Hit *and* Miss:

State Managed Care Laws

A REPORT BY

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INTRODUCTION

The way most Americans obtain and pay for health care has altered dramatically over the past few years. A decade ago, fewer than three out of ten people with health insurance coverage were in managed care plans—health maintenance organizations (HMOs), preferred provider organizations (PPOs), and point-of-service (POS) plans. Today, more than three out of four people are in such managed care plans.

The origins of managed care lie in efforts to improve access to preventive, primary, and coordinated care. More recently, purchasers of health coverage have turned to managed care in response to health care costs that were spiraling out of control. The traditional fee-for-service system offered powerful incentives to provide more and more costly diagnostic tests, health procedures, and lengthy hospitalizations—even when such health services were of questionable benefit to patients. Managed care plans, on the other hand, are designed to control health care utilization and to curb unnecessary and inappropriate care.

While it appears that managed care has succeeded in slowing the increase in health care costs, this change has been quite unsettling for consumers. Many fear that the reversal of economic incentives will result in the denial of needed and appropriate care. Those fears are reinforced by stories of a significant number of people who have already experienced problems, ranging in severity from time-consuming bureaucratic red tape to life-threatening denials of care.

A growing number of Americans believe that managed care plans are withholding needed care. A recent survey by The Henry J. Kaiser Family Foundation and Harvard University's School of Public Health found that a majority of Americans believe managed care plans make it harder for sick people to see medical specialists. Over half of those surveyed say managed care has hurt the quality of care for people who are sick. And, in one of the most troublesome

findings, a majority of the public (55 percent) are at least "somewhat worried" that, if they are sick, their "health plan would be more concerned about saving money than about what is the best medical treatment" (see box below).

PERCENT OF AMERICANS WHO SAY DURING THE PAST FEW YEARS HMOs AND OTHER MANAGED CARE PLANS HAVE . . .

Decreased the amount of time doctors spend with patients:	61%
Made it harder for the sick to see medical specialists:	59%
Decreased the quality of health care for the sick:	51%
Decreased the quality of health care for patients:	45%

Source: The Henry J. Kaiser Family Foundation, *Kaiser/Harvard National Survey of Americans' Views on Managed Care*, November 5, 1997.

Hit *and* Miss

Increasingly, states have taken aim at the problems that have so alarmed managed care consumers. Virtually all states have, by now, adopted one or more laws addressing different specific consumer concerns. These laws run the gamut from laws increasing consumer access to services (e.g., emergency care, prescription drugs, specialists), to laws prohibiting the use of incentives that encourage physicians to deny care, to laws assuring consumer rights in the case of disputes. To varying degrees, each of these laws hits the mark, providing consumers needed reassurance.

Unfortunately for consumers who are in need of protection, there are more misses than hits: managed care consumers still cannot count on basic protections. From state to state there is little consistency in managed care consumer protections. Some states have enacted only one or two protections—for example, the prohibition of so-called provider "gag rules" or the guarantee for women that they have direct access to obstetricians and gynecologists. Few states have established comprehensive protections for managed care enrollees.

Even in states that have enacted strong consumer protection laws, these laws do not apply to a large number of their residents. As a result of the federal Employee Retirement Income Security Act (ERISA) of 1974, some 51 million

Americans—those receiving health coverage from an employer who "self-insures"—are exempted from the managed care patient protections established by state law. Moreover, the vast majority of people who receive their health coverage through a private sector employer—approximately 124 million Americans—are prevented by the ERISA statute from securing a remedy under state law when a managed care plan improperly delays or denies needed health care.

This Report

This report looks at common problems experienced by managed care consumers and the relevant consumer protections enacted by the states as of June 1998. For most of these consumer protections, examples of especially good state laws and/or regulations are highlighted. The report then focuses on an illustrative sampling of 13 of these consumer protections and looks at which states have legislation for each of them.

The 13 areas selected for special analysis in this report were chosen for a combination of reasons. First, they are important rights to help ensure that health plan enrollees get the care promised by their plans. Second, these rights are sufficiently specific and understandable that consumers can assess their significance. And third, these rights provide good illustrations of the diverse state-by-state approaches to regulating managed care. These 13 protections are:

- the right to go to an emergency room, and have the managed care plan pay for resulting care, if a person reasonably believes he or she is experiencing an emergency;
- the right to receive health care from an out-of-network provider when the health plan's network of providers is inadequate;
- the right of a person with a serious illness or disability to use a specialist as a primary care provider;
- the right of a seriously ill person to receive standing referrals to health specialists;
- a woman's right to gain direct access to an obstetrician or gynecologist;
- the right of a seriously ill patient or a pregnant woman to continue receiving health care for a specified period of time from a physician who has been dropped by the health plan;

- the establishment of a procedure that enables a patient to obtain specific prescription drugs that are not on a health plan's drug formulary;
- the right to appeal denials of care through a review process that is external to, and independent of, health plans;
- the establishment of consumer assistance, or ombudsman, programs;
- prohibitions against plans' use of so-called "gag rules"—rules that prevent physicians and health providers from fully disclosing treatment options to patients;
- prohibitions against plans' reliance on inappropriate financial incentives to deny or reduce necessary health care;
- the establishment of state laws that prevent plans from prohibiting participation in clinical trials; and
- the establishment of state laws enabling enrollees to sue their health plans when they improperly deny care.

The report provides data on the number of people in each state who are in ERISA plans and are unable to secure the remedies established by state laws for people who have experienced wrongful delays or denials of health care. The report concludes with background information about other types of rights that states are considering.

Key Findings

As of June 1998, the following is a survey of the consumer protection laws in effect for managed care enrollees:

- No state has passed a series of laws addressing all 13 of the sampling of protections listed above.
- Vermont has enacted the greatest number of those protections (11), and South Dakota the fewest (none). Vermont is the only state that has adopted ten or more of those protections and South Dakota is the only state to have established none.
- Sixteen states have enacted between five and nine of these protections.
- Thirty-three states have enacted from one to four of these protections.
- Approximately one-third of Americans with employer-provided health care, approximately 51 million persons, are in "self-insured" plans and are preempted from patient protections established by state laws.

- Of those who have health insurance provided by their employer, 83 percent (approximately 124 million Americans) are preempted under ERISA from seeking state-prescribed remedies for wrongful denials of care—and these individuals are bereft of meaningful federal remedies as well.

SECTION II
HITTING THE TARGET:
STATE CONSUMER PROTECTION LAWS

Emergency Room Services

THE ISSUE: In an effort to curb the inappropriate use of hospital emergency rooms for routine health care, many managed care plans have instituted policies regulating emergency room care. Such policies, while effective in discouraging inappropriate use of emergency rooms, can also discourage *appropriate* use. What is more, they can delay needed care.

Some health plans require members to obtain approval from the plan before they receive emergency care. These prior authorization requirements are, at best, a burden on someone who is ill and, at worst, the cause of potentially dangerous delay for someone who needs immediate medical attention. A person having a heart attack should get to the hospital as quickly as possible, without stopping first to find a telephone and call his or her health plan for authorization of treatment.

Plans also may refuse to pay for an emergency room visit unless the condition turns out to be a genuine emergency. But only a trained professional can determine what is, and what is not, an emergency. Are chest pains caused by a heart attack or by indigestion? Does abdominal pain with a fever and vomiting signal appendicitis or a virus? Consumers who fear that they will have to pay a large emergency room bill themselves if they guess wrong may decide to forgo care—possibly complicating their condition or even threatening their lives.

Once an emergency room patient is stabilized, he or she may require hospitalization or further treatment. Many health plans require approval before

that patient can be treated further. Emergency room physicians have to contact the health plan directly to get approval for post-stabilization care. Emergency room physicians have reported that managed care plans are often unresponsive to their requests for continuing care. They have been unable to reach plan personnel with authority to approve a hospital admission or additional treatment.[1]

STATE LEGISLATION: To clear up the confusion about emergency room coverage, to ensure that consumers use the emergency room during critical and life-threatening situations, and to make it possible for emergency patients to receive continued care post-stabilization, states have passed a variety of laws related to emergency room access.

Prudent Layperson - More than three-fifths of the states have passed laws requiring health plans to pay for emergency care based on a "prudent layperson" standard. This standard is met when a "prudent" or "reasonable" layperson, with an average knowledge of medical care, is experiencing the sudden onset of symptoms (including pain) so severe that he or she could reasonably believe his or her health would be in serious jeopardy without medical treatment. With this law in place, enrollees who reasonably believe their life or their health to be in serious and immediate danger can go to an emergency room and know that their health plans are required to cover screening and needed care. Georgia's statute is exemplary of the prudent layperson legislation enacted in many states.

Some states have passed legislation prohibiting health plans from requiring members to get a prior authorization before emergency care is provided. Although prohibition of prior authorization is an important consumer protection, the prudent layperson standard encompasses this requirement and goes further.

Continued Post-Stabilization Care in the Emergency Room - Some states require that plan personnel be available 24 hours a day to handle requests for continued care following stabilization of the patient. Some states require plans to respond to all requests within a specified time period or the request for continued care will be automatically approved. Arizona's law, for example, establishes a procedure for ensuring that emergency patients receive follow-up care. Texas, which contains a strong protection, goes further: Texas requires plans to have a procedure for ensuring follow-up specialty care in a hospital emergency department. In Texas, approval or denial of care must occur within an

appropriate time, but in no case should the decision take more than one hour.

Access to Providers

THE ISSUE: The cornerstone of managed care is the requirement that all care be coordinated by a primary care "gatekeeper" who makes referrals to specialists when appropriate. Ideally, the gatekeeper system controls costs by eliminating unnecessary care while simultaneously ensuing that all necessary care, including preventive care, is provided. For this to happen, health plans must have a network of primary care physicians and specialists who are conveniently located, accepting new patients, able to address consumers' health care needs, and available 24 hours a day. When plans lack experienced, accessible providers with suitable expertise to meet the specific health care needs of their patients, those plans should refer members to outside specialists. And, finally, plans must have internal procedures that give consumers reasonable access to specialists within the plan.

Managed care does not always live up to this potential. Consumers may find that their plan has too few physicians in a particular specialty area or that specialists are not easily accessible. Enrollees with chronic conditions requiring regular attention from a specialist have been forced to get a referral from their primary care doctor for every visit to the specialist. This is not only inconvenient for the affected enrollees, but it also adds unnecessary costs. People who have complicated chronic illnesses or disabling conditions may fare better when a specialist familiar with their condition acts as their primary care provider, but plans often refuse to permit specialists to serve as primary care providers. A recent University of Maryland study showed that most women (57 percent) received their general medical examinations from OB-GYNs,[2] yet many women in managed care plans cannot easily do this. Women who prefer to go to their obstetrician or gynecologist instead of their family physician or internist for their annual examination have to first go to their primary care provider, which means an extra appointment and more time. Managed care enrollees who suffer from rare or especially complicated conditions have been denied referrals to physicians with unique expertise in their condition or to "centers of excellence" with good track records in treating their conditions if those providers are not part of the plans' network.

STATE LEGISLATION: In an effort to improve patient access to providers, states have enacted a number of consumer protections requiring plans to have adequate networks of providers, to refer outside the plan when they don't, and to ease access to specialty care.

Adequacy of Provider Network - Some states have passed laws that require plans to have sufficient providers or allow enrollees to go out-of-network for their health care. While some states have adopted vague language requiring plans to provide reasonable access, Maine is an example of a state that goes further. Maine regulations require plans to obtain the state's approval of a detailed plan for how they will ensure adequate access to providers for plan members; failure to fully implement this plan is grounds for suspension or revocation of the plan's certificate of authority. Plans must also report to the state within 10 days the net loss of five or more primary care physicians in any county in any 30-day period. The access plan must include: the health plan's current and projected annual enrollment by county; a full description of the proposed provider network; a description of the HMO's physician and health professional recruitment plan; and a description of the HMO's plan for providing services for rural and underserved populations and for developing relationships with essential community providers.

Referral to Out-of-Network Providers - Nearly one-third of the states have passed laws that explicitly require health plans to refer outside of the plan's network when the plan does not have accessible and appropriate network providers available to meet an enrollee's medical needs. States may have qualifications on the payment amount or on who must approve the referral. Colorado provides a good example of a state law that requires plans to make referrals to out-of-network providers when the network is insufficient. Colorado also requires that the individual shall pay no more than he or she would have to pay if the provider were a member of the network.

Specialists Can Be Primary Care Providers under Specified Circumstances - One out of five sates has enacted laws requiring plans to allow enrollees with chronic, disabling, or life-threatening conditions to use specialists as their primary care provider. This protection not only makes it easier for enrollees with disabilities or chronic conditions to see their specialty provider, it also reduces the number of unnecessary visits to the primary care provider. New York has a strong law requiring that such referral be part of a treatment plan. The New York

law requires plans to have a procedure in place to allow enrollees with life-threatening or disabling conditions to be referred to a specialist for primary and specialty care. This specialist can authorize referrals, procedures, tests, and other medical services.

Standing Referrals to Specialists - Almost one out of four states has passed laws requiring managed care plans, when appropriate, to allow a primary care provider to authorize a referral to a specialist for more than one visit without having to obtain the plan's approval for subsequent visits. Ohio law provides a good example: Ohio requires that a procedure be established so a primary care provider, in consultation with a specialist, can allow an individual continuing access to the specialist pursuant to an approved treatment plan.

Direct Access to Qualified Specialists for Women's Health Services - Three out of five states have passed laws allowing women at least limited direct access to an obstetrician-gynecologist (ob-gyn) without first obtaining a referral from a primary care physician. While the state laws vary, each gives women direct access to ob-gyns or other women's health providers, such as nurse midwives, for their annual visit. Some of these laws require plans to permit qualified ob-gyns to serve as primary care physicians; others allow unlimited access, or access for routine gynecological and pregnancy services only, without a referral. Alabama's law is among the strongest because it both allows a woman to choose an ob-gyn as a primary care physician and allows women to have direct access to the services of a participating ob-gyn with no limits. A few other states, including New Mexico, allow direct access, although with some limitations, to a wider range of women's health providers.

Continuity of Care

THE ISSUE: When a health plan drops an individual physician from its network of providers, that physician's patients will have to find a new doctor. Similarly, when an employer switches to a new health plan that does not include the same providers as the old plan, employees may no longer be allowed to see their doctor. Although changing providers may cause only inconvenience for some, a sudden involuntary change of providers can have damaging medical and psychological repercussions for persons undergoing care for a chronic or disabling condition, in the midst of a life-threatening illness, or in the middle of pregnancy.

A cancer patient in the early stages of radiation or chemotherapy, a woman who is five months into a difficult pregnancy, a child with complicated sickle cell disease who is experiencing a crisis—all could be severely harmed if their treatments were interrupted because they could no longer see the same physicians.

STATE LEGISLATION: To assure that patients who are undergoing a continuous course of treatment do not have that treatment unnecessarily interrupted, some states have adopted laws promoting continuity of care.

When a Physician Leaves the Plan - More than one-fourth of the states have passed laws requiring plans to continue paying for treatment provided by primary care or specialty providers whose contracts are not renewed for reasons other than quality of care. These laws usually apply where continuity of care is medically necessary for enrollees with life-threatening diseases or conditions, degenerative and disabling diseases or conditions, or acute conditions. Most of these state laws specify a minimum number of days plans must provide such transitional care. Tennessee's law requires the longest transitional care period: 180 days. In addition, some laws require plans to continue paying for care for pregnant women from their second or third trimester of pregnancy through post-partum care. New York requires that women in their second trimester be allowed to continue through the pregancy and post-partum care with a doctor who has left a plan.

When an Individual Joins a New Plan - A few states require plans to permit new enrollees to continue seeing their previous providers for up to 60 days if the enrollees have a life-threatening, degenerative, or disabling disease or condition or an acute condition. A few states allow a pregnant woman to continue seeing her doctor. New York is an example of a state that requires plans to continue to pay a provider for 60 days and, for pregnant women, from their second trimester through post-partum care.

Prescription Drugs

THE ISSUE: Managed care plans often use formularies—a list of specific prescription drugs approved for use by the plan—to determine which drugs their physicians can prescribe. In 1995, nearly 80 percent of managed care plans had established formularies.[3] In an "open formulary," the plan will pay for prescription drugs that are not on the formulary, although patients may have to pay an extra

copayment or the plan may offer incentives to encourage doctors and pharmacists to prescribe and dispense drugs that are on the formulary. If the plan has a "closed formulary," only a select number of drugs in each therapeutic class will be covered; physicians must prescribe from this list. Sometimes a plan with a closed formulary will pay for a non-formulary drug, but prior approval must be given.

The use of formularies *per se* is not a problem. Properly implemented, they can result in more efficient, less costly care. The problem lies in the restrictive nature of many formularies and the difficulty managed care enrollees may have in obtaining non-formulary drugs. All drugs used to treat a specific condition are not chemically identical and, as a result, they can differ in their success in treating particular problems. Patients may also tolerate a particular drug but react badly to another. They may have an allergic reaction to a certain drug or that drug may harmfully interact with other prescriptions, while similar drugs will avoid such damaging reactions. As a result, one drug cannot necessarily be substituted freely for others in the same class. Often, drug formularies include only one or two anti-depressant drugs, although the effectiveness of these drugs varies dramatically with individual patients.[4] According to the *New York Times*, "medical journals have . . . reported problems when drugs were switched for migraine headaches, thyroid conditions and epilepsy."[5] Consumers must be assured that their doctors can prescribe effective medication—even if the medication is not on the plan's formulary—and that their prescription benefits will cover non-formulary prescription drugs when necessary.

STATE LEGISLATION: In an effort to improve consumer access to needed drugs, a few states have passed legislation requiring health plans to allow access to non-formulary prescription drugs in specific circumstances.

Access to Non-Formulary Prescription Drugs - Nearly one out of six states has passed laws requiring plans to allow enrollees to obtain non-formulary prescription drugs without financial penalty when the formulary equivalent is ineffective or when the formulary drug causes, or could reasonably be expected to cause, an adverse or harmful reaction. Arkansas provides an illustration of this approach. State law requires that every plan have a procedure for enrollees to obtain non-formulary drugs when they meet the following criteria: "(1) the formulary's equivalent has been ineffective in the treatment of the covered

person's disease or condition; or (2) the formulary's drug causes or is reasonably expected to cause adverse or harmful reactions in the covered person."[6]

Appeals Procedures

THE ISSUE: Consumer satisfaction in any setting requires a prompt and fair process for resolving the disputes that inevitably arise. This is especially true for health care consumers, who may believe that their health or even their life depends on the resolution of the dispute. Managed care plans, as well, stand to gain from the dispute resolution process, which can alert plans to problems, such as confusing information in membership materials or poor communications between some providers and patients.

Too often, however, appeals procedures are inadequate. Enrollees may be unaware of their rights and plans may fail to inform them in writing that they can appeal. The appeals process may be cumbersome and take weeks, if not months, to reach resolution. An overly long appeals process can discourage enrollees from even bothering to appeal and, for those with urgent medical concerns requiring speedy treatment, can endanger their health or their lives. There may not be experts with appropriate knowledge of the issues at hand participating in the decision-making process. And finally, because one party to the dispute—the health plan— oversees the internal appeals process, consumers may not have confidence in the fairness of the process unless they have recourse to an independent review of the plan's decision if their appeal is denied.

STATE LEGISLATION: States have taken a number of steps to establish appeal rights for patients wishing to contest denials, delays, and reductions of care as well as health plan refusals to pay for care.

Explicit Time Frames for Internal Plan Appeals for Non-Urgent Care - While some state laws have vague language requiring plans to develop an appeals process, other states go further and establish a specific time frame for decisions on appeals. Some of the laws establish long appeals time frames or allow decisions to be made on explicit time frames after all paperwork regarding the appeal has been received. The more protective laws require plans to respond to appeals for non-urgent care within a specified time frame, such as 30 days. Texas requires that the total time for acknowledgment, investigation, and resolution of the complaint by a health maintenance organization (HMO) not exceed 30

calendar days after the date the HMO receives the complaint.

Expedited Review for Emergency and Urgent Care Situations - Most states have passed laws that require health plans to have an expedited appeals process for emergency and urgent care situations. States vary in the specificity of their time frames. Some vaguely refer to the need for expedited review. Others require plans to respond to urgent care appeals within two business days or 72 hours. Nevada is an example of a state that requires the review board to notify the enrollee of the decision, in writing, within 72 hours after the complaint is filed. Maryland has the shortest time frame—requiring decisions within 24 hours.

Oral Complaints/Requests for Assistance Concerning Denials, Reductions, and Terminations of Care Trigger the Appeals Process - Some states have passed laws requiring plans to treat oral complaints regarding denials, reductions, and terminations of care as triggers of the appeals process. Other states require plans to have a procedure to accept oral complaints, but only for expedited appeals. Indiana's law is strong: In Indiana, an HMO must make available to enrollees and subscribers a toll-free telephone number through which grievances are filed. The toll-free number must:

- be staffed by a qualified representative of the health maintenance organization;
- be available for at least 40 normal business hours per week; and
- accept grievances in the languages of the major population groups served.

A grievance is considered to be filed on the first date it is received, either by telephone or in writing.[7]

Internal Review Made by Clinical Peers Who Were Not Associated with the Original Decision - To reduce any biases on the part of the health plan during the appeals process, some states have passed laws requiring that reviewers be medical doctors who: (1) have expertise in the clinical area being reviewed, and (2) were *not* involved in the original decision resulting in the appeal. Virginia's law is very detailed on this subject: A physician advisor who reviews cases under appeal in Virginia must be a peer of the treating health care provider, must be board-certified or board-eligible, and must be specialized in a discipline pertinent to the issue under review. A physician advisor or peer of the treating health care provider who renders a decision on appeal in Virginia shall:

- not have participated in the adverse decision or any prior reconsideration thereof;
- not be employed by or a director of the utilization review entity; and
- be licensed to practice in Virginia, or under a comparable licensing law of a state of the United States, as a peer of the treating health care provider.[8]

Denial Notices - Most states require plans to provide written notice when a service is denied, reduced, or terminated. The notice must include the reason(s) for the denial of care and provide information on how to appeal the decision. Maine clearly lays out the required contents of such a notice, which must include the following:

- the principal reason or reasons for the determination;
- instructions for initiating an appeal or reconsideration of the determination;
- instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used to make the determination; and
- a phone number to call for information on, and assistance with, initiating an appeal or reconsideration and/or requesting clinical rationale and review criteria.[9]

External Review by Qualified Independent Decision Maker - Almost one out of three states has passed laws that permit enrollees to appeal a plan's adverse decision on an appeal to an independent review entity that is external to the managed care plan and has the medical expertise needed to decide the appeal. Some of the state laws require plans to pay the costs associated with such an external appeal and explicitly make the external appeal decision binding on the health plan. State laws differ considerably in specificity. Some make simple references to an outside appeals process while others provide significant details on the review process, the types of appeals eligible for review, and the process for appointing the independent review entity or the independent reviewers.

Vermont's external appeals system has a number of explicit features. The scope of issues consumers can bring to an independent review is broader than in most states. Enrollees may appeal: to determine whether a denied service is medically necessary; to contest a limitation placed on a covered service; to challenge a finding that a given treatment is experimental; and to contest plan decisions about pre-existing conditions. The independent review organization contracts directly with the state, not with the plan. The reviewers must be

credentialed in the relevant field of expertise and have no conflicts of interest. The plan pays the appeal cost (except for a small filing fee) and the appeal decision is binding on the plan.

State-Funded, Independent Consumer Assistance Programs

THE ISSUE: Today, health care consumers face unprecedented new choices—and limitations—as they select health plans and then seek services from those plans. A reorganized health care delivery system, new kinds of health plans, and new laws and regulations governing both public and private insurance—all these changes leave consumers increasingly perplexed and bewildered. How can they make an informed choice of a health plan? Where can consumers find an objective, reliable source of information and guidance to help them choose? And what recourse do consumers have if they encounter problems getting the services they need?

Consumers need assistance with information, referrals, counseling, and intervention with their health plans and providers. As experience with long-term care ombudsman programs has demonstrated, this assistance is best provided by nonprofit entities that are independent of health plans and insurance companies, providers, payers of care, and regulators. In its 1995 evaluation of the Long-Term Care Ombudsman programs, the Institute of Medicine concluded that formal independence of an ombudsman program from the agency with responsibility for overseeing nursing homes is a critical factor in its efficacy.[10]

A number of states provide some consumer assistance services through their Department of Insurance or Department of Health. Some states have consumer assistance programs for the Medicare and Medicaid populations, although not all operate independently. In 1996, California passed legislation requiring HMOs that serve the Medicare population to provide additional funding for the state's Health Insurance Counseling and Advocacy Programs (HICAPs) to provide education, counseling, and legal assistance to Medicare beneficiaries.

STATE LEGISLATION: The establishment of independent health care consumer assistance programs for people with private insurance is a new frontier.

Establishment of an Independent Consumer Assistance Program that Provides Education and Counseling and Assists Enrollees with Appeals - In

response to consumers' need for more information, two states have passed laws establishing independent consumer assistance programs. Florida established an independent agency, but the program has no funding and operates only with volunteers. Vermont, in 1998, became the first state to enact an independent consumer assistance program by requiring the state to contract with a nonprofit organization that will fulfill this function. The program responsibilities include assisting health insurance consumers with plan selection by providing information, referrals, and assistance about how to obtain insurance; helping consumers understand their rights and responsibilities; identifying, investigating, and resolving complaints on behalf of consumers; and assisting consumers with filing and pursuing complaints.

Patient-Provider Relationship

THE ISSUE: Trust is at the heart of the patient-physician relationship. The shift to managed care has sometimes strained or broken this bond between patients and health plan providers. Rules or practices that prohibit doctors from fully explaining treatment options to patients or that punish doctors for advocating on behalf of their patients—so-called "gag rules"—can undermine the trust between caregivers and patients.

The U.S. General Accounting Office (GAO), in a review of HMO provider contracts in 1997,[11] found little evidence of explicit gag rules. GAO noted, however, that managed care plans may influence physician behavior through their ability to terminate contracts with physicians. Plans have also been criticized for seeking cost savings by providing financial incentives that may encourage physicians to deny care to their patients. Under most of these arrangements, physicians receive bonuses or other financial rewards for limiting the number of referrals and expensive tests they order. Physicians who specialize in treating patients with high-cost chronic and disabling diseases complain that plans or subcontracting medical groups discriminate against them either in the contracting process or when they conduct an "economic profile" of a contracting physician, comparing his or her utilization costs to those of other physicians in the network. These providers are sometimes excluded from plans.

STATE LEGISLATION: States have enacted different kinds of rules designed to strengthen physician responsiveness to patients.

Disclosure of Treatment Options and Provider Advocacy - Virtually all states have enacted laws prohibiting health plans from penalizing providers for discussing all possible treatment options with patients. In addition, some states have passed laws that prevent health plans from prohibiting or penalizing a network provider for advocating on behalf of enrollees within the plan's utilization review or appeals process. Kansas, for example, has established both of these prohibitions.

Prohibiting Physician Financial Incentives - Nearly two out of five states have passed legislation to ensure that physician financial incentives do not adversely affect patient care. Provisions of these laws are generally quite vague, simply prohibiting plans from using financial incentives that will result in a denial of medically necessary care. Rhode Island's law is more specific. It prohibits plans from making "specific payments directly or indirectly to the provider as an inducement or incentive to reduce or limit services, to reduce the length of stay or the use of alternative treatment settings or the use of a particular medication with respect to an individual patient. . . ."[12]

Plans Cannot Discriminate against Providers with High-Cost Patients - Some states prohibit health plans from excluding providers from their networks simply because they serve high-cost patients—people with higher than average medical needs. Other laws require plans to take into account the medical conditions of a provider's patient mix when assessing his or her performance. In 1997, Connecticut enacted legislation that requires managed care organizations that use provider profiles or measure their health care providers' performance to "make allowances for the severity of illness or condition of the patient mix" and "for patients with multiple illnesses or conditions." Plans must also make available to the state documentation on how they make these allowances and must provide this information, upon request, to enrollees and plan providers.[13]

Provider Protections for Disclosure to Regulators of Health Plan Problems - A few states have adopted whistleblower rules to protect the rights of health care workers who speak up about managed care abuses. A New Jersey law applies to both health plan employees generally and to licensed or certified health care workers specifically. Anyone can report a violation of a law or regulation, but health care professionals can also report violations of professional codes of

ethics. While some states allow disclosures only to public bodies, such as the Department of Health or a law enforcement agency, New Jersey allows disclosures to a supervisor as well. Individuals can sue an employer who retaliates against them.

Rhode Island's law allows physicians and other providers to report violations to a broad spectrum of agencies and individuals. It also provides civil and criminal penalties and permits providers to bring a civil action seeking actual and punitive damages.

Clinical Trials

THE ISSUE: Managed care plans sometimes refuse to reimburse patients for the routine costs of their care when they participate in a clinical trial. Clinical trials often provide individuals the best, and sometimes the only, hope for a cure for life-threatening diseases. For society as a whole, these clinical trials offer learning opportunities to determine the efficacy of potential life-saving procedures and therapies. As such, patients and researchers deem it important to prevent health plans from establishing unreasonable impediments to the conducting of clinical trials.

STATE LEGISLATION: States are beginning to address this problem by requiring health plans to pay for the routine costs of care associated with participation in an approved clinical trial.

Right to Participate in a Clinical Trial - Two states, Maryland and Rhode Island, have passed comprehensive laws that prevent plans from prohibiting their enrollees to participate in clinical trials. The Maryland law provides for individuals with life-threatening or serious illnesses to participate in an approved clinical trial as long as there is meaningful potential for significant clinical benefit. Rhode Island prohibits plans from excluding services for individuals who participate in approved clinical trials, but only for new cancer therapies.

Liability

THE ISSUE: When a service, referral, or test is denied to a managed care enrollee, the decision to deny care is often made by the health plan, not the attending physician. Although patients can seek remedies for wrongful denials of care by their physicians (such as through malpractice litigation), they often have

no such recourse against their health plan. As a result, effective deterrents to improper denials of care by health plans are often absent.

There are a number of barriers that prevent individuals from suing their health plans. First, about half the states have laws that prohibit corporations from practicing medicine; plans, therefore, claim that they do not practice medicine and cannot be sued for malpractice. Second, most states have not created "causes of action" allowing people to sue plans that delay or deny care. And third, as described more fully on pages 26-29, the federal ERISA statute preempts states from establishing remedies on behalf of virtually everyone who receives health coverage through a private employer.

STATE LEGISLATION: Two states have passed legislation to hold plans accountable for wrongful denials or delays of health care services.

Right of Members to Sue Health Plans - Only two states—Texas and Missouri—have passed laws exempting managed care corporations from their laws against suing corporations for malpractice. Only Texas, however, has taken the additional step of creating a cause of action so individuals can sue their health plans. The Texas law, however, is being challenged in federal court, and it is unclear whether it will run afoul of the federal ERISA statute's preemption strictures.

SECTION III
THE MISSES: PROTECTION GAPS

Despite all these state laws, too many consumers have been missed—left unprotected. Many are missed because their state has not yet adopted the specific protection that addresses their problem (see Table 1 on pages 20-21). Tennessee, for example, has enacted a number of consumer protections. Yet a Tennesseean in managed care who is facing a medical emergency has no assurance that emergency care will be covered. For that consumer, the state laws miss the mark. Additionally, millions of Americans are excluded from these protections—they are missed—because their health coverage falls under the federal ERISA statute (see below).

Table 1

THE VARIABILITY OF STATE MANAGED CARE CONSUMER PROTECTION LAWS

STATES	E.R. SERVICES	ACCESS TO PROVIDERS				CONTINUITY OF CARE
	Prudent Layperson Standard	Referral to Out-of-Network Providers	Specialists as Primary Care Providers	Standing Referrals to Specialists	OB-GYN Direct Access	When Physicians Leave Plan
ALABAMA				●	●	
ALASKA						
ARIZONA						
ARKANSAS	●				●	●
CALIFORNIA	●			●	●	
COLORADO	●	●			●	●
CONNECTICUT	●				●	
DELAWARE					●	
DISTRICT OF COLUMBIA	●					
FLORIDA		●		●	●	●
GEORGIA	●				●	
HAWAII	●					
IDAHO	●				●	
ILLINOIS					●	
INDIANA	●	●	●		●	●
IOWA	●					
KANSAS				●		●
KENTUCKY	●	●				
LOUISIANA	●				●	
MAINE	●	●			●	
MARYLAND	●				●	
MASSACHUSSETTS						
MICHIGAN	●					
MINNESOTA	●			●	●	●
MISSISSIPPI					●	
MISSOURI	●	●	●	●		●
MONTANA		●			●	
NEBRASKA	●				●	
NEVADA	●					
NEW HAMPSHIRE						
NEW JERSEY			●		●	●
NEW MEXICO	●	●	●	●	●	
NEW YORK	●	●	●	●	●	●
NORTH CAROLINA	●	●			●	
NORTH DAKOTA						
OHIO	●	●	●	●		
OKLAHOMA						
OREGON	●				●	
PENNSYLVANIA	●		●	●	●	●
RHODE ISLAND						
SOUTH CAROLINA	●				●	
SOUTH DAKOTA						
TENNESSEE		●	●	●	●	●
TEXAS	●	●	●		●	●
UTAH		●				
VERMONT	●	●	●	●	●	●
VIRGINIA	●				●	●
WASHINGTON	●				●	
WEST VIRGINIA	●				●	
WISCONSIN	●					
WYOMING						

STATE MANAGED CARE LAWS

PRESCRIPTION DRUG ACCESS	APPEALS PROCEDURES	CONSUMER ASSISTANCE	PATIENT-PROVIDER RELATIONSHIP		CLINICAL TRIALS	LIABILITY	STATES
Access to Non-Formulary Prescriptions	Independent External Reviews	Independent Ombuds Programs	Disclosure of Treatment Options	Prohibit Physician Financial Incentives	Clinical Trials	Right to Sue Health Plans for Damages	
							ALABAMA
			●	●			ALASKA
	●		●				ARIZONA
●			●				ARKANSAS
●			●	●			CALIFORNIA
			●				COLORADO
	●		●				CONNECTICUT
			●				DELAWARE
			●				DISTRICT OF COLUMBIA
	●	●	●				FLORIDA
●			●	●	●		GEORGIA
	●		●				HAWAII
			●	●			IDAHO
							ILLINOIS
●			●				INDIANA
			●				IOWA
			●	●			KANSAS
			●				KENTUCKY
			●	●			LOUISIANA
			●				MAINE
	●		●	●	●		MARYLAND
			●				MASSACHUSETTS
	●		●				MICHIGAN
	●		●				MINNESOTA
							MISSISSIPPI
●	●		●			●	MISSOURI
			●	●			MONTANA
			●	●			NEBRASKA
			●	●			NEVADA
			●				NEW HAMPSHIRE
	●		●	●			NEW JERSEY
	●		●	●			NEW MEXICO
			●				NEW YORK
			●				NORTH CAROLINA
			●				NORTH DAKOTA
●			●	●			OHIO
			●				OKLAHOMA
●			●				OREGON
	●		●	●			PENNSYLVANIA
	●		●	●	●		RHODE ISLAND
							SOUTH CAROLINA
							SOUTH DAKOTA
	●		●				TENNESSEE
	●		●	●		●	TEXAS
			●	●			UTAH
●	●	●	●	●			VERMONT
			●				VIRGINIA
			●				WASHINGTON
			●	●			WEST VIRGINIA
			●				WISCONSIN
			●				WYOMING

THE VARIABILITY OF STATE MANAGED CARE LAWS

Although all of the states except South Dakota have enacted one or more provisions to protect consumers from managed care-related problems, state rules are inconsistent and vary widely. This is well illustrated through a look at state legislative activity on 13 different and important areas of consumer protections.

The 13 areas were chosen for a number of reasons. First, they are importants rights for health care consumers. Second, they are specific and easily understandable. And third, they provide good examples of the variability of state laws. The 13 areas we selected are as follows:

- **emergency room services** – which states have passed laws setting the prudent layperson standard;
- **access to providers** – which states have passed laws:
  - requiring plans to refer to out-of-network providers when the network is insufficient;
  - requiring plans to allow specialists to be primary care providers in certain circumstances;
  - requiring plans to allow standing referrals to specialists for people with chronic or life-threatening illnesses; and
  - requiring plans to give women direct access to obstetricians and gynecologists;
- **continuity of care** – which states have passed laws requiring plans to allow certain patients to continue to see their physician when the provider has left the plan;
- **drug formularies** – which states have passed laws requiring the plan to have a process for obtaining non-formulary prescription drugs;
- **appeals** – which states have passed laws that require a meaningful process for external review of appeals decisions;
- **consumer assistance programs** – which states have passed laws that establish independent ombuds or consumer assistance programs;
- **patient physician relationship** – which states have passed laws:
  - prohibiting plans from preventing the disclosure of treatment options; and
  - prohibiting plans from offering incentives to physicians for denying or reducing care;

- **clinical trials** – which states have passed laws that prevent plans from prohibiting participation in clinical trials; and
- **liability** – which states have passed laws that allow consumers to sue health plans for significant damages for wrongful denials of care.

As Table 1 shows, no state—as of June 1998—has passed *all* of these managed care consumer protections.

- Only one state—Vermont—has enacted ten or more of these protections.
- The following 16 states have enacted between five and nine of the protections: Arkansas, California, Colorado, Florida, Georgia, Indiana, Maryland, Minnesota, Missouri, New Jersey, New Mexico, New York, Ohio, Pennsylvania, Tennessee, and Texas.
- The following 33 states have enacted at least one but fewer than five: Alabama, Alaska, Arizona, Connecticut, Delaware, the District of Columbia, Hawaii, Idaho, Illinois, Iowa, Kansas, Kentucky, Louisiana, Maine, Massachusetts, Michigan, Mississippi, Montana, Nebraska, Nevada, New Hampshire, North Carolina, North Dakota, Oklahoma, Oregon, Rhode Island, South Carolina, Utah, Virginia, Washington, West Virginia, Wisconsin, and Wyoming.
- One state—South Dakota—has not passed any of these laws.

- The following states have passed laws requiring plans to use the **prudent layperson** standard: **Arkansas, California, Colorado, Connecticut, the District of Columbia, Georgia, Hawaii, Idaho, Indiana, Iowa, Kentucky, Louisiana, Maine, Maryland, Michigan, Minnesota, Missouri, Nebraska, Nevada, New Mexico, New York, North Carolina, Ohio, Oregon, Pennsylvania, South Carolina, Texas, Vermont, Virginia, Washington, West Virginia,** and **Wisconsin**. [States that have adopted variations of the prudent layperson standard are included.]

- The states that require plans to **permit access to out-of-network providers** when the plan's network is insufficient are: **Colorado, Florida, Indiana,**

Kentucky, Maine, Missouri, Montana, New Mexico, New York, North Carolina, Ohio, Tennessee, Texas, Utah, and **Vermont.**

- The states that have passed laws allowing **specialists to serve as primary care providers** are: **Indiana, Missouri, New Jersey, New Mexico, New York, Ohio, Pennsylvania, Tennessee, Texas,** and **Vermont.**

- The states that have passed laws enabling **enrollees to obtain standing referrals to specialists** are: **Alabama, California, Florida, Kansas, Minnesota, Missouri, New Mexico, New York, Ohio, Pennsylvania, Tennessee,** and **Vermont.**

- The states that have passed laws requiring **direct access to obstetricians and gynecologists** or allowing obstetricians or gynecologists to serve as primary care physicians are: **Alabama, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Idaho, Illinois, Indiana, Kentucky, Louisiana, Minnesota, Mississippi, Montana, Nebraska, New Jersey, New Mexico, New York, North Carolina, Oregon, Pennsylvania, South Carolina, Tennessee, Texas, Vermont, Virginia, Washington,** and **West Virginia.** [States that require direct access for only one annual visit are not included in this list.]

- The states that have passed laws requiring plans to allow **some patients to continue to see the same provider for a specific number of days when their physician leaves the plan** are: **Arkansas, Colorado, Florida, Indiana, Kansas, Minnesota, Missouri, New Jersey, New York, Pennsylvania, Tennessee, Texas, Vermont,** and **Virginia.** [Some states require plans to provide transitional care for primary care *only* and not for specialty care; those states are not included in the list.]

- The states that have passed laws requiring plans to **have a procedure to allow individuals to obtain non-formulary prescription drugs** are: **Arkansas, California, Georgia, Indiana, Missouri, Ohio, Oregon,** and **Vermont.** [States that require plans to disclose the procedure for obtaining non-formulary drugs

(if the plan uses a formulary)—but that do not require that plans have such a procedure—are not included in this list.]

- The states that have passed laws requiring plans to **adopt a meaningful independent external review** process for all services are: **Arizona, Connecticut, Florida, Hawaii, Maryland, Michigan, Minnesota, Missouri, New Jersey, New Mexico, Pennsylvania, Rhode Island, Tennessee, Texas,** and **Vermont**. [Some states have set up independent external review processes for limited circumstances—only for experimental and investigational procedures or services, for example. Some states allow the plan to pick any provider—including employees of the managed care plan—to be on the review panels. We have not included these states on the list.]

- The states that have passed laws to **establish independent statewide consumer assistance programs** are: **Florida** and **Vermont.** [Some states have established consumer assistance programs within state agencies. We have not included these states on the list.]

- The states that have passed laws **prohibiting plans from preventing the disclosure of treatment options** to enrollees are: **Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, the District of Columbia, Florida, Georgia, Hawaii, Idaho, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin,** and **Wyoming.**

- The states that have passed laws requiring plans to **prohibit physician financial incentives to reduce or deny care** are: **Alaska, California, Georgia, Idaho, Kansas, Louisiana, Maryland, Montana, Nebraska, Nevada, New Jersey, New Mexico, Ohio, Pennsylvania, Rhode Island, Texas, Utah, Vermont,** and **West Virginia.**

- The states that have passed laws that **protect participation in clinical trials** are: **Georgia**, **Maryland**, and **Rhode Island**.

- The states that have passed laws that enable **enrollees to sue their health plan for damages** are: **Missouri** and **Texas**.

ERISA

The federal Employee Retirement Income Security Act (ERISA) of 1974 was enacted to establish uniform federal standards for pension and employee "welfare benefit" plans, including health plans offered through private-sector employers and unions.[14] The ERISA statute, while primarily enacted to protect workers and retirees with employer-provided pensions, has had a profound impact on what states can—and, more importantly, cannot—do to protect consumers who receive their health coverage through private employers. Although the statute contains several provisions designed to protect people with employer-provided health coverage, it is more notable today for its role in preempting states from regulating employer-provided health care coverage.

Under ERISA, employer-provided health plans are required to make available certain information to plan participants, to provide the benefits that are promised under the plan, and to establish and disclose complaint and appeals procedures. The statute does not require any particular complaint procedure and does not require the establishment of appeals systems independent of health plan administrators. Regulations promulgated pursuant to ERISA require employer health plans to approve or deny claims within 90 days and to approve or deny appeals of claims denials within 60 days. As analysts have noted, the ERISA statute and regulations were designed in the fee-for-service era, a period when dispute resolution focused on payment for services *already rendered*.[15] Today, under managed care, disputes often focus on whether a contested service will be provided at all.

When enacting ERISA, Congress attempted to ensure that multi-state employers would not be subject to varying regulatory requirements from one

state to another.[16] At the same time, Congress did not wish to usurp the states' traditional role regulating insurance. As a result, the statute, as interpreted by federal courts, has resulted in very different sets of rules *for people in the same state, depending on the form and source of their health coverage.*

ERISA preempts states from regulating employer-provided health coverage when the employer "self-insures"—that is, when the employer assumes all or some of the financial risk for the care provided to its employees rather than simply purchasing coverage from an insurer. Thus, state laws—whether they establish "prudent layperson" rules relating to emergency care, direct access to obstetricians and gynecologists, procedures for accessing prescription drugs not on a formulary, or rights to receive care from an out-of-network provider when a plan's network is inadequate—are preempted and inapplicable for people in self-insured plans. Such state laws, however, do apply and protect people who are "fully insured," whether that coverage is purchased directly by the consumer or by the consumer's employer.

Today, approximately one-third of those with employer-provided health coverage, approximately 51 million people, are in self-insured plans.[17] For these health care consumers, only the sparse protections spelled out in the ERISA statute and regulations apply. They are not covered by any of the managed care consumer protection laws established by their states.

The ERISA statute's preemption of state laws is far broader when it comes to provisions relating to grievance resolution, including the right to sue for improper delays or denials of needed health care. Virtually everyone who receives health coverage from a private employer, whether the employer self-insures or purchases health insurance, is preempted by ERISA from receiving the remedial protections established by state law. Approximately 124 million Americans are affected by this broad preemption.[18]

For these 124 million persons, who are precluded from using state courts and law to contest a delay or denial of health care services, the only recourse is the "negligible assistance" afforded by the ERISA statute. Under that statute, a consumer can contest an alleged wrongful delay or denial of health services in federal court. However, even if the complainant demonstrates that the delay or denial was inappropriate (whether due to negligence or worse), the only remedy

available is the ultimate provision of the denied service or the cost of the denied service—a remedy that often is too little and comes too late.[19]

This broad preemption means that people who get health coverage from private employers have limited means of holding their health plans accountable for wrongfully withheld care. People in plans purchased or provided by employers are precluded from seeking compensatory or punitive damages, and hence no meaningful deterrent exists to inhibit such plans' wrongful denials and delays of needed health care. The number of people in each state who are affected by this broad preemption of state remedies is shown in Table 2 on page 29.

SECTION IV
OTHER ISSUES

In addition to the managed care issues discussed in Sections II and III, there are a number of other general areas that are very important to managed care consumers. Utilization review procedures, confidentiality of medical records, quality assurance plans, and information disclosure to consumers—all these have a bearing on the well-being of managed care enrollees. These areas of consumer protection are arguably more complex and subtle than those covered in the preceding sections of this report. Managed care plans, state regulators, and others, for example, are currently attempting to develop the parameters of what kinds of information consumers need and will be able to use. Below is a discussion of these issues and of state efforts to come to terms with them.

Utilization Review (UR)

THE ISSUE: The purpose of utilization review (UR) is to determine, based on the best information or "clinical guidelines" available, what is and is not appropriate care. When UR works, it can significantly improve care. Increasing evidence suggests that following carefully constructed clinical guidelines, or "protocols," can decrease costs and reduce illnesses and deaths. For example, two cardiologists at the Minneapolis Heart Institute developed a protocol to determine which patients with chest pain should be given an angiogram—an expensive diagnostic procedure used to detect coronary artery disease. By applying these protocols, the doctors were able to cut the number of unnecessary

Table 2

People Covered by ERISA Preemption of State Remedies

State	Employer-Provided Insured*	ERISA-Covered** Among Employer-Provided Insured	% ERISA-Covered Among Employer-Provided Insured
Alabama	2,300,000	1,953,910	84.95%
Alaska	300,000	179,063	59.69%
Arizona	2,100,000	1,755,959	83.62%
Arkansas	1,300,000	1,055,561	81.20%
California	15,300,000	13,496,973	88.22%
Colorado	2,300,000	1,953,019	84.91%
Connecticut	2,000,000	1,818,646	90.93%
Delaware	400,000	345,997	86.50%
Florida	6,700,000	5,661,123	84.49%
Georgia	4,100,000	3,431,727	83.70%
Hawaii	600,000	454,473	75.75%
Idaho	700,000	549,942	78.56%
Illinois	7,300,000	6,444,009	88.27%
Indiana	3,700,000	3,163,100	85.49%
Iowa	1,700,000	1,343,101	79.01%
Kansas	1,300,000	984,049	75.70%
Kentucky	2,100,000	1,698,308	80.87%
Louisiana	2,100,000	1,596,383	76.02%
Maine	700,000	535,735	76.53%
Maryland/1	3,000,000	2,372,410	79.08%
Massachusetts	3,700,000	3,373,175	91.17%
Michigan	5,800,000	4,959,500	85.51%
Minnesota/1	2,800,000	2,232,408	79.73%
Mississippi	1,200,000	964,038	80.34%
Missouri	3,000,000	2,507,674	83.59%
Montana	400,000	268,260	67.06%
Nebraska	1,000,000	769,621	76.96%
Nevada	1,000,000	869,266	86.93%
New Hampshire	700,000	596,983	85.28%
New Jersey	4,900,000	4,292,681	87.61%
New Mexico	800,000	532,301	66.54%
New York	9,600,000	8,062,195	83.98%
North Carolina	3,800,000	3,245,821	85.42%
North Dakota	300,000	193,785	64.60%
Ohio	6,900,000	5,922,491	85.83%
Oklahoma	1,600,000	1,259,980	78.75%
Oregon	2,900,000	2,600,590	89.68%
Pennsylvania	7,200,000	6,422,232	89.20%
Rhode Island	600,000	518,093	86.35%
South Carolina	2,200,000	1,885,656	85.71%
South Dakota	400,000	289,875	72.47%
Tennessee	2,900,000	2,453,877	84.62%
Texas	9,600,000	7,895,378	82.24%
Utah	1,300,000	1,012,239	77.86%
Vermont	400,000	334,641	83.66%
Virginia	4,100,000	3,279,748	79.99%
Washington	2,900,000	2,332,020	80.41%
West Virginia	900,000	670,194	74.47%
Wisconsin	3,400,000	2,846,562	83.72%
Wyoming	300,000	206,058	68.69%
U.S. TOTAL	146,600,000	123,590,830	84.30%

* From EBRI tabulations, rounded to the nearest 100,000.

**ERISA-covered lives. Total employer-provided insured covered lives minus public sector employer-provided insured covered lives.

Source: Based on statistics compiled by the Employee Benefits Research Institute (see EBRI Issue Brief, #170, February 1996, "Sources of Health Insurance and Characteristics of the Uninsured," Analysis of March 1995 Current Population Survey).

angiograms by more than half, for an estimated annual saving of $2.1 million, without compromising patient care.[20]

Managed care physicians argue that UR guidelines are often applied too rigidly, without considering the individual needs of patients. A recent study reported in the *Journal of the American Medical Association* reviewed the frequency of tube insertions for chronic middle ear infections. The researchers found that, according to one UR criterion, the tube insertions were unwarranted in 80 percent of the cases reviewed; by contrast, physicians with substantial expertise in the area concluded that only 31 percent of the tube insertions were unwarranted.[21]

Providers are also concerned about the quality of the utilization reviewers. They contend that decisions are sometimes made by UR personnel without the expertise needed to make an appropriate decision.

Managed care consumers as well as providers complain about the time and effort involved to obtain a UR decision. Moreover, managed care enrollees find that they often cannot obtain the information they need on how a plan treats a particular disease or the clinical guidelines upon which an adverse UR decision is made.

STATE LEGISLATION: A number of states have passed laws addressing the timeliness of UR decisions, competency of reviewers, and the adequacy of the guidelines.

Strict Time Frames for Making UR Decisions and Expedited Review for Urgent Care - Some states require explicit time limits for UR decisions generally, with shorter limits for urgent care situations. New Mexico regulations require that "[a]ll determinations shall be made on a timely basis as required by the exigencies of the situation and in accordance with sound medical principles, which, in any event, shall not exceed 24 hours for emergency care and seven days for all other determinations."[22]

Utilization Review Denials Made by Clinical Peers - Some states, such as Oklahoma, require that either a "licensed clinical peer" or a physician approve all adverse utilization review determinations. Others only require that denials be made by a qualified medical provider or by physicians in specified circumstances.

Development and Application of UR Clinical Guidelines - Some states require that the process for the development and periodic evaluation of evidenced-based clinical guidelines be predicated on sound patient care principles and that utilization reviewers consider the individual medical needs of enrollees along with the clinical guidelines when making utilization review decisions. Virginia legislation requires input from board-certified medical advisors representing major areas of specialty in the development of UR standards. Standards must be "objective, clinically valid, and compatible with established principles of health care" and must "be sufficiently flexible to allow deviations from norms when justified on case-by-case bases."[23]

Clinical Guidelines upon Which UR Decisions Are Based Must Be Available upon Request - Some states, such as Rhode Island, require plans to provide clinical guidelines and protocols to enrollees on request. Rhode Island also requires that this information be available to *prospective* enrollees on request.

CONFIDENTIALITY

THE ISSUE: Consumers are concerned about the confidentiality of their medical records and whether the most intimate details of their health and health care will be passed on to their employer or others, threatening their jobs and privacy. A 1993 Harris poll found that 85 percent of the American public believed that protecting the confidentiality of medical records was absolutely or very important. In a 1996 survey, 206 respondents reported that they lost their employment and insurance coverage or were ineligible for benefits because their genetic information was not kept private.[24] Recently, the director of one employer-sponsored work-site clinic testified that he was frequently pressured by plan supervisors to release all medical information about his patients.[25]

Although there is some agreement on the need for confidentiality of patient records and Congress is under a self-imposed deadline to pass health privacy legislation by August 1999, there is disagreement on how it should be done. Many privacy and consumer advocates want to prohibit the release of all information without the written authorization of the patient. Researchers worry that placing too many restrictions on the release of patient data will undermine research. Plans argue that they will not be able to sort through medical records to conduct

quality initiatives—such as sending out mammogram alerts or informing asthma patients about new treatments—if patient record restrictions are too stringent. Drug companies and pharmacies are worried about creating new federal regulations that will block their use of medical records for commercial purposes. States and accrediting agencies are concerned that laws not impinge on their access to medical records for monitoring and accrediting purposes. And law enforcement agencies want to ensure that they can search records in criminal investigations.

STATE LEGISLATION: In the last few years, a number of states enacted managed care legislation or promulgated regulations addressing the confidentiality issue. Most of the state laws prohibit managed care plans from selling names or identifying information about enrollees. Most of the managed care provisions relating to confidentiality are simply statements of the need to protect the confidentiality of patient records. For example, Connecticut legislation requires plans to: conform to all federal and state confidentiality statutes; ensure that patient records are protected; and establish written confidentiality policies and procedures. The legislation also prohibits managed care organizations from selling for any commercial purpose the names or any identifying information concerning enrollees.

While no state has comprehensive health privacy laws, a few states—such as Minnesota and New York—have enacted laws that are far-reaching in some respects. Minnesota law requires that researchers must get patient consent, in most instances, before using identifiable information. New York's law focuses on the privacy of genetic information.

QUALITY ASSURANCE

THE ISSUE: Well-implemented quality assurance plans are central to ensuring that managed care enrollees receive high-quality care and that plans have systems in place to identify and correct problems in the delivery of health care. While many managed care plans already have internal quality assurance plans, they are highly variable.

STATE LEGISLATION: Some states have passed laws requiring health plans to implement quality assurance programs. Some laws establish detailed

requirements for such programs. Minnesota regulations are very detailed. They require plans to submit a written quality assurance plan. The plan must address such issues as: who is responsible for the evaluation of the quality of care; how the data collection and reporting systems are handled; how the plan will monitor complaints; and what are the plan's policies and procedures for provider selection. Minnesota requires ongoing quality evaluation and corrective action for problems identified. And Minnesota plans must carry out a minimum of three focused studies on specific problem areas each year.

INFORMATION

THE ISSUE: For many consumers, managed care is a new form of health coverage. They may not understand how to gain access to care within their plan, and they may have questions about their rights and responsibilities: What doctors are available to them? Is there a drug formulary? What drugs are on the formulary? What benefits are covered? What are the copayments for office visits?

Consumers need accurate, reliable information that will allow them to assess differences in the quality and cost of health plans, the health care providers who will treat them, and the facilities and institutions that the plan uses. Consumers need this information to choose the health plan that is best for their families and, once they are in a plan, they need the information to allow them to use the plan effectively. To be useful, this information should be comprehensive and detailed, covering such matters as:

- A summary of all covered benefits, including any limits on coverage and whether the plan uses a prescription drug formulary, and disclosure of enrollee cost-sharing requirements.
- Information on the plan's internal procedures and policies, including disclosure of preauthorization requirements and utilization review procedures, an explanation of the plan's grievance and appeals procedures, and information on how to obtain non-formulary drugs.
- Basic information about the plan: its structure, its licensure and accreditation status, any available measurements of enrollee satisfaction and/or plan performance, and whether the plan meets federal and state requirements for fiscal solvency.

- Detailed information on all plan providers, including board certification status; compensation methods, including the plan's use of any incentive payments such as withhold accounts, for providers; procedures for getting referrals to specialists and for obtaining after-hours care; and rules regarding out-of-network referrals.

STATE LEGISLATION: Many states have passed legislation requiring health plans to give enrollees information about their plans. New York is among the strongest in meeting the needs of consumers: New York's disclosure provisions require HMOs to provide to all prospective or current enrollees, or to make available upon request, information such as the following:

- benefits, cost-sharing, emergency room coverage, and continuity of care procedures;
- referral and prior authorization procedures;
- utilization review information;
- provider qualifications and compensation arrangements;
- rules relating to a plan's drug formulary, including information on included and excluded drugs;
- rules relating to confidentiality of medical records;
- review criteria or treatment policies relating to particular conditions or diseases;
- statistics relating to a plan's grievance system;
- rules governing experimental and investigational treatment;
- procedures for addressing the needs of non-English speaking enrollees; and
- quality assurance programs.

SECTION V
CONCLUSION

State legislatures throughout the country have responded to consumers' increasing concerns about managed care by passing laws that seek to protect consumers from abuses. Unfortunately, the states have a hit and miss record on managed care consumer protections: While some states have laws establishing a strong appeals process, for example, other states have been silent on this issue. In one state people are assured that they will be covered if they go to an emergency room when they believe their health or their life to be in jeopardy; other states leave it up to the health plan. The unevenness in state consumer protection legislation is compounded by ERISA, which exempts many millions of Americans from the state protections that do exist. As a result, even within the same state, protections vary. There is one set of rules for those who purchase their own insurance, another for those in employer-paid self-insured plans, and yet another for those in employer-paid plans that are not self-insured. This variability is the source of enormous confusion for consumers, leaving them uncertain about their health care coverage and concerned about whether they will get the care they need. Clearly, these protections—as important and useful as they are—are "hit *and* miss" in their application.

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