care plans may defeat their very purpose. While the horror stories make the headlines, the reality is that managed care has become a way of life for most Americans. At last count, more than 160 million people were enrolled in some form of managed care. These plans appear to serve the needs of many enrollees, especially those with few

INNOVATIVE AND CONTROVERSIAL IDEAS

As the managed care debate evolves in the media and on the floor of state legislatures, new (some might say far-reaching) provisions have been enacted by selected states:

◆ **The right to sue your HMO:** Texas is the first state to enact an "insurer liability" provision that holds health maintenance organizations liable for health treatment decisions. Missouri used another approach by repealing an earlier law prohibiting the "corporate practice of medicine." Health plans decry right to sue provisions and say they will prompt premium increases of up to 10 percent; in addition federal law limits the reach of states' authority. However, 31 states reported that this is a legislative issue for 1999.

◆ **Report cards:** In an effort to assist consumers in choosing a plan, 11 states now require publication of an evaluation booklet, commonly called a "report card." In Vermont, for example, the public report card will measure how well plans are complying with about 60 selected state laws and regulations. "Ultimately it will be a great tool for consumers," noted William Little of Kaiser Permanente, Vermont's largest HMO.

◆ **Specialists as primary doctor:** For people with a single chronic health problem, the usual procedure of calling a primary care provider first can be frustrating and unproductive. In 1998, Indiana, Kentucky, New Mexico and Pennsylvania joined New Jersey, New York and Texas in allowing an enrollee to select a specialist (such as a neurologist, a mental health provider or a cancer specialist) to be their main provider.

◆ **Medical director requirements:** Some managed care organizations' chief officers have business degrees rather than medical credentials. In the past two years, 18 states have established specific qualifications and responsibilities for HMO medical directors; most require a current in-state medical license. Several states make such directors "responsible for treatment policies...of the carrier," which means they could be legally liable for actions of their staff.

◆ **Consumer assistance/ombudsman programs:** Over a dozen states established ombudsman programs for Medicaid managed care. Now California, Maine and Vermont have launched such publicly funded advocacy programs for private market enrollees, and other states are looking closely at these examples.

major health problems. And they do so with fewer complaints than most people believe.

Some legislators are looking for a middle ground. "Yes, I believe some regulation is necessary, but we don't want to drive HMOs out of business," says Representative



Representative
Gregg
Underheim
Wisconsin

Gregg Underheim, chair of the Wisconsin Assembly Health Committee. He adds, "Some HMOs behave very appropriately. Clearly there are some bad actors in the HMO industry and they are making the environment more difficult for those who have operated ethically and efficiently."

"It was really the private employer who caused the rapid growth of managed care over the last decade," says John Iglehart, founding editor of *Health Affairs*, a leading national journal. "It wasn't really until the private sector came along with the private employer's contribution and decided that rather than put it into indemnity insurance, which was uncontrolled at that point, they would move into managed care.

"So we should remember that the conflict and the

commotion really isn't a consequence of governmental action... governments we all like to kick around; it really was a result of private decision making," he says.

MANAGED CARE HERE TO STAY

Agree or disagree, policymakers recognize that managed care is here to stay. The business community accepts the analysis of health leaders such as Stanford University's Dr. Alan Enthoven that managed care has the best chance of increasing access, improving quality and moderating the rate of increase in health care costs.

For private employers and governments alike, the biggest HMO success story is cost savings.

"The role of managed care is to attack unnecessary and inappropriate costs," says Stephen de Montmollin, vice president of A/Med Health Plan of Florida, a managed care plan. "Double digit inflation caused millions to lose access to affordable health care insurance," he emphasizes. "In 1988, the average per employee cost for medical benefits in the United States shot up 18.6 percent; in 1989, another 16.7 percent; in 1990, up 17.1 percent; in '91 up 12.1 percent. With managed care, these figures have been reduced dramatically, with increases below 2 percent for 1998. In 1997, premiums actually decreased by 1.3 percent."

Citing several national and local polls, de Montmollin also says that most Americans, including those enrolled in managed care plans, are satisfied with their health care coverage. He also warns that burdensome regulations will result in higher costs, and that the alternative to a managed care system often is "uncoordinated care. Don't put the entire managed care system at risk in the absence of conclusive evidence that there is some systemic problem."

A SYSTEMIC PROBLEM?

Others believe there is a systemic problem. "The U.S. health care system is in chaos," asserts Ted Lewers, a vice chair of the American Medical Association's executive committee. "A lot of the satisfaction statistics that you've seen are from people who probably have not used the health care system—who have not had any chance to know whether it works or doesn't work.

"For example, if you look at mental health care, only 7 percent of Americans use those benefits. So if you look at your satisfaction questionnaire, you'd say you're satisfied with your mental health coverage, even if you haven't used it," he points out.

Many people aren't aware of the innovative things HMOs do, de Montmollin counters. Commenting on the Helen Hunt character and her asthmatic son, he says, "The irony is that many HMOs have been pioneers in putting together comprehensive asthma programs that help children control their symptoms and reduce

(Continued on page 19)

WHAT ELSE TO LOOK FOR IN 1999

◆ **Higher premiums:** After several years of almost level rates charged to employers and consumers, premiums are headed up. The latest survey, released in January, confirmed HMO premiums are rising 8 percent to 10 percent this year, the largest jump since 1993 (the year of President Clinton's national health reform proposal). At the same time, traditional indemnity health insurance rates also are rising 8 percent, but HMO premiums remain about 20 percent cheaper.

However, copayments and deductibles will become higher and more widespread, as many employers seek ways to continue health benefits for employees without footing the entire bill. Some state regulators may again examine the possibility of capping certain insurance rates.

In the private market, the Midwest Business Group, representing 110 large employers in 11 midwestern states, is "strongly encouraging members to hold the line on premium renewals and to consider tactics such as freezing enrollment in plans where there are large rate increases, raising copayments and deductibles for employees, and warning employees that more drastic changes might be contemplated," according to Larry Boress, the group's vice president.

◆ **Prescription costs:** Most analysts, including the federal Health Care Financing Administration (HCFA), say the main cause of 1999 rate increases is pharmaceutical prices, which are up about 17 percent since last year. Perhaps that's why 24 legislatures say they will look more closely at drug costs, either through regulating formularies and generic substitutes or acknowledging special drug copayments.

◆ **Slow-down of government program enrollment:** After almost a decade of enthusiasm for enrolling Medicaid consumers in managed care, the focus is shifting. There is more emphasis on enforcing the rights of consumers, as well as legislative studies and audits to determine if cost savings are real, and if they can continue. Meanwhile, a push to enroll Medicare recipients in managed care collapsed in a high-visibility dispute between HCFA and managed care organizations about reimbursement rates. HMOs in 29 states announced they were pulling out of the Medicare market, affecting over 450,000 seniors. This dispute may fuel state legislative oversight hearings and investigations, although the resolution remains under federal jurisdiction.

◆ **Direct contracting:** Many large employers and some smaller ones are watching very closely an experiment in Minneapolis-St. Paul. A

business consortium has pooled resources to contract directly with doctors and hospitals to provide health care, effectively bypassing HMOs. Policymakers in some other states may conduct their own studies to determine how direct contracting might work in their regions.

◆ **Voluntary improvements:** The American Association of Health Plans is putting its faith in improving quality and in convincing consumers that new regulatory burdens will make things worse, says Karen Ignani, trade association president and corporate executive officer. She expects a "continued evolution" that puts consumers in the driver's seat by giving them more choice of providers and benefits. However, legislators remain skeptical. As Massachusetts Senator Mark Montigny, chair of the Senate Ways and Means Committee and chief sponsor of a 1999 consumer rights bill, notes: "Health care decisions are now driven by third party money managers, obsessed with the bottom line. A comprehensive managed care reform bill will restore the provider-patient relationship and ensure quality health care delivery at reasonable cost. Angry consumers will demand reform in 1999 and we must act with an aggressive bill that puts patients first."



Senator
Mark
Montigny
Massachusetts

◆ **Health vouchers:** Some private sector employers are proposing a simplified voucher system, providing each employee with a standardized monthly payment. This could get employers out of the health decision business in which they have to preselect a limited list of health plans. However, some policymakers question whether the average employee will be able to pick up the remaining costs, especially of family coverage. Expect to see some state interest in either encouraging or further regulating such arrangements.

◆ **Congressional action.** Both parties in Congress and the Clinton administration have said "patient protection" is a top priority for 1999. In the wake of last year's debate over sharply differing bills, key questions are not yet resolved: Will a new federal law replace or preempt existing state laws, especially when the state law is stronger? Will it fully cover other insurance plans that now are outside state regulatory authority?

"The future of state regulation of insurance hangs in the balance of the ongoing debate on regulating managed care," notes Joy Johnson Wilson, director of NCSL's Health Committee.

(Continued from page 18)

the need for emergency hospitalizations."

In fact, says de Montmollin, the most noteworthy thing about the movie scene is that a single waitress in a diner has health insurance for her son at all. "Wow, that's fabulous—fewer than half the women in her situation have any access to coverage," he says.

Rising costs make it harder for businesses and governments alike to provide coverage for the nearly 44 million Americans who remain uninsured. Managed care has been touted as a way to save money that can be used to cover additional people. However, the numbers of uninsured have increased in the past 10 years.

Compared to other insurance, "HMOs generally offer more benefits, including coverage for prescription drugs,

and fewer deductibles and copayments," notes William Falk of Towers Perrin, a research firm in Chicago. He expects most employers to stick with HMOs. They are "still an attractive alternative."

But striking a balance between consumer protections and micromanagement remains a challenge.

CONSUMERS NEED HELP

Establishing publicly funded consumer assistance or "ombudsman" programs may be one way to address consumer needs without overregulating managed care plans.

"The public is very confused," says Ron Pollack, executive director of Families USA, a consumer advocacy group. He says the managed care backlash comes from a variety of factors. "I think people clearly do not understand

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FOR MORE MANAGED CARE INFORMATION, ORDER THESE NCSL REPORTS:

- *Health Care Legislation, 1997* (#6669) and 1998 (#6674) editions.
- *1999 State Health Care Priorities* by the Health Policy Tracking Service (#3029).
- *Issue Brief: Comprehensive Consumer Rights Bills*, by the Health Policy Tracking Service (#0233).
- *Major Health Care Policies: 50 State Profiles, 1998* (#3027).
- Also check out NCSL's Health Care Web index: www.ncsl.org/programs/health/hc

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today what their choices are, what their rights are and how they can claim those rights. To the extent that we're really going to address the core of people's problems or concerns, we need to provide some specific assistance to consumers."

Pollack says consumer assistance programs would give people information about plans, help them understand their choices and rights, answer questions through free phone access, and help those who want to file an appeal. He also says that such programs can help the managed care plans, employers and regulators. "They can provide a basis for getting quick information about what the problems are that arise as our health care system changes.

"A 'patients bill of rights' should not dictate clinical decisions or redesign health benefits packages," Pollack says. "But such state laws are very important because they help to ensure that patients get the care they need, when they need it. And they give patients and physicians effective tools to fight HMOs' wrongful denials and delays of care," he explains.

THE FUTURE

Evidence points to continued lively and high visibility debate about managed care, including new state laws, renewed congressional debate and more in-depth studies of the effect of the recent state laws.

"What will eventually shake out as the health care system in the next century likely will be a muddle of market, policy, regulatory and professionally driven solutions," says Edward O'Neil, director of the Center for the Health Professions at the University of California.

"Such pluralistic approaches are typically the American way of doing things. The best solutions occur when we are clear about our aims and use the various vehicles of market, policy and professions to implement what we desire. But in this case, we do not have the capacity to generate a community or public definition of aim. Until we find a genuine voice for the varied interests in health care, we are likely to continue to suffer the cacophony of competing interests clashing over the \$ 1.1 trillion that is health care in America, and to blame managed care for it all."

1999 State Roundup

(as of mid-April)

At least 30 states are looking at over 90 bills relating to HMO liability, while no less than 27 states have pending bills relating to external appeals. However, bills have stalled or failed in Arizona, Oklahoma and Hawaii. Several measures allowing HMO liability died in Virginia, when the General Assembly adjourned in February.

- In Colorado a bill (HB1197) to allow HMO liability up to \$250,000 in punitive damages was "indefinitely postponed" in committee; however a bill to require external appeals by statute (HB1306) was advanced.
- On March 3, the Montana House considered a bill (H607) that includes a Texas-like liability provision. However, the final bill, passed by a 66-32 vote dropped the liability section.
- The Georgia House passed a bill on a vote of 172-0 allowing patients to sue HMOs that deny or delay needed medical care, although it does not include punitive damages. HB 732 was sent to the Governor's desk on March 26, and was signed April 20.

Courts and the managed care industry are changing at least as rapidly as state laws.

- In January 1999, Aetna announced a far-reaching initiative to establish "voluntary" external review for all its plans in 22 states, affecting some 16 million enrollees. However, some advocates disagree about the effectiveness of the voluntary model. "They [external reviews] have not reached the level where they are truly independent until the state has a role; until you create a firewall between the reviewer and the payer so that there is no conflict of interest," said Adrian Hahn of Consumer's Union.
- Also in January, a California jury awarded \$116 million in punitive damages for "malice, oppression and fraud" against an HMO, plus \$4.5 million in damages for medical expenses. Aetna will "vigorously appeal" this largest-ever award, which involved coverage of experimental cancer treatment.
- In February, seven Georgia HMOs announced they all would voluntarily allow independent reviews of patient appeals. However, some Georgia sources have interpreted this announcement as a strategy to head off an HMO liability bill supported by Gov. Roy Barnes.
- On Feb. 22, the American Association of Health Plans Board recommended that its more than 1,000 members adopt binding independent review programs.
- On March 16, the National Committee for Quality Assurance released new standards for HMOs that make independent appeals for consumers a requirement for accreditation approval beginning next year.

Visit this web page again: www.ncsl.org/programs/health/txlaw386.htm

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Revised post date: 5/4/99 - RC



National Conference of State Legislatures

Texas Court Affects Liability & External Appeals

Other states' managed care laws may be affected

[NCSL Home Page](#)

April, 1999

This article appeared as the cover story in the NCSL Health Chairs Bulletin, Spring, 1999

When Texas passed the first-in-the-nation "right to sue your HMO" law in 1997 (H386), it sent shock waves through the health and legal communities nationwide. Earlier court rulings held that federal ERISA law (the Employee Retirement Income Security Act of 1974) preempts and prevents state regulation in this area. Thus it was no surprise when Aetna and other Texas-based health plans challenged the Texas law in federal court. On Sept. 18, 1998, U.S. District Judge Vanessa Gilmore issued a 64-page opinion that is being scrutinized in state capitals from California to Rhode Island.

- **Liability Upheld & Restricted** - The court upheld enrollees' rights to sue their health plan for damages for harm "that result[s] from the plan's failure to exercise ordinary care." As health law attorney Patricia Butler explained it, the court reiterated the interpretation of the law current in most parts of the country, that "a suit may be brought under the act that simply challenges the quality of the benefits received, not a benefit determination." In other words, ERISA would preempt a challenge to a coverage decision, but not to a plan's involvement in actual care delivery.
- **"Hold harmless" clauses struck down** - Texas was one of 14 states that had prohibited HMOs from including clauses in contracts that shift all liability to the provider, thus insulating the health plan. Judge Gilmore's decision struck down this "ban on hold harmless clauses" section of the law.
- **Drafting detail matters** - In an important lesson for state law drafters, the court found that the Texas statute "cannot be said to make a reference to ERISA plans in any manner." If a law or bill does mention ERISA by name, it increases the likelihood that it "relates to" that federal law and could be struck down in court.
- **External Appeals Preempted?** - The 1997 Texas law established the right of a consumer to an independent review of any denial of care by an HMO. From a state perspective, a critical element of the judge's decision was the rejection of independent review, due to ERISA preemption. The judge did "stay" her order on Oct. 8, 1998 leaving the new law in force for now.
- **A pragmatic consensus?** - Interestingly, major health insurers in Texas now support the independent review process. The American Medical Association reports that some Texas HMOs have gone so far as to bypass their internal review process in some cases, finding it more cost effective to start at the external review stage. After the judge's ruling, Aetna agreed voluntarily to comply with the independent review process until the appeal is completed.

Meanwhile, the federal 5th Circuit Court of Appeals issued a ruling on another Texas managed care case, "Giles versus NYLhealth" (*updated April 9, 1999*). The court action again favored the enrollee (in this case deceased) so expect additional rounds in this debate.

The Texas Legislature is keeping a close eye on these issues. Sen. David Sibley, chair of the Economic Development Committee, was lead sponsor of the 1997 law. On Feb. 26, 1999, he provided updated observations and advice for other states grappling with similar issues:

NCSL: How is the Texas law working out? - Have there been many consumer appeals or liability suits?

DS: There's been a total of two or three lawsuits filed in the two years that the law has been in effect. We were told by the opponents that there would be a landslide of litigation, but that just hasn't developed. As for independent reviews, a few hundred of those were filed. The results have been split: the consumer wins about fifty percent of the time and the HMO wins about fifty percent of the time. Both sides are claiming victory: the HMOs are saying, see how well it works; people aren't filing many reviews. The consumer groups are saying that the HMOs are being more responsive and are looking more carefully at the needs of the patient before they deny claims.

I think it has worked well. The evidence we get from talking to some of the people who have lost their independent review case is they felt like they had their day in court. They felt a nonbiased source or a non-HMO group looked at the case, listened to them and then they lost. While they wish that they had won, they are not mad. They don't have that bitterness against HMOs that some others have. I think the fact that there haven't been a lot of law cases is in large part because of the Independent Review Organization (IRO). I recommend that highly. Here in Texas, the law says that patients have to go through the IRO process before they can go to court. If they go all the way through the IRO process and lose and there is permanent damage or some kind of injury, then they can sue. But only then. Many, even though they lost, don't feel the need to sue anymore.

NCSL: Is the state appealing the external appeals portion of the ruling? What is the status of that law?

DS: Yes, the state has appealed. Since the ruling we feel like the HMOs may be getting the worst of both worlds. Before, the IRO process had to be used before you could sue. Now with that knocked out, you can go directly to court. Except [the law] is still in force while the case is on appeal. We are talking to managed care groups right now about [retaining] the IRO process, but there is no [1999] bill yet.

NCSL: Do you have any advice for other states?

DS: The Texas experience has been very positive. [Our law] has been widely accepted; the groups that don't like it are the HMOs. If you actually talk to employers, they are not having any problems.

In 1995 we had a tort reform revolution in Texas. We capped punitive damages at \$750,000, two times economic damages, we have joint and several liability reform and venue reform - the HMOs are beneficiaries of all that. Our law also excludes employers from being sued. So our 1997 law was not done in a vacuum. We laid the foundation in '95 and then built on it in '97 with the liability and IRO law.

For more information on liability:

The Texas statute is online at <http://www.capitol.state.tx.us/tlo/75r/billtext/SB00386E.HTM>

The 9/98 federal court decision is available via <http://www.ncsl.org/programs/health/health.htm>

Other sources:

American Medical News, 10/26/98; Los Angeles Times, 1/21/99.

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NORTH CAROLINA

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4/30/99

 SEARCH

Managed-care bill survives legislative crush

By JENA HEATH, LYNN BONNER and WADE RAWLINS, Staff Writers

When the dust settled Thursday at the end of a frantic week at the General Assembly, the 1.2 million members of health maintenance organizations in North Carolina had reason to take notice.

The House passed a bill that lowers the fee patients pay when they seek treatment from doctors outside their *managed-care* networks and allows HMO patients to see out-of-network eye-care providers without a referral from their primary-care doctors.

To some health-care advocates, the bill, which now goes to the Senate, is a small gesture to consumers in need of significant reform of the the *managed-care* system.

But approval of the bill, one of dozens on a range of topics passed Thursday as members of the House and Senate rushed to meet a crucial deadline, showed that legislators are keenly aware that health-care reform has struck a chord with voters.

Several bills aimed at fixing problems consumers perceive with *managed care* have been introduced this session.

Taking stock at Thursday's deadline for bills to pass at least one chamber of the General Assembly or die, consumer health-care advocate Adam Searing said reformers haven't given up.

"Most of the consumer protection issues have not been addressed so far," he said. "So far, it's a tie game. Consumers haven't scored big, but nobody has fouled out, either. We've still got the second half, so let's see what happens."

The bill that passed the House on Thursday was sponsored by Rep. Edd Nye, a Democrat from Elizabethtown. It was approved 88-19.

Other health measures stalled. House members sent a bill that would allow consumers to sue their HMOs for malpractice back to a committee when complications emerged behind the scenes. Sponsored by Rep. Joe Hackney, a Chapel Hill Democrat, the bill could come up later in the session. A package of reforms from Democratic Sen. Oscar Harris of Dunn also wound up in committee.



Staff Photo By Corey Lowenstein
Tonya Hardy shows her support for a bill benefiting electric cooperatives.



For more information on bills acted on during the current session, see the Bill Info section of the General Assembly's Web site:
<http://www.ncga.state.nc.us/>

Paul Mahoney, lobbyist for the N.C. Association of Health Plans, which represents *managed-care* groups, said he is relieved that legislators, while eager to appease consumers, are casting a critical eye on the proposals.

"I think some of the right questions are being asked," he said. "What are the cumulative costs? How would this work in the marketplace? If these are consumer issues, how do consumer groups feel about them?"

House and Senate leaders are discussing setting up a *managed-care* study commission that would take a comprehensive look at reforms after the legislature adjourns. Rep. David Redwine, a Democrat from Ocean Isle Beach, wants to establish a separate commission to study the cumulative cost of mandates on insurance companies and employers.

Democratic legislators have taken note of freshman U.S. Sen. John Edwards' effective use of the health-care issue in unseating Republican Lauch Faircloth last November.

Health-care reform "is a powerful issue," Redwine said. "I think Democrats feel there are some different directions we might go in North Carolina where we can manage health-care costs and at the same time ensure good care. Edwards made that very plain in his campaign. It resonated well in the body politic, and we're sensitive to that."

Beyond health

Legislators also dealt with a host of nonhealth-related bills before Thursday's mid-session crossover deadline.

The state's 27 rural electric cooperatives won a victory when the House gave final approval to a bill that would allow them to form for-profit subsidiaries. The nonprofit co-ops -- serving 1.7 million members and formed with low-interest government loans -- want to branch out and provide a host of services to the state's poorest and most rural areas.

Faced with vocal opposition, the already well-represented N.C. Association of Electric Cooperatives hired three additional lobbyists late last week to push the bill. After heavy debate, it passed 92-22 and now moves to the Senate.

A bill restoring North Carolina's ban on corporate political contributions passed the Senate and was sent to Gov. Jim Hunt for his signature. It already had House approval.

The legislation closes a gap in the campaign finance laws created when the 4th U.S. Circuit Court of Appeals last year struck down portions of the state's election statutes. In addition, a House bill introduced Thursday calls for public financing of elections. Candidates for statewide and legislative offices could get public money if they agree to election-spending limits. They also would have to raise thousands of dollars in small contributions first.

Automotive rights

Vehicle owners could get greater protections from unscrupulous mechanics under a bill the Senate passed Thursday.

Consumers would be entitled to a written estimate of the cost of repairs, notification if the cost is more than the estimate, and the option of receiving the worn-out parts.

Georgia will be third to pass HMO liability law

A legislative victory could break a two-year logjam of HMO liability bills in other states.

Leigh Page
AMNEWS STAFF

THE GEORGIA LEGISLATURE'S passage of what will be the third HMO liability law in the nation was a delightful surprise for Alva Mayes, MD.

A similar bill last year sponsored by the Medical Assn. of Georgia,

where Dr. Mayes is chair of the council on legislation, didn't even make it out of committee.

This year's version sailed through the Legislature just before the session ended on March 24, and the office of Democrat Gov. Roy Barnes confirmed it will be signed into law. Barnes drafted the bill upon entering office in January, following a fiery 1998 campaign against HMOs.

In addition to giving enrollees the right to sue their health plans, the measure, effective in July, allows them to appeal HMO coverage decisions to an independent panel of physicians,

whose judgment is binding.

Move could break logjam of bills

THE VICTORY IN GEORGIA COULD break a frustrating two-year logjam of HMO liability bills in state houses.

Twenty-nine states considered such legislation last year, and 32 states did so this year, but not one bill has been enacted since Texas and Missouri passed laws in 1997, said Dick Cauchi, policy specialist at the National Conference of State Legislatures.

Cauchi said anxious legislative aides are calling him to see if other states have passed the controversial

measure. "This seems to be an issue where they want someone else to go first," he said.

Although this year's bills have died in six states so far, they have cleared one chamber in New York, Massachusetts, Illinois and Montana, Cauchi reported. The legislation is also pending in California, where Democrat Gov. Gray Davis pledged to sign such a measure.

Governor's winning strategy

BARNES' WINNING STRATEGY IN Georgia involved a combination of incendiary charges against HMOs and savvy bargaining with them.

His rhetoric drummed up a "visceral negative reaction" to HMOs, said Betsey Weltner, spokeswoman for Georgia Assn. of HMOs. For example, Barnes advised lawmakers in a February speech to ignore HMO lobbyists with "eel-skinned briefcases and alligator shoes. It's their job to scare us."

But as a 16-year veteran of the state Senate, the governor "did a good job of listening to the industry," Weltner said. "There was a lot of give and take."

HMOs won concessions, such as a requirement that plaintiffs in liability lawsuits must first go through the new external review system and cannot collect punitive damages if they lose that review.

The fact that only one lawsuit had been filed in Texas and none in Missouri blunted arguments that the bill would open a wide avenue of lawsuits, said Bill Clark, the medical association's associate general counsel.

"The sky has not fallen, contrary to what the opposition would have you believe," Clark said.

But another Barnes bill creating a new consumer insurance office encountered some resistance. Lawmakers argued it would overlap with HMO oversight exercised by the insurance commissioner's office. The bill passed anyway.

A third successful bill requires HMOs to offer access to doctors and hospitals outside their provider networks, reflecting a major Barnes campaign promise. But the measure differs little from a point-of-service law passed in 1996, except that it prevents plans from charging more than 17.5% of HMO premiums.

Shifting balance of power

BARNES' ARRIVAL HAS BUOYED PHYSICIANS' clout while reducing that of HMOs.

"We have a governor who has shown a great deal of interest in health care issues, and he is just beginning a four-year term," Dr. Mayes said.

Barnes also endorsed a late payment regulation in talks with the medical association. Under the rule, doctors can charge 18% interest per year on clean claims not paid within 15 days.

Forced to play defense, Weltner said that HMOs' scorecard this year "could have been a lot worse." Her group dropped opposition to the liability bill because "it was pretty clear the governor was going to be successful," she said. ♦

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The Dallas Morning News

Business

Court says patients can sue HMOs Circuit ruling expected to affect law in Texas

04/10/99

By Charles Ornstein / The Dallas Morning News

A federal appeals court in New Orleans opened the door Friday for consumers to sue their HMOs for damages in state court if they believe their health insurers did not provide them adequate care.

The decision by a three-judge panel of the 5th U.S. Circuit Court of Appeals came in the case of Bridgett Giles, a Houston resident whose 9-year-old son, Alex, died after his primary-care physician failed to detect an enlarged heart.

The ruling marks the first time the 5th Circuit has allowed a patient's lawsuit against an HMO to be tried in state court. In three previous cases, dating to 1992, the court determined that consumers had no remedy for harm allegedly committed by their health plan.

The opinion carries the weight of law in Texas, Mississippi and Louisiana. But it is sure to have national implications, experts say, because Congress and at least 30 states are debating whether to give consumers the right to sue their HMOs for damages if they believe they received inadequate care.

The ruling does not settle the HMO liability issue.

It will now allow consumers to sue their health plans in state court if they were misdiagnosed or otherwise unhappy with their care. It does not, however, allow patients to sue because the HMO wouldn't pay for a needed treatment.

George Parker Young, Ms. Giles' lawyer, said he was elated by the decision. "This is huge," he said. "This means that you can sue your HMO in state court."

NYLCare spokeswoman Jill Griffiths said her company had not reviewed the opinion, handed down at 5 p.m. Friday, and could not comment on it.

Ms. Giles, 39, said she prayed after hearing the verdict. "I'm really at a loss for words," she said. "I'm not surprised. I'm just so thankful. I know this is just one case, but it has a ripple effect to help other people."

The 5th Circuit's decision could also play a major role in how the court rules on a pending appeal of Texas' landmark HMO liability law, the only one of its kind in the nation. A federal district judge in Houston upheld the right to sue in September, but the case has been appealed by the industry.

"This is a big win for patients who have to little leverage against their HMOs and now have a new threat under their belt to sue if an HMO compromises quality," said Jamie Court, director of Consumers for Quality Care, an advocacy group in Santa Monica, Calif. "This will have huge ramifications for half the states in the nation now dealing with whether they can and should pass laws like Texas'."

Ms. Giles sued NYLCare Health Plan in state court, saying that the insurer failed to properly screen or supervise her son's doctor. NYLCare officials denied wrongdoing and removed the case to federal court,

arguing that the case was pre-empted by the Employee Retirement Income Security Act of 1974.

Known as ERISA, the law governs employer-paid pension and health plans. ERISA replaced traditional state legal claims - such as malpractice and wrongful death - with a uniform set of rules that requires employees to pursue their claims in federal court.

At the same time, ERISA limited the federal awards to the cost of any benefits that were denied by the insurer. Injured parties cannot seek damages.

Several legal scholars expected the 5th Circuit to agree with NYLCare's position. But the court ruled that health care is a traditional area of state law regulation. Nonetheless, it said that NYLCare could argue the ERISA defense in state court.

"State courts, being of equal dignity to federal courts, are equally competent to address that potential defense," Circuit Judge Jerry E. Smith wrote for the court.

The 5th Circuit didn't touch its earlier decisions, which held that patients can't sue for damages if the dispute is about money and contract law. Those cases are preempted by ERISA.

However, the distinction between bad care and denied care is not always clear. In practice, for example, people upset over the denial of benefits have been framing their issue legally in terms of improper care, fuzzing the distinction for judges.

"This is a big step forward for this court given that its decisions have been so resolute in the past in terms of upholding ERISA pre-emption," said Mark A. Rothstein, director of the Health, Law and Policy Institute at the University of Houston.

Stanford University law professor Hank Greely said the case follows the logic of several other federal appeals courts, which have issued similar rulings. He also said state courts are less likely to allow health plans to win using a federal law defense. "It could lead to a great deal more litigation against employer-provided health plans in ways that could have major effects on the industry."

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Thursday, March 25, 1999

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Do Maine patients need more health-care rights?

By PAUL CARRIER
Staff Writer

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AUGUSTA — Deborah Klane has her hands full caring for her son Evan, who is so badly disabled that he suffers seizures, must be fed through a tube and needs someone to turn him over in bed.

But whenever Evan needs routine and entirely predictable care from any of several specialists who see him regularly, his parents must get a new referral from the boy's primary-care physician to satisfy Blue Cross and Blue Shield of Maine.

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Tracy Piantoni of Hartford had to carry her crippled 9-year-old daughter from a hospital last year after the child had surgery on both legs, because she could not get a decision from her insurer on whether the family's managed-care policy covered a wheelchair.

"We carried her around for four days in our house" before the insurer finally announced its decision — no coverage. Medicaid kicked in eventually, but not until Healthsource Maine finally said no to the wheelchair days after it was first needed.

Such complaints about health insurance in the era of managed care have prompted seven state legislators to file seven separate bills, each of which would create a "patients' bill of rights" to protect consumers who are insured by health-maintenance organizations and other managed-care providers.

The bills vary dramatically in scope and content, ranging from legislation that would only guarantee one or two rights to the most sweeping bill, filed by Senate Majority Leader Chellie Pingree, D-North Haven. Pingree's bill includes more than a dozen safeguards for everything from easier access to specialists and prescription drugs, to outside review of disputed claims and the right to sue insurers for personal injury or wrongful death.

The Legislature's Banking and Insurance Committee began the difficult task of sifting through those proposals Wednesday during a lengthy hearing that pitted the concept's supporters — disgruntled consumers and the Maine Medical Association — against insurers who either oppose the very idea of a patients' bill of rights or believe

IDEAS

The Legislature's Banking and Insurance Committee is reviewing eight bills to create a patients' bill of rights for Mainers covered by managed-care insurance policies. Some of the bills are comprehensive while others propose only one or two specific rights. All told, though, the bills would guarantee more than a dozen rights for patients. Here are some of the major ideas:

Write into law an existing state rule allowing patients to use hospital emergency rooms without referrals in some cases.

Allow specialists to serve as primary-care physicians for some patients.

Allow patients who must consult specialists on a regular basis to do so without getting referrals over and over again from their primary-care physicians.

Allow women to get direct care from obstetricians and

most of the bills go too far.

"I think we are at a historic moment in the Maine Legislature," Rep. Jane Saxl, D-Bangor, a sponsor of one of the bills, said at a news conference preceding the hearing. With a proposed federal bill of rights in legislative limbo on Capitol Hill, it has become all the more important for states to take the initiative in protecting consumers, Saxl said.

"No issue was talked about more when I was campaigning (last year) than what is going on in health care," said Senate President Mark Lawrence, D-Kittery, the sponsor of another bill. There is, Lawrence said, "a crisis in health care" because many Mainers believe they are "losing control over their health-care decisions."

Supporters told the committee that steps taken in the past to protect consumers don't go far enough. They said safeguarding patients' rights would increase insurance premiums slightly, but the costs would be outweighed by better care for patients.

Klane endorsed a provision in four of the seven bills allowing patients to have standing, long-term referrals to specialists so they would not have to get new referrals over and over to see the same specialists for the same problems.

For her part, Piantoni said the proposed reforms might not have made her insurer more efficient in ruling on her request for a wheelchair for her daughter. But if state law required an independent outside review of disputed claims, as six of the pending bills do, she might eventually have won a ruling in her favor, Piantoni said.

gynecologists without referrals from their primary-care physicians.

Guarantee continued care from the same physician for a fixed period of time after a health plan drops a patient's doctor and after a patient's employer changes health plans.

Expand coverage for prescription drugs.

Provide independent reviews of disputed claims.

Prevent insurers from giving providers financial incentives to restrict care.

Allow patients to participate in approved clinical trials.

Allow patients to sue insurers for personal injury or wrongful death.

Create an independent consumer-assistance ombudsman.

Guarantee access to needed specialists, even if they are not part of a patient's

Insurers countered that the supposed managed-care plan. safeguards would raise the cost of insurance significantly and jeopardize the quality of health care, all in the name of making improvements that are, in some cases, already being implemented by insurers. They said the state should let recent reforms work.

Ban discrimination by insurers based on age, disability and other factors.

"If these measures are enacted, it will become virtually impossible for managed care to operate effectively in the state of Maine," said Jim Puiia, vice president and general manager of Tufts Health Plan in South Portland, which has about 70,000 customers in Maine.

The committee should move slowly, Puiia said, because the combined impact of the proposed safeguards "will inevitably make health insurance unreachable for many employers and their employees."

Increasing the liability of insurers would boost administrative costs and trigger more litigation, making insurance more expensive without improving the quality of care, said Dr. Lawrence Baker, senior vice president for medical affairs at Blue Cross and Blue Shield of Maine.

Baker, a cardiologist, said medical specialists are consistently overused, so there's no reason to guarantee even greater access to them.

Describing the quality of health care under managed-care plans as "extremely high," Baker urged lawmakers not to place too much weight on tales of woe from individual consumers whose gripes may be legitimate but misrepresent the overall state of managed care in Maine. The Legislature, Baker said, "should not make health-care policy by anecdote."

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Legislature working out kinks in bill to protect patients' rights

By [JONATHAN ROOS](#)
Register Staff Writer
03/09/1999

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Extra

Urged on by Gov. Tom Vilsack, the Iowa Legislature is expected to take a major step this week toward adopting safeguards for patients covered by managed care plans.

However, there doesn't appear to be total agreement about the legislation - including what to call it.

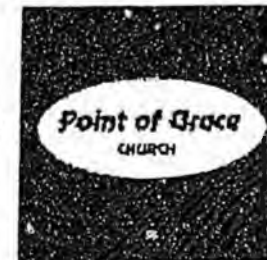
During separate news conferences Monday, Vilsack, a Democrat, urged passage of a managed care "patients' bill of rights." Leaders of the Republican-controlled Legislature said the Senate later this week will approve "patient protection legislation." Then the House will debate the measure.

Both sides are talking about a bill that would establish an independent review process for patients who are denied coverage of a medical procedure.

The measure also would ensure that:

- * Emergency room charges are covered when that level of care is required.
- * Physicians are free to discuss treatment options.
- * Coverage of a physician's care of a pregnant woman continues throughout the pregnancy even though there are changes in insurance.

"It's important a patient and their doctor make treatment decisions based on the patient's needs, not an insurer's bottom line," said Rep. Brad Hansen, R-Carter Lake. He credited insurers and physicians for helping to develop legislation that ensures "no one who needs medical care falls through the cracks of our health care system."



Vilsack said the bipartisan plan "offers all Iowans an opportunity to secure good health for themselves and their youngsters." However, he has a few concerns about the legislation's adequacy in its present form.

The governor said health maintenance organizations must be required to provide people with details about their plans' benefits and other information, so that plans are easy to understand and compare.

Despite differences over some details, there is little doubt that before the 1999 session ends this spring that the Legislature will pass a managed care bill that Vilsack signs into law. With Congress slow to act on the issue, both sides say Iowa is ready to adopt its own protections for patients.

"Our patient protection legislation takes important steps to ensure that Iowa families have access to the highest quality of medical care," said state Sen. John Redwine, R-Sioux City.

U.S. Rep. Greg Ganske, R-Ia., in a statement released by legislative leaders, said the Iowa bill "takes important first steps" guaranteeing protections to patients who receive coverage from HMOs.

Ganske, who is a doctor and has lobbied hard for a federal bill, said work also will continue in Congress to correct HMO abuses.

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Health-care package passes 98-0 / More control over choice and treatments is key point

Friday, February 26, 1999

BY RUTH S. INTRESS
Times-Dispatch Staff Writer

The House last night passed 98-0 an HMO and managed-care reform package that will give hundreds of thousands of Virginians greater control over which doctors they see and what treatments they receive.

The House's action was bittersweet for Democrats, who made health-care reform a platform issue this session only to see their so-called Patient's Bill of Rights heavily rewritten by Republicans and then claimed as the GOP's own.

Winning bragging rights to the populist health reform issue is widely viewed by legislators as a key prize given this fall's elections that will decide whether Republicans strengthen their thin majority in the Senate and win control of the House for the first time in modern history.

"They [Republicans] put the pressure on their people," said Gail Shea Nardi, a Democratic caucus spokeswoman. "They succeeded in watering down the patient Bill of Rights and leaving Virginians without the kind of health-care reform they want and deserve."

After days of behind-the-scenes maneuvering, lawmakers yesterday flooded both the House and Senate with dozens of 11th-hour amendments designed to subtly -- and in a few cases substantially -- alter the health-care reform package. The day's long-awaited battling began last night in the House, which had previously passed components of the reform package but was voting for the first time on the GOP's omnibus version of the legislation.

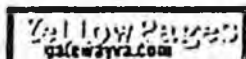
Among the most significant amendments was a controversial measure that would have allowed patients to sue their HMOs for denial of treatment. Democrats heavily backed the change, arguing that managed-care plans currently are protected -- while virtually all other businesses are not -- from being held accountable for their decisions.



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News coverage of the 1999 General Assembly



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"A doctor sitting next to a phone 200 miles away can wreck your life, your family, and he's not accountable . . . that is not fair," said Del. C. Richard Cranwell, D-Roanoke County.

Republicans, joined by six Democrats, defeated the liability provision on a 53-44 vote, arguing that it would drive up health insurance costs and was unnecessary given the bill's creation of a binding appeals process in which independent health experts would hear patients' complaints and act on them.

Only the state of Texas has passed legislation allowing patients to sue their HMOs. Conversely, about a third of the states have enacted appeals plans similar to the one outlined in the Virginia legislation.

"If this [appeals process] does not succeed, then perhaps it will be time to turn to that [liability] recourse," Del. John H. Rust Jr., R-Fairfax, said in opposing the right-to-sue amendment. "But it's not now, not in this bill."

Democrats' failure to push through the liability clause in the House prompted them to rapidly abandon other attempts to alter the health-care package.

ACCESSVA.com

Similar amending efforts are still pending in the Senate, but at 10:30 last night, senators threw in the towel and recessed, putting off until today their continuing partisan struggles over the bill. Despite such late-night theatrics, the Senate is not expected to dramatically alter the bill, which it passed unanimously two weeks ago.

personal
possibilities

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Gov. Jim Gilmore has indicated support for the measure, which, following his signature, will become law July 1.

Despite heavy partisan battling, much of what Democrats penned in their reform package remained in the prevailing Republican version. In addition to the creation of an appeals process, the legislation calls for the launching of a statewide ombudsman's office to handle and investigate consumer complaints about managed-care plans.

The legislation also will broaden patients' access to needed drugs and allow people with major health problems to see specialists on an ongoing basis without having to gain permission each time they seek to do so.

The bill will further prohibit insurance companies from linking financial incentives to physicians' or hospitals' denials of care, though it will not do so in as strong a fashion as Democrats wanted. The bill also will require insurers to provide 24-hour telephone access for patients required to gain pre-authorization treatment approvals.

Components of the managed-care reform package, though initially eyed with alarm by industry lobbyists, have since won some of their praise as a reasonable, bipartisan approach to aiding patients while not overburdening health coverage providers.

Nonetheless, lobbyists and legislators said fewer than a third of Virginia's 6.5 million residents will be affected by the legislation immediately since it applies only to people in commercially obtained health plans -- those purchased individually by consumers or by small businesses for their workers.

The legislation does not cover people in self-insured plans, which are favored by major corporations insuring thousands of employees. Despite that fact, however, experts predict the bill's consumer protections will quickly gain widespread acceptance, if only because managed-care providers will seek to avoid the headaches of determining who is and isn't protected under the legislation.

Indeed, state workers, though covered by the state's self-insured plan, already have been included in the legislation on Republicans' insistence.

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The Boston Globe

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Metro | Region**For some patients, managed care means no relief**

As plans deny procedures, outrage grows

By Dolores Kong, Globe Staff, 02/11/99

Nonstop menstrual bleeding and a painful growth in her uterus have made Lynda Tottenham's life so miserable that the 47-year-old can no longer comfortably stand on her feet all day at her Cape Cod hairdressing shop.

"I'm talking about very heavy bleeding with clotting, to the point where I feel like I'm going to drop dead sometimes," said Tottenham, who has had the bleeding and fibroids for years. "I can't take this anymore."

So she and her physician have scheduled a hysterectomy, considered a definitive treatment for a patient with Tottenham's symptoms, according to criteria established by the American College of Obstetricians and Gynecologists.

But Tottenham's managed care plan has not approved the procedure, saying it was "unable to verify the clinical need" based on its guidelines, according to the plan's denial letter to Tottenham's gynecologist, Dr. Kenneth E. Smith.

"This is an example of what's happening in managed care," said Smith, who has joined hundreds of physicians, nurses, psychologists, and other health care workers in a national effort known as the Ad Hoc Committee to Defend Health Care, prompted by mounting concerns surrounding changes in the health care system.

The case, under appeal through Health Risk Management Inc., a Minnesota-based for-profit company that manages the plan for Tottenham's insurer, Arbella Life and Health, is among a growing number of examples being cited in Massachusetts and nationwide by patients and physicians frustrated with managed care.

In December, a seriously ill 84-year-old man was discharged against

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Help

his and his doctor's wishes from a Boston-area hospital after concerns were raised by HMO officials about whether he met hospitalization criteria, according to Dr. David Dodson, the man's doctor.

Last month, in the largest verdict ever against an HMO, a California jury awarded \$116 million to a woman whose husband died trying to get Aetna US Health Care of California to cover an experimental cancer treatment.

Late last year, a jury awarded \$13.1 million to a Kentucky woman who was denied coverage for a hysterectomy, after her doctor said it would cure her cervical cancer. Humana Health Plan Inc., which refused to pay for the procedure, lost one appeal last month but plans another.

In response to the mounting populist revolt, legislation has been filed at the federal and state levels, calling for such patient protection measures as an outside appeals process, disclosure of any financial incentives for doctors or other providers to limit treatment, a documented process of determining medical necessity, and the right to sue an HMO.

In Massachusetts, where more than 50 percent of insured people are enrolled through managed care plans, among the highest rates in the country, and where regulation of plans is among the weakest, several bills have been filed to change the system, according to the Boston-based consumer advocacy group Health Care For All.

And the Ad Hoc Committee to Defend Health Care, in Boston, plans to gather enough signatures to place a binding statewide referendum on the 2000 ballot in favor of universal health care and against for-profit medicine.

Managed care officials defended their contributions to the health care system, saying they have trimmed costs while improving care, and reduced unnecessary hysterectomies, caesarean sections, and other overusage that drove costs up under the old fee-for-service health care system.

"Because our CEO and founder is a physician himself, he's very concerned that people make sure that we aren't trying to do the doctor's jobs for them," said Laura Pigott, public relations manager for Health Risk Management, or HRM, which is expected to be deciding Tottenham's appeal by the end of the week.

With HRM's own set of guidelines, "We're trying to help them, so they can make the best informed decision for their patients," Pigott said. "I know the perception a lot of times is that guidelines are just there to facilitate denials," but that is not the case, she said.

Pigott said patient confidentiality prevented her from discussing Tottenham's case. "We very carefully make it so that patients' interest is respected," she said.

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If the medical specialist reviewing Tottenham's case upholds the denial of the hysterectomy, Pigott said Tottenham can still appeal to Arbella.

Out of 100,000 cases reviewed by HRM last year for the approximately 70 health plans it manages nationwide, just .5 percent were appealed because the treating physician disputed the finding, Pigott said. And out of the cases appealed, 76 percent of the "non-recommendations" were upheld, while the rest were modified or overturned, she said.

For Tottenham - who pays nearly \$700 a month to Arbella for coverage for just her and her husband, and can't afford the additional cost for hospital coverage for their sons - that answer isn't good enough.

"My surgery is scheduled for March 9. I haven't canceled it," she said. "If the insurance company continues to refuse, I'm going to work something out with Dr. Smith, and then I'm going to see a lawyer."

This story ran on page B01 of the Boston Globe on 02/11/99.
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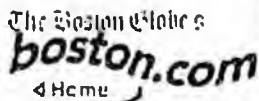
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Bills would give patients more information about HMOs

By Paul Tolme, Associated Press, 02/04/99 01:03

PROVIDENCE, R.I. (AP) - Consumers could check the grades of health insurance plans on a report card to be published by the state under legislation pushed by Lt. Gov. Charles Fogarty.

The Consumer Report Card would gauge customer satisfaction with health maintenance organizations, helping consumers decide which programs to enroll in.

"Consumer protection laws are necessary to ensure patient care, not profits, come first," Fogarty, chairman of the Long-term Care Council, said Wednesday.

Another bill in the legislative package would allow consumers to shop around to find the lowest cost for medications. Most consumer complaints regarding HMOs are related to limits on where prescription drugs can be bought, according to Fogarty.

Other bills would strengthen the appeals process for consumers denied care, require HMOs to provide customers with a Consumer Bill of Rights, and establish a program within the Department of Elderly Affairs to help senior citizens deal with managed care organizations.

Fogarty already has introduced a bill that would give people the right to sue HMOs.

Under the legislation, patients would be allowed to take legal action against HMOs that fail to provide appropriate and medically necessary care, or care that meets accepted standards.

A similar bill died last year in the Senate, and Congress also is considering legislation to allow consumers to sue HMOs.

Currently, HMOs can be held responsible only for the cost of the procedure that was denied or delayed.

Insurance companies and many members of Congress say they believe increased liability significantly will drive up insurance premiums paid by businesses and patients.

"What this can do is serve as a strong incentive for HMOs when making decisions to approve or deny coverage," Fogarty said.



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Business

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Managed care is found to limit costs for non-HMO patients

Doctors treat all patients alike, a study found. Money is not behind treatment choices, the author concluded.

By Phil Galewitz
ASSOCIATED PRESS

NEW YORK -- Consumers who thought they could escape the effect of managed health care by staying with traditional insurance might be in for a surprise.

A new study suggests that doctors in regions with fast-growing health maintenance organizations order fewer tests and cut other costs even for their patients who are not in HMOs.

"Managed care seems to have a spillover effect," said Uwe Reinhardt, a Princeton University health economist.

Health expenses for patients in traditional Medicare plans tend to fall in regions with growing HMOs, according to a report published yesterday in the Journal of the American Medical Association.

Stanford University researcher Laurence Baker, the study's author, said the findings suggest that doctors used to treating HMO patients alter their practice habits in treating all patients either out of convenience or because they agree with the more conservative HMO treatment style.

Baker's study is one of the first to draw attention to the effect that managed care has on all patients, not just those in HMOs.

The study's findings raise doubts about suspicions that doctors treat patients differently based on their insurance coverage, said Reinhardt, who wrote an accompanying editorial in the journal. Economists, he said, have long assumed that doctors were influenced by how they were paid.

"This article says the world is more complicated, and doctors are not the economic animals that our economic models suggest they are," he said.

NEWS

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The study examined Medicare costs from 1990 to 1994, a time when HMO market share increased nationally from 15 percent to 20 percent. The study accounted for a number of factors that influence health costs, including the age and health status of patients.

Baker found that as HMO market share increased in a region from 10 percent to 20 percent, Medicare hospital costs fell by 2 percent and Medicare physician and outpatient expenses fell by 1.5 percent. Medicare costs fell even more sharply in regions where HMO market share was bigger.

In 1994, the average Medicare expense per beneficiary was about \$3,270.

Several reasons could explain how HMOs cut costs for patients not in HMOs. The presence of health plans in a community tends to spur construction of more lower-cost health settings such as outpatient surgery centers, and HMO doctors influence how non-HMO doctors practice, Baker said.

Yet Baker concludes that the most likely cause is that doctors treat all of their patients the same way. And if HMOs move doctors to limit hospitalizations and expensive tests for their members, doctors follow the same approach for all their patients.

"A lot of patients think that they can escape the effects of managed care by joining some other type of health plan," Baker said. "In places with a lot of managed care that is not true."

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National Conference of State Legislatures

106th CONGRESS HOUSE MANAGED CARE PROPOSAL COMPARISON

Staff Contact: Joy Johnson Wilson, Director, Health Committee

March 1999

Large file, approx. 67 KB

During the 105th Congress, several managed care bills were introduced. The only piece of legislation that moved was the House GOP proposal, which the GOP Leadership took directly to the House floor for an up or down vote. This session, nine bills have already been introduced - five in the Senate and four in the House. Many of the bills are reintroduced versions of last year's bills with only minor adjustments made. Once again, NCSL supports the Senate Republican approach of limiting federal regulation to Employee Retirement Income Security Act (ERISA) plans. S. 300 would apply only to ERISA plans except for the provisions on grievances and appeals; discrimination based on genetic information; and confidentiality of medical records. Each of the other eight introduced bills would apply to all private health plans.

Most of the bills contain a core of common provisions including: using the prudent layperson standard to determine coverage for emergency room services; point-of-service; disclosure of certain health plan information; direct access to certain medical specialists (usually OB/GYNs and pediatricians); a prohibition on "gag clauses"; continuity of care; grievances and appeals; and confidentiality of medical records. The House and Senate Republican proposals also contain "access" provisions such as expanding the Health Insurance Portability and Accountability Act (HIPAA) Medical Savings Account (MSA) pilot program; acceleration of 100% deductibility for health insurance premiums for the self-employed; and "HealthMarts" or "Association Health Plans". In particular, the primary House proposal (H.R. 448) has reintroduced the concept of "HealthMarts" and "Association Health Plans". NCSL opposes these provisions because they remove more of the insurance market from state regulation. The language has been somewhat revised to appease states, but NCSL still believes that consumers would not be adequately protected as the bill is written.

Prepared By:
Joy Johnson Wilson
Steve Lewis
Heather Mackey
Molly Stauffer



106th CONGRESS HOUSE MANAGED CARE PROPOSALS

Staff Contact: Joy Johnson Wilson, Director, Health Committee

| PROVISION <i>(State Comparison in this Column)</i> | DINGELL (P.R. 358) SENATE DEMOCRATS (S. 6) | NORWOOD (AQCA of 1999) | BILIRAKIS (H.R. 448) |
|--|--|--|---|
| REGULATED ENTITIES | | | |
| Regulated Entities | All private health plans. | Individual plans, ERISA health plans, and non-ERISA group health plans. | All private group health plans. |
| PLAN CHOICE/ENROLLMENT PROTECTIONS | | | |
| <p>Point of Service (POS) Requirements</p> <p><i>[16 states require health plans to offer point-of-service option: Alaska, Georgia, Idaho, Indiana, Iowa, Maryland, Minnesota, Montana, New Jersey, New York, Oklahoma, Oregon, South Carolina, Tennessee (POS or PPO offering), Texas (dental plans only), and Virginia.]</i></p> | <p>Must offer POS option at time of enrollment.</p> <p>Requires the health plan, not the employer, to make the POS option.</p> <p>Employers are not required to contribute to the POS option.</p> <p>No requirement for guaranteed availability.</p> | <p>Must offer POS option at time of enrollment.</p> <p>Requires the health plan, not the employer, to make the POS option available.</p> <p>Employers are not required to contribute to the POS option.</p> <p>Providers may balance bill.</p> | <p>Subject to certain exceptions, closed-panel HMOs will be required to offer a point-of-service option in conjunction with plans that limit choice.</p> <p>Employers will be able to accept or decline the expanded choice option at the time of enrollment.</p> <p>If employers decline, the insurance company will be required to offer a point-of-service option as supplemental coverage to employees through the individual market.</p> |
| INFORMATION DISCLOSURE | | | |
| <p>Covered and Excluded Benefits</p> <p><i>34 states have enacted laws or implemented regulations related to disclosure covering a wide range of provisions.</i></p> <p><i>[23 states require the disclosure of drugs contained on formularies: Arizona, Arkansas, California, Colorado,</i></p> | Required. | Required. | Required. |

| | | | |
|--|--|---|---|
| <i>Connecticut, Florida, Georgia, Idaho, Indiana, Kansas, Kentucky, Louisiana, Maine, Michigan, Missouri, New Jersey, New York, North Carolina, Oregon, Rhode Island, Vermont, Washington, and Wyoming.]</i> | | | |
| Enrollee Financial Obligations | Required. | Required. | Required. |
| List of Health Plan Providers | The name, address, and telephone number of participating providers and an indication of whether each provider is available to accept new patients is required. | A detailed list of the names of the providers and their geographic location. | Upon request. |
| Prior Authorization/UR Process & Requirements | Required. | Required. | Upon request. |
| Grievance/Appeals and UR Process/Requirements | Required. | Required. | Required. |
| Outcomes of Grievance, Appeals, and UR Process | Information on the number of grievances and appeals and the aggregate outcomes must be available upon request. | Must disclose the number of external review cases conducted annually, how often the plan decision is upheld, and how often the plan decision is modified or overturned. | Upon request for external review. |
| Quality Indicators | Required. | Required. | Upon request. |
| Enrollee Satisfaction Data | Required. | Required. | Upon request. |
| Enrollee Utilization Data | No provision. | No provision. | No provision. |
| Provider Selection Standards | No provision. | Required. | No provision. However, enrollees may request to see credentials of providers. |
| Provider Financial Incentives/Payment Methods | Required. | Upon request. | Enrollee may request information from provider. |
| Disclosure of Utilization Criteria/Algorithms | A description of procedures used and requirements are available upon request. | Upon request, plans must disclose screening criteria, weighting elements, and computer algorithms in UR reviews and a | No provision. |

| | | description of the method by which they were developed. | |
|--|--|--|---------------|
| Data Standardization | Required. | No provision. | No provision. |
| Plan Loss Ratios | Required. | No provision. | No provision. |
| DISCRIMINATION | | | |
| Anti-Discrimination Provisions <i>[8 states have enacted legislation. In addition, HIPAA prohibits discrimination based on "health status-related" factors which includes:</i> <ul style="list-style-type: none"> • <i>Health status,</i> • <i>Medical condition,</i> • <i>Claims experience,</i> • <i>Receipt of health care,</i> • <i>Medical history,</i> • <i>Genetic information,</i> • <i>Evidence of insurability (including conditions arising out of domestic violence), and disability]</i> | Prohibits discrimination against a participant, beneficiary, or enrollee in the delivery of health care services consistent with law based on race, color, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information, or source of payment. | No provision. | No provision. |
| ACCESS | | | |
| Sufficient Number, Mix, & Distribution of Providers <i>[At least 10 states have enacted laws requiring access to sufficient numbers and types of providers without unreasonable delay.]</i> | Required. | Required. | No provision. |
| Special Rules for Underserved Areas | No provision. | Telemedicine and other innovative means may be considered. | No provision. |
| Enrollee Choice of Primary Care Provider | Permits each enrollee to receive care from any provider who is able to accept the individual. | Enrollees under network coverage must be allowed to choose personal health care professional from all participating providers and change selection in the event of a disciplinary complaint against the provider or at least every 4 months. | No provision. |

| | | | |
|--|---|--|---|
| <p>Emergency Care Access</p> <p><i>[At least 13 states require emergency care access 24 hours per day, seven days per week: California, Colorado, Georgia, Minnesota, Mississippi, Missouri, New Mexico, Nebraska, New Jersey, Ohio, Pennsylvania, Tennessee, and Virginia.]</i></p> | No provision. | No provision. | No provision. |
| <p>Standard for Specialist Access</p> | Requires access to specialty care when medically necessary. | Enrollees must have access when it is medically or clinically indicated in the professional judgment of the treating health professional. | No provision. |
| <p>Standard for Access to Specialists for Individuals with Chronic Illness</p> <p><i>[7 states allow individuals with chronic illnesses to have specialists as their primary care provider: Indiana, New Jersey, New Mexico, New York, Pennsylvania, Tennessee, and Texas.]</i></p> | Consumer with an ongoing special condition may receive a referral to a specialist who is responsible for the consumers primary and specialty care. | <p>Coordination of care or cost control programs may not create undue burden for enrollees with special health care needs or chronic conditions.</p> <p>A plan, in conjunction with enrollee and treating provider, must determine in these cases whether specialist or care coordinator appropriate to ensure continuity of care.</p> | No provision. |
| <p>Care by Obstetricians and Gynecologists</p> <p><i>**36 states require either direct access to OB/GYNs, OB/GYNs as primary care providers (PCPs), or both.</i></p> <p><i>Direct access: Arkansas, Colorado, Georgia, Illinois, Minnesota, Mississippi, Nevada, New Hampshire, New York, North Carolina, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Vermont, Virginia, and Washington.</i></p> <p><i>PCP: Florida, Indiana, Nebraska, New Jersey, and</i></p> | <p>Permits women to designate an OB/GYN as the individual's primary care provider.</p> <p>If primary care provider has been established, no authorization or referral by the individual's PCP is required for routine gynecological care.</p> | Provides for direct access to the services of OB/GYNs without the prior approval of a "gatekeeper". | Provides for direct access to the services of OB/GYNs without the prior approval of a "gatekeeper". |

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| <p><i>West Virginia.</i></p> <p><i>Both: Alabama, California, Connecticut, Delaware, Idaho, Louisiana, Maine, Maryland, Missouri, Montana, New Mexico, Oregon, and Utah.</i></p> | | | |
| <p>Direct Access to Pediatricians</p> | <p>Pediatricians may be designated as PCPs for children.</p> | <p>Allows pediatricians to be designated as the primary care physician for minors.</p> | <p>Allows families enrolled in plans that provide services to children under age 18 and that have general pediatricians participating in the plan, the ability to choose a pediatrician as their child's primary care provider.</p> |
| <p>Clinical Trials</p> | <p>Plans may not prevent enrollees from participating in clinical trials nor discriminate against them.</p> <p>Plans must cover routine costs but not costs reasonably expected to be paid for by the clinical trial sponsors.</p> | <p>No provision.</p> | <p>No provision.</p> |

CONTINUITY OF CARE

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| <p>Enrollee Protection when Provider Contract Changes</p> <p><i>[18 states have continuity of care laws that allow enrollees to see non-participating providers when they first join a plan (for certain medical conditions) or when a provider is no longer with a plan: Arkansas, California, Colorado, Florida, Indiana, Kansas, Maryland, Minnesota, Missouri, New Jersey, New York, Pennsylvania, South Carolina, Tennessee, Texas, Vermont, Virginia, and Wisconsin.]</i></p> | <p>Provides for "continuity of care" under the following conditions:</p> <ul style="list-style-type: none"> • For at least for 90 days; • For institutional care, until discharge; • For pregnancy, includes women in second or third trimester of pregnancy through post-partum care directly related to the delivery; and • For terminal illnesses, for the remainder of the individual's life. | <p>When change might disrupt continuity of care, plans must cover services furnished by the treating provider for a reasonable period of time.</p> | <p>No provision.</p> |
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EMERGENCY SERVICES

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| <p>Coverage of Evaluation and Treatment w/o Prior</p> | <p>Required, if emergency care is a covered benefit.</p> | <p>Required, if emergency care is a</p> | <p>Required if emergency care is a</p> |
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| Authorization | | covered benefit. | covered service. |
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| <p><i>[32 states require coverage: Arizona, California, Connecticut, Florida, Georgia, Hawaii, Idaho, Indiana, Kansas, Kentucky, Maine, Maryland, Michigan, Minnesota, Missouri, Montana, Nevada, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma (out-of-area only), Oregon, Pennsylvania, Tennessee, Texas, Vermont, Virginia, Washington, West Virginia, and Wisconsin.]</i></p> | | | |
| <p>Coverage of Maintenance and Post Stabilization Care</p> | <p>Required.</p> | <p>Required.</p> | <p>No provision.</p> |
| <p>Prudent Layperson Standard</p> <p><i>[29 states use "prudent layperson" as defined under the Balanced Budget Act of 1997: Arkansas, Colorado, Connecticut, Georgia, Hawaii, Idaho, Indiana, Iowa, Kentucky, Louisiana, Maine, Maryland, Michigan, Minnesota, Missouri, Nebraska, Nevada, New York, North Carolina, Ohio, Oregon, Pennsylvania, South Carolina, Tennessee, Texas, Virginia, Washington, Wisconsin, and West Virginia.</i></p> <p><i>Another four states use variations on this definition: Arizona, California, Florida, and New Mexico.]</i></p> | <p>Yes, adopts the Medicare/Medicaid standard established in the Balanced Budget Act of 1997.</p> | <p>Yes, adopts the Medicare/Medicaid standard established in the Balanced Budget Act of 1997.</p> | <p>Yes, adopts the Medicare/Medicaid standard established in the Balanced Budget Act of 1997 and adds emergency mental health provision.</p> |
| <p>Reasonable Payment Standard for Participating and Non-participating Providers</p> | <p>Must cover service in a manner that would not leave enrollee financially liable for more than they would be if the services had been provided within the network.</p> | <p>Must cover service in a manner that would not leave enrollee financially liable for more than they would be if the services had been provided within the network.</p> | <p>No provision.</p> |
| <p>MEDICAL NECESSITY</p> | | | |
| <p>Definition</p> | <p>Consistent with generally</p> | <p>No provision.</p> | <p>Plan standard.</p> |

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| | accepted principles of professional medical practice. | | |
| GRIEVANCE PROCEDURES, INTERNAL | | | |
| <p>Process</p> <p><i>[All 50 states require MCOs to have to have grievance and appeals procedures.]</i></p> | <p>Requires a system to address enrollee grievances regarding access and availability to services, quality of care, choice and accessibility of providers, network adequacy, and compliance with the requirements of this act.</p> | <p>Procedures are required for addressing adverse utilization review determinations and for other enrollee complaints of inadequate access.</p> | <p>Required upon written request by enrollee.</p> |
| <p>Timeliness Standard</p> <p><i>[At least 32 states require explicit timeframes: Alabama, Arizona, California, Colorado, Connecticut, Delaware, Florida, Illinois, Indiana, Kentucky, Maine, Maryland, Michigan, Minnesota, Missouri, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Oklahoma, Oregon, Pennsylvania, South Dakota, Tennessee, Texas, Utah, Vermont, West Virginia, and Wyoming.]</i></p> | <p>Plan must conclude each appeal as soon as possible, but no later than:</p> <ul style="list-style-type: none"> • 72 hours after time of receipt of an expedited appeal; and • 30 business days for all other appeals. <p>If circumstances occur beyond the control of the issuer, the deadline shall be extended for up to an additional 10 business days.</p> | <p>Plan must respond within 14 days after receiving all necessary information required to review decision.</p> <p>Urgent care reviews must be made within two days.</p> | <p>Emergency decisions within 72 hours.</p> <p>Urgent care decisions within 10 days.</p> <p>Internal review decisions 30 days.</p> <p>Reconsideration within 25 days of adverse decision.</p> <p>Specialty decision period 72 hours.</p> |
| <p>Professional Qualifications of Reviewers</p> <p><i>[At least 22 states address the professional qualifications of reviewers: Arizona, Arkansas, California, Connecticut, Florida, Indiana, Maryland, Missouri, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, Ohio, Rhode Island, South Dakota, Tennessee, Texas, Utah, Vermont, and West Virginia.</i></p> <p><i>Most states prohibit use of provider involved in prior decision.]</i></p> | <p>Reviewers must be a physician or other health care professional who has been selected by the plan and who has not been involved in the appealable decision.</p> | <p>A physician must conduct the reviews.</p> | <p>A physician must review the decision if it relates to medical necessity or to experimental treatments.</p> |
| <p>Ombudsman Program</p> | <p>The role of Ombudsmen is to:</p> | <p>No provision.</p> | <p>No provision.</p> |

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| | <ul style="list-style-type: none"> • must assist consumers in choosing health insurance coverage; and • provide counseling and assistance to enrollees dissatisfied with treatment by issuers in regards to coverage and respect to grievances and appeals. | | |
| <p>Written Documentation of Adverse Determinations</p> <p><i>[At least 21 states require written notification, either automatically or upon commissioner's request: Arizona, Arkansas, California, Colorado, Florida, Georgia, Illinois, Indiana, Maine, Michigan, Nevada, New Hampshire, New Jersey, New Mexico, New York, Ohio, Oregon, Tennessee, Texas, Vermont, and West Virginia.]</i></p> | <p>Requires written notification of the final determination that includes:</p> <ul style="list-style-type: none"> • information on the reason for the determination; and • how a consumer can appeal that decision to an external entity. | <p>Requires written notification (or other form of communication specified by the plan) of the final determination that includes information on the reason for the determination</p> | <p>Requires written notification of the final determination that includes:</p> <ul style="list-style-type: none"> • the decision; and • grounds for the decision. |
| <p>Maintenance of Internal Record of Process</p> <p><i>[Most states require some form of maintenance of internal record of process.]</i></p> | <p>Plans must maintain written records for at least 3 years.</p> | <p>No provision.</p> | <p>No provision.</p> |
| GRIEVANCE PROCEDURES, EXTERNAL/INDEPENDENT | | | |
| Procedures | Required when: | Requirement applies under two conditions: | Requirement applies under two |

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| <p>[Varies among 18 states that require independent review. Usually requires exhaustion of all internal review processes first: Arizona, California (experimental or investigational therapy decisions only), Colorado, Connecticut, Florida, Hawaii, Maryland, Minnesota, Michigan, New Jersey, New Mexico, New York, North Carolina (two out of three reviewers on the panel must be external), Ohio (experimental or investigational therapy decisions only), Pennsylvania, Rhode Island, Tennessee, and Vermont.]</p> | <ul style="list-style-type: none"> • The amount involved exceeds a significant threshold; or • The patient's life or health is jeopardized. <p>Plans may also condition use of the external appeals process on exhaustion of the internal appeals process.</p> | <ul style="list-style-type: none"> • The health plan does not make a timely decision during internal review of an adverse decision; or • In the case of any adverse decision that is not related to a benefit specifically excluded as a plan benefit. <p>Beneficiary must make a written request within 30 days after the adverse internal review decision.</p> <p>Decision must be made within 14 days for routine requests and 2 days for urgent requests.</p> <p>Reviewer must make written report to health plan of decision and the clinical basis for the decision.</p> | <p>conditions:</p> <ul style="list-style-type: none"> • The health plan does not make a timely decision during internal review of an adverse decision; or • In the case of any adverse decision that is based on medical necessity or experimental treatment. |
| <p>Certification of Reviewer <i>[Same as above.]</i></p> | <p>External review entity must be certified by either the state or the Department of Labor.</p> | <p>Reviewers must have "appropriate" credentials and be recognized as an expert in the applicable health care field.</p> | <p>Must be a physician or, if appropriate, another medical professional who has appropriate credentials and has attained recognized expertise in the applicable field.</p> |
| <p>Binding Process <i>[At least 10 states: Arizona, California, Connecticut, Hawaii, New York, Ohio, Pennsylvania, Rhode Island, Tennessee, and Vermont. In Maryland, the Insurance Commissioner decides if whether or not the decision is binding.]</i></p> | <p>Decision is binding on the plan or issuer.</p> | <p>The decision is binding on the health plan.</p> | <p>Decision is binding on plan. The Secretary may impose civil monetary penalties on ERISA plans.</p> |
| <p>UTILIZATION REVIEW</p> | | | |
| <p>Utilization Review (UR) Program</p> | <p>Required.</p> | <p>Required.</p> | <p>Required.</p> |
| <p>Applicable Standards</p> | <p>Plans must utilize written clinical review criteria</p> | <p>Plans must uniformly apply review criteria.</p> | <p>No provision.</p> |

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| | developed with the input of appropriate physicians. | | |
| Enrollee or Provider Input | Requires physician input. | Required. | No provision. |
| Reviewer of Professional Standards | Reviewer must be a physician or other health care provider. | Must disclose, upon request, the names and credentials of individuals conducting utilization review. | A physician must review decisions if it relates to medical necessity or to experimental treatments. |
| Timeliness Standard | <p>Prior authorization within 3 business days.</p> <p>Continuation of care within 1 business day.</p> <p>Retrospective review within 30 days.</p> | <p>Must provide "timely" access to UR personnel.</p> <p>Prior authorization requirements are waived when access to UR personnel is not "timely" (as defined by the applicable state authority).</p> <p>Requests for benefit payments or advance determination of coverage must be answered within 7 days.</p> <p>Failure to issue a decision will be construed as an adverse decision.</p> | <p>Emergency decisions within 72 hours.</p> <p>Urgent care decisions within 10 days.</p> <p>Specialty decision period 72 hours.</p> |
| Consistency Standard | Must be conducted consistent with written policy and procedures. | Requires uniform application of review criteria. | No provision. |
| Notice or Documentation of UR Decisions | <p>Notices of determination must include:</p> <ul style="list-style-type: none"> • an explanation of the basis of the determination, • how to initiate an appeal, and • upon request, the availability of the clinical review criteria used in determination. | Notices of determination must include an explanation of the basis of the determination and any rights of review. | Initial coverage decision must be issued in writing. |
| Other Patient/Provider Protections | Favorable prior authorization determination must be treated as final for payment purposes. | No provision. | No provision. |
| QUALITY ASSURANCE PROGRAM | | | |
| Requirements | Plans must: | Health plans must establish a "quality | No provision. |

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| <p><i>[22 states have laws or regulations requiring quality assurance programs.]</i></p> | <ul style="list-style-type: none"> • have a separate, identifiable unit with responsibility for administration; • have a written plan for the program that is updated annually; and • provide for systematic review of the type of health services provided, consistency of services provided with good medical practice, and patient outcomes. | <p>assessment program" that assesses:</p> <ul style="list-style-type: none"> • Enrollee health status, patient outcomes, processes of care, and enrollee satisfaction; and • The administrative and funding capacity of the plan to support and emphasize preventive care, utilization, access and availability, cost effectiveness, acceptable treatment modalities, specialists referrals, the peer review process, and the efficiency of the administrative process. | |
| <p>Data Collection</p> | <p>Required.</p> | <p>Plans must analyze quality assessment data to determine specific interactions in the delivery system that have an adverse impact on the quality of care.</p> | <p>No provision.</p> |
| <p>Advisory Board</p> | <p>The Advisory Board must:</p> <ul style="list-style-type: none"> • Provide information to Congress and the Administration on issues relating to quality monitoring and improvement in the health care provided under group health plans; • Identify, update, and disseminate measures of health care quality for plans and issuers, including network and non-network plans; • Advise the Secretary on the development and maintenance of the minimum data; | <p>No provision.</p> | <p>No provision.</p> |

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| | <ul style="list-style-type: none"> and • Advise the Secretary on standardized formats for information on group health plans. | | |
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PRIVACY AND CONFIDENTIALITY

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| <p>Safeguards for Individually Identifiable Information</p> <p><i>[Most states have laws on privacy and confidentiality but they vary considerably.]</i></p> | <p>Plans must:</p> <ul style="list-style-type: none"> • Establish procedures to safe-guard the privacy of individually identifiable enrollee information; • Maintain such records and information in a manner that is accurate and timely; and • Assure timely access of such individuals to such records and information. | <p>Plans must establish procedures for compliance with state and federal laws.</p> | <p>Requires providers, plans and employers to develop safeguards to protect the confidentiality of medical information.</p> <p>Allows patients access to their medical records to view, copy, and amend by addition.</p> <p>Requires providers, plans and employers to disclose their confidentiality policies to patients, enrollees, and employees.</p> <p>Encourages health researchers to use non-identifiable information by preempting state laws.</p> <p>Permits providers and plans to use information within their network for certain defined purposes, including outcomes evaluation, health promotion, and utilization review.</p> |
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PROTECTIONS RELATED TO COVERED BENEFITS

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| <p>Mandated Benefit Coverage</p> | <p>Direct access to OB/GYNs and pediatricians.</p> <p>Mastectomy length of stay.</p> | <p>Direct access to OB/GYNs and pediatricians.</p> | <p>Direct access to OB/GYNs and pediatricians as primary care providers.</p> |
| <p>Drug Formularies</p> | <p>Plans must disclose whether a formulary is used and, if</p> | <p>Plans must provide a description of the</p> | <p>Plans must provide a description of the</p> |

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| <p><i>[11 states require plans to disclose the formulary list: Arizona, California, Florida, Idaho, Kansas, Kentucky, Michigan (upon enrollee request), New Jersey, New York, Rhode Island, and Wyoming. Eleven states require disclosure and the procedure to obtain non-formulary drugs: Arkansas, California, Connecticut, Georgia, Indiana, Louisiana, Maine, Missouri, North Carolina, Oregon, Vermont (by administrative rule), and Washington. Ohio requires plans to establish a procedure by which an enrollee may obtain a non-formulary drug, but does not require disclosure of the drugs on the formulary.]</i></p> | <p>so, how decisions are made regarding the inclusion of drugs, and provide for exceptions from formulary limitation when a non-formulary alternative is medically indicated.</p> | <p>extent to which covered benefits are determined by the use of a drug formulary and the process for determining what is included on the formulary.</p> <p>Plans must give at least 30 days notice when excluding a specific drug from the formulary that is used in the treatment of a chronic illness or disease.</p> | <p>extent to which covered benefits are determined by the use of a drug formulary and the process for determining what is included on the formulary.</p> <p>Plans must give at least 30 days notice when excluding a specific drug from the formulary that is used in the treatment of a chronic illness or disease.</p> |
| <p>Mastectomy Length of Stay</p> <p><i>[18 states require a minimum length of stay following a mastectomy: Arkansas, California, Connecticut, Florida, Illinois, Kentucky, Maine, Montana, New Jersey, New Mexico, New York, North Carolina, Oklahoma, Pennsylvania, Rhode Island, South Carolina, Texas, and Virginia.]</i></p> | <p>Inpatient length of stay following a mastectomy must be determined by the attending physician.</p> | <p>No provision.</p> | <p>No provision.</p> |
| <p>Balanced Billing Limits for Out of Network Services</p> | <p>Prohibits balanced billing for emergency out-of-network services.</p> | <p>Prohibits balanced billing for emergency out-of-network services.</p> | <p>For emergency care out-of-network, usually limited to standard cost-sharing arrangement.</p> <p>For other out-of-network services, depends on type of managed care plan.</p> |
| <p>ANTI-GAG RULE</p> | | | |
| <p>Medical Communications Between Patient and Provider</p> | <p>The plan may not prohibit communications on health status, medical care,</p> | <p>A health insurance issuer may not prohibit or restrict a</p> | <p>Prohibits health plans from restricting physicians from</p> |

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| <p><i>[44 states ban the use of "gag clauses." The following states have not enacted laws: Alabama, Hawaii, Illinois, Mississippi, South Carolina, and South Dakota.]</i></p> | <p>treatment options, any UR requirements that may affect treatment options or any financial incentives that may affect the treatment of the patient.</p> | <p>health care professional from advising a patient about the health status of the individual or medical care or treatment for the patient's condition or disease, regardless of whether benefits for such care or treatment are provided under the coverage if the professional is acting within the lawful scope of practice (consistent with Medicare language in BBA).</p> | <p>giving advice to a patient about his or her health status, or the medical care or treatment for the condition or disease of that patient, regardless of whether benefits of the care or treatment is provided under the terms of the patient's health benefit plan.</p> |
| <p>Exceptions Based on Religious or Moral Considerations</p> | <p>No provision.</p> | <p>Plans are <u>not</u> required to provide, reimburse for, or provide coverage of a counseling or referral service if the plan objects to the provision of the service on moral or religious grounds.</p> | <p>No provision.</p> |

PROVIDER PROTECTIONS

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| <p>Provider Incentive Plans</p> <p><i>[21 states ban the use of financial incentives between managed care plans and providers: Alaska, California, Florida, Georgia, Idaho, Illinois, Kansas, Louisiana, Maryland, Missouri, Montana, Nebraska, Nevada, New Jersey, New Mexico, Ohio, Pennsylvania, Rhode Island, Texas, Vermont, and West Virginia.]</i></p> | <p>Prohibits provider incentive plans as defined by the 1997 BBA.</p> | <p>Prohibited unless: (1) payments are not made as inducement to restrict medically necessary services; (2) the plan puts provider at substantial financial risk; and (3) the plan provides stop-loss protection.</p> <p>The plan must provide the state or the Secretary with sufficient information to determine whether the incentive plan is acceptable.</p> | <p>No provision.</p> |
| <p>Anti-Discrimination</p> | <p>Prohibits discrimination in provider selection on basis of race, color, origin, religion, gender, age, disability, or sexual orientation.</p> <p>Prohibits discrimination in participation, reimbursement, or indemnification against health professional solely on basis of professional's license or certification under</p> | <p>No provision.</p> | <p>No provision.</p> |

| | applicable state law. | | |
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| <p>Provider Contracting</p> <p><i>[25 states have laws regarding provider contracting and termination rules: Alaska, Arkansas, California, Colorado, Connecticut, Florida, Idaho, Indiana, Louisiana, Maine, Maryland, Michigan, Mississippi, Missouri, Montana, Nevada, New Jersey, New York, Ohio, Oklahoma, Oregon, Rhode Island, Texas, Vermont, and Virginia.]</i></p> | <p>Prohibits plans from transferring liability to providers.</p> | <p>Plans must provide reasonable notice of decision to terminate provider for cause, an opportunity to review reasons behind the termination, and an opportunity to enter into corrective action plan before the termination becomes subject to appeal.</p> <p>Plans are <u>not</u> required to renew a contract with a participating provider.</p> | <p>No provision.</p> |
| <p>Provider Application/Participation Requirements</p> <p><i>[22 states have AWP laws. Five of those apply to physicians and the remainder applies primarily to pharmacies or pharmacists: Alabama, Connecticut, Delaware, Florida, Georgia (broad; BC/BS plans only), Idaho (broad), Illinois (non-institutional providers), Indiana (broad), Kentucky (broad), Massachusetts, Minnesota (independent health care providers), Mississippi, New Hampshire, New Jersey, North Carolina, North Dakota, South Carolina, South Dakota, Tennessee (pharmacy), Texas, Wisconsin, and Wyoming (broad). In addition, at least five other states have "opportunity to apply" laws, which allow providers to apply for inclusion on an MCOs panel but does require the MCO to accept all qualified providers: California, Georgia, Montana, Oregon, and Texas.]</i></p> | <p>Plans must provide:</p> <ul style="list-style-type: none"> • Notice of the rules regarding participation; • Written notice of participation decisions adverse to providers; and • A process within the plan for appealing adverse decisions. | <p>Plans must allow all providers to apply for participation at least annually, provide reasonable notice of the application period, provide for review of applications by a committee, appropriately representing types of providers, and select providers based on objective standards.</p> <p>When economic considerations are used in the selection process, plans must apply them objectively, adjust any economic profiling to account for patient characteristics that could result in atypical service utilization, and disclose profiling results.</p> <ul style="list-style-type: none"> • Plans must offer providers an opportunity to review/correct information related to nonselection, and to appeal all adverse determinations. | <p>No provision.</p> |

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| <p>Payment Timeliness Standard</p> <p>**18 states require plans to pay claims to providers within a certain timeframe ranging from 30 to 60 days.</p> <p><i>[Alabama (45 days), Arkansas (55), California (45), Colorado (60), Connecticut (45), Florida (45), Maryland (30), Mississippi (45), Missouri (45), Montana (30), Nevada (30), New Jersey (60), New York (45), Oklahoma (30), Pennsylvania (45), Texas (45), Vermont (45), and Wyoming (45).]</i></p> | <p>No provision.</p> | <p>No provision.</p> | <p>No provision.</p> |
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MINIMUM SOLVENCY REQUIREMENTS

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| <p>Provisions</p> <p><i>[All 50 states have solvency requirements for health plans.]</i></p> | <p>No provision.</p> | <p>Insurers must meet applicable state solvency requirements and establish mechanisms required by the state to protect enrollees and health care providers from insurer failure.</p> | <p>No provision.</p> |
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INSURER LIABILITY

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| <p>Provision</p> <p><i>[Texas and Missouri have enacted insurer liability laws. The Texas law allows personal injury or wrongful death claims to be brought in State court against insurers. In Missouri, the corporate medicine law was repealed which may open health plans up to medical malpractice claims.]</i></p> | <p>Amends ERISA to allow a cause of action for personal injury or wrongful death to be brought in State court against insurers or third party administrators.</p> <p>Exempts employers from liability as long as employers do not make claims decisions.</p> | <p>Amends ERISA to allow a cause of action for personal injury or wrongful death to be brought in State court against insurers or third party administrators.</p> <p>Allows direct access to courts for equitable relief before final administrative remedies have been attained if a physician determines that exhaustion of administrative remedies would result in undue risk of irreparable harm for the enrollee.</p> | <p>No provision.</p> |
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ENFORCEMENT

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| <p>Provision</p> | <p>Coordinated regulatory effort by HHS, DOL, and</p> | <p>Coordinated regulatory effort by</p> | <p>Coordinated regulatory effort by</p> |
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| <i>[Usually the Department or Division of Insurance. The Department of Corporations regulates HMOs in California.]</i> | the Department of Treasury for areas not related to state authority over insurance. | HHS, DOL, and the Department of Treasury for areas not related to state authority over insurance. | HHS, Department of Treasury, and DOL for areas not related to state authority over insurance. |
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MEDICAL SAVINGS ACCOUNTS (MSA)

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| <p>Provision</p> <p><i>[27 states have enacted legislation authorizing the establishment of Medical Savings Accounts (MSAs): Arizona, Arkansas, California, Colorado, Florida, Idaho, Illinois, Indiana, Kansas, Louisiana, Maryland, Michigan, Minnesota, Missouri, Mississippi, Montana, New Jersey, New Mexico, Nevada, Ohio, Oklahoma, Oregon, Pennsylvania, Utah, Washington, West Virginia, and Wisconsin. The provisions vary widely among the states. Several states made changes in their laws to comply with the MSA provisions in the Health Insurance Portability and Accountability Act of 1996 (HIPAA)]</i></p> | No provision. | No provision. | <p>Allows both employers and employees to make contributions to a MSA.</p> <p>Lowers the deductible floor from \$1,500 to \$1,000 for individuals and from \$3,000 to \$2,000 for families.</p> <p>Allows MSA deposits up to the amount of the deductible.</p> <p>Makes MSAs an option in cafeteria plans.</p> |
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CAFETERIA PLANS/FLEXIBLE SPENDING ACCOUNTS

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| Provision | No provision. | No provision. | No provision. |
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PROVIDER LIABILITY

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| Provision | Prohibits plans from transferring liability to providers. | No provision. | No provision. |
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ASSOCIATION HEALTH PLANS/MEWAS

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| Provision | No provision. | No provision. | <p>Permits small employers to create groups to purchase health insurance.</p> <p>Similar to Multiple Employer Welfare Associations (MEWAs), but permits additional</p> |
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