

## State-Based Managed Health Care Policies for Consumer Professionals

The session provided information useful to states who are not currently but may be addressing issues relative to managed care redress options. Persons made presentations from states where redress options have been enacted.

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In October 1999, the U.S. House of Representatives passed a patient protection act that encompasses some of the redress options that states have adopted. Because the U.S. Senate passed a more restrictive bill around the issue of arbitration or legal suit against a managed care entity, the issue was not settled by the time of the annual meeting. However, several states had enacted consumer protections around patient protection and state based health care coverage, addressing the issue of consumer redress.

Panelists were invited to present information about the laws enacted in Texas, Missouri, and California. All states were unique in their handling of the issue.

### Missouri

The Missouri law went into effect in 1997 with final regulations available in June 1998. The consumer protections relate to information disclosure, emergency room care (the prudent layperson standard), and network adequacy. Other protections refer to transitory care in the case of changes in providers, utilization review, data collection, report cards, internal grievance procedures (both relative to time frame and notice), patient-physician communications (no "gag orders"), and financial incentives (those affecting delivery of care must be disclosed). Consumers must have access to care particularly obstetrician/gynecologist annual visit, mental health, standing reference to specialists and out of network reference (if none exist within network) without additional cost to the consumer. Missouri does not require consumers to exhaust review before requesting a binding review through the Missouri Department of Insurance. Medical decisions are binding.

HMOs may be deemed to be practicing medicine, and potentially liable for medical malpractice. The law also defines an HMO as a 'health care provider' for determining damages in tort actions based on improper health care. To date, there have been no lawsuits brought against an HMO, which would test this aspect of the law. If the HMO offers a gatekeeper plan, they must also offer an open referral plan. Limits on prescription quantities must be applied uniformly to all network pharmacy providers. This provision has been challenged in court and has yet to be decided.

Dr. Cavanagh highly recommended the Kaiser Family Foundation site for reference to the Missouri legislation. That site is: <http://www.kff.org/content/1999/1518/>

### California

California's most recent effort at legislation is called the 1999 California Health Care Reform Package. However, major health care regulation began during the 1997-98 legislative session. Most of the reform legislation went into effect in January 2001. Health care is an important issue in California given that those who work for both state and some local governments until age 50 may receive post-retirement health care benefits paid by the state. The California legislation has been used for the Clinton model for patient protection to the U.S. Congress. A California advisory group, Health Administration Responsibility Project (HARP), monitors HMOs in other states in addition to California's "giant," Kaiser Permanente. Information about the monitoring of California's health care reform and evaluation of reform bills can be seen on HARPs website (<http://www.harp.org>).

Under the legislation, a new Department of Managed Care was formed to license and regulate health care service plans. Within this department is a new Office of Patient Advocacy which will assist health plan enrollees

with complaints, provide education guides, issue annual reports and make recommendations on consumer issues. The Department of Corporations also must establish an independent medical review system for patients.

The California legislation requires an independent review, written, and quick response to grievances. Patients are given a right to sue their plan, but California caps damages for medical malpractice. The list of managed health care consumer protections includes disclosure of benefits, limits and exclusions, and other coverages and costs. Further, disclosures are required as to financial status, how consumer's participation may effect choice of hospital or provider, if financial bonuses are used for administrators or providers, and if required profiles are used to hire physicians. For those who answer consumer questions by phone, medical licensure is required.

Some coverages are mandated with some conditions, e.g.: second opinions, direct access to obstetricians/gynecologists, standing referrals, specialists for prolonged illnesses, cancer screenings, post-mastectomy needs, pain management for terminal illness if pharmaceuticals are covered, no denial of enrollment if family breast cancer history, some mental health coverage, hospice care coverage, testing for PKU, and testing for diabetes and coverage of its related supplies.

### Texas

Texas was an early leader in managed care reforms, beginning in 1995 with the passage and subsequent veto of the Patient Protection Act. That action triggered state agency rulemaking, a special legislative committee, and comprehensive reforms in 1997. The reforms included liability for managed care plans and an independent review process. As of March 2000, over 800 cases had passed to one of three independent review organizations authorized by the Texas Department of Insurance. In total, approximately 50% of those cases have been overturned. Some plans have higher overturn rates.

Only a handful of liability cases have been filed since 1997, possibly in part due to a lawsuit filed by Aetna. The suit questioned whether the liability and independent review law applies to ERISA plans. The lower court decided that liability applies to ERISA plans only when care is given and not when care is denied. Further, the decision was that ERISA preempts the independent review process and several provider protections in the challenged legislation. Currently, ERISA plans may participate voluntarily in the independent review organization review.

In addition to these reforms, Texas' comprehensive consumer protections cover issues such as continuity of care for pregnant women and people with disabilities and terminal illness; access to specialists and emergency room care; information to consumers about benefits (including formularies) and the limitations and conditions of their plan; access to drugs not on the formulary throughout the plan contract period; and a standardized internal complaint process.

Texas is in the process of implementing their Children's Health Insurance Program (CHIP) by May 1, 2000, which is a separate program from Medicaid. A major problem in getting the lowest income children to be enrolled is the complex application process experienced in order to receive Medicaid. The process requires a face to face visit, burdensome documentation of income, recertification every 6 months. These barriers have been lifted for children eligible for CHIP. Advocates are working to remove these barriers for Medicaid.

Ms. McGiffert is available for further questions regarding the Texas experience. Call the Southwestern Office of Consumers Union in Austin at 512-477-4431 or go to <http://www.consumersunion.org>

### Endnotes

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