REPORT OF THE
JOINT COMMISSION ON HEALTH CARE

STUDY OF THE APPROPRIATE ROLE OF THE AGENCIES OF THE COMMONWEALTH IN OVERSEEING THE MANAGED CARE INDUSTRY PURSUANT TO SJR 67 OF 1996

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

SENATE DOCUMENT NO. 7

COMMONWEALTH OF VIRGINIA
RICHMOND
1997

JOINT COMMISSION ON HEALTH CARE

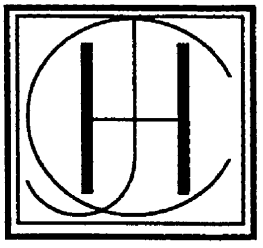
Chairman
The Honorable Stanley C. Walker

Vice Chairman
The Honorable Kenneth R. Melvin

The Honorable William T. Bolling
The Honorable Joseph V. Gartlan, Jr.
The Honorable Benjamin J. Lambert, III
The Honorable Stephen H. Martin
The Honorable Edward L. Schrock
The Honorable Jane H. Woods
The Honorable Thomas G. Baker, Jr.
The Honorable David G. Brickley
The Honorable Julia A. Connally
The Honorable Jay W. DeBoer
The Honorable Alan A. Diamonstein
The Honorable Franklin P. Hall
The Honorable George H. Heilig, Jr.
The Honorable Harvey B. Morgan

Secretary of Health and Human Resources
The Honorable Robert C. Metcalf

Director
Jane Norwood Kusiak



Preface

Senate Joint Resolution (SJR) 67 of the 1996 Session of the General Assembly directed the Joint Commission on Health Care and the Bureau of Insurance to study the appropriate role of the agencies of the Commonwealth in overseeing the managed care industry.

Over the past several years, there has been a significant growth in the number of Virginians with insurance coverage through managed care plans. Managed care includes a range of different types of insurance plans, including Health Maintenance Organizations (HMOs), point-of-service plans, preferred provider organizations and others. The increase in managed care enrollments is due, at least in part, to the ability of these plans to hold down increases in health care costs. However, in recent years there has been growing concern among some provider groups and patient advocates that some forms of managed care have gone too far in controlling patients' access to certain providers and health care services. In response to these concerns, the General Assembly directed the Joint Commission to evaluate the appropriate role of state agencies in overseeing the managed care industry.

Based on our research and analysis, we concluded the following:

- The growth of managed care has raised new questions about the appropriate role of insurance regulators and other state agencies. The traditional role of regulators (i.e., ensuring financial solvency, licensing plans, and reviewing marketing conduct) remain essential functions of state government. However, managed care's impact on the type, extent and quality of care that managed care enrollees receive raises new questions about the degree to which state regulators and other agencies should oversee these aspects of managed care plans.

- Virginia has passed a number of managed care-related insurance laws to provide protections for enrollees and providers. As a result of the most recent laws, Virginia is cited in one consumer publication as having some of the broadest protections in the country.

- Virginia's insurance laws and regulations for HMOs are similar to those in other states; a few variations exist.

- While Virginia has numerous regulatory requirements for HMOs, the health insurance industry administers other managed care products that are not monitored as closely as HMOs.

- Until very recently, the Department of Health has exercised very little of the authority included in the HMO Act for monitoring the quality of care provided by HMOs; consideration should be given to clarifying its role in overseeing managed care.

- There is disagreement among interested parties regarding certain aspects of the state's role in monitoring managed care. Specifically, some provider groups and patient advocates believe the Bureau of Insurance should have broader authority to investigate and adjudicate disputes that providers and patients have with their managed care health plans. Additionally, these groups feel that an independent appeals process or ombudsman program is needed to assist consumers and providers.

  The Bureau of Insurance believes that the current authority provided in the Code as well as its regulatory and enforcement activities are appropriate. The insurance industry and representatives of the business community feel the current statutory and regulatory framework is appropriate and that further government oversight would be unnecessary and burdensome.

- There is general agreement among all parties that additional consumer information on health plans will assist consumers make informed decisions when selecting managed care plans and will provide valuable information on the quality of health plans.

A number of policy options were offered for consideration by the Joint Commission regarding the issues addressed in this report. These policy options are discussed on pages 47-50.

Our review process on this topic included an initial staff briefing which you will find in the body of this report followed by a public comment period during which time interested parties forwarded written comments to us on the report. In many cases, the public comments, which are provided at the end of this report, provided additional insight into the various topics covered in this study.

Jane N. Kusiak
Executive Director

December 19, 1996

TABLE OF CONTENTS

I.
Authority for Study

Senate Joint Resolution (SJR) 67 of the 1996 Session of the General Assembly directed the Joint Commission on Health Care and the Bureau of Insurance to study the appropriate role of the agencies of the Commonwealth in monitoring, policing and regulating the managed care industry. A copy of SJR 67 is provided at Appendix A.

II.
Background

Managed Care Seeks to Coordinate Access to Care, Control Costs and Improve Quality of Care; Managed Care Processes Exist In Different Types of Health Plans

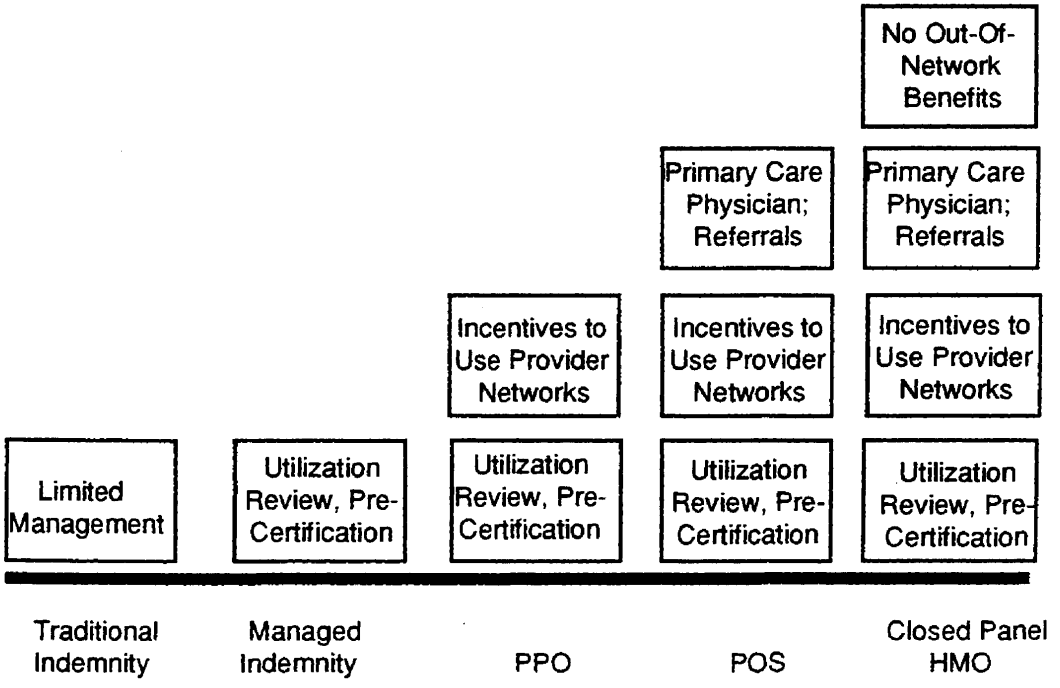
Managed care can be defined in many ways and can involve different levels of care management. In its simplest form, managed care may include pre-certification of hospital stays or utilization review to ensure services that are received by patients are medically necessary. As such, "managed care" processes exist in many different types of health insurance, including indemnity plans.

More advanced forms of managed care, such as preferred provider organizations (PPOs) and point-of-service (POS) plans, not only require utilization review and medical necessity determinations, but also provide incentives for enrollees to receive care from network providers in order to obtain the highest level of the plan's benefits. Some PPOs and most POS plans also require an enrollee to select and use a primary care physician (PCP) who provides primary care and coordinates access to other health care services. The most advanced form of managed care is provided by health maintenance organizations (HMOs). HMOs require enrollees to select a PCP; require use of network physicians (unless a POS option is included); and generally have smaller

specialty networks than PPOs and POS plans. Figure 1 provides a generalized continuum of managed care plans that are available in the marketplace.

Figure 1

Variations in Managed Care Plans



Note: The plan designs shown here are generalizations; there are variations among these different types of plans

Source: Joint Commission on Health Care Staff Analysis

Because HMOs provide the highest level of managed care services, the term "managed care" often is associated only with HMOs. However, as discussed above and illustrated in Figure 1, "managed care" processes exist, at least to some degree, in many health plans. In most instances, the managed care "industry" refers to those plans which not only impose utilization review and medical necessity determinations, but also control enrollees' access to care by requiring the use of a PCP and network providers.

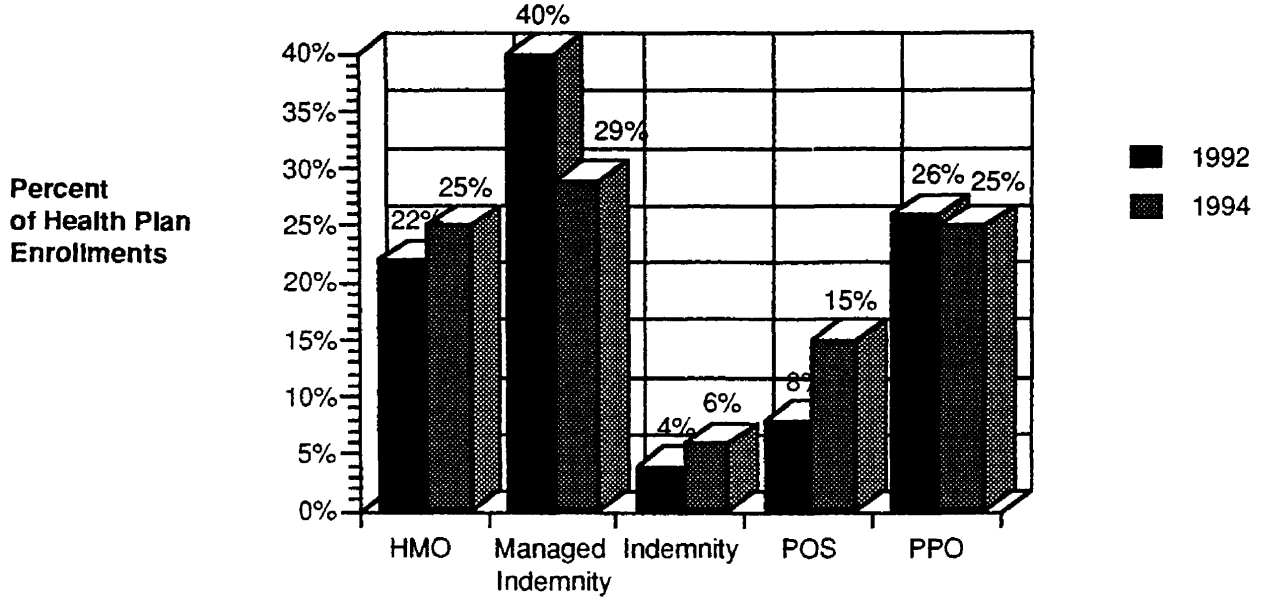
There Has Been Dramatic Growth In Managed Care Plans in Recent Years

While managed care processes exist in many different forms of health insurance, more and more of the marketplace is moving to the more advanced forms of managed care in which patients have limited choices of providers and access to care is coordinated and managed by a PCP. Evidence of the move to managed care abounds and can be measured in numerous ways. In 1994, 65 percent of the nation's workers employed by large companies (200 or more employees) were enrolled in managed care plans, including HMOs, preferred provider organizations (PPOs), and point-of-service (POS) plans. In 1990, this percentage was less than 50 percent. Figure 2 illustrates the move toward managed care plans as measured by national health enrollments from 1992 to 1994.

The American Managed Care & Review Association reports that total enrollment in managed care plans has increased from 93 million persons in 1992 to 157 million in 1995, a 69% increase in just three years.

Figure 2

Trends In National Health Plan Enrollments
1992 - 1994



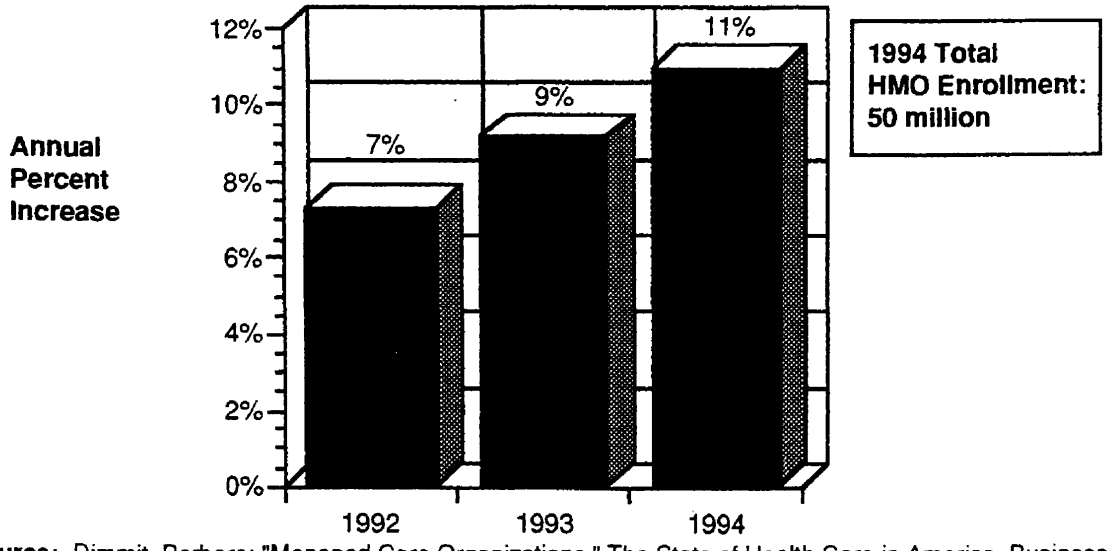
Source: KMPG, Peat Marwick, National Survey of Employer-Sponsored Health Plans, 1992, 1994.

According to the Group Health Association of America (GHAA), nationwide enrollment in HMOs increased by 5.3 million people (11%) in 1994, representing the single largest one year jump ever recorded by the industry trade group. Figure 3 illustrates the increases recorded over the past few years.

Much of the trend to the more tightly controlled managed care plans is due to the cost savings that employers and other purchasers are seeking in the marketplace. These plans, especially HMOs, have consistently charged lower premiums to their enrollees than less managed plans such as traditional indemnity coverage.

Figure 3

Annual Increases in National HMO Enrollments 1992 - 1994



Source: Dimmit, Barbara; "Managed Care Organizations," The State of Health Care in America, Business and Health Magazine, 1995

State Benefit Programs Have Moved To Managed Care

While Virginia's move to managed care has not been at the pace seen in some parts of the country, it nonetheless has been significant. In 1992, the state employee benefits program implemented a statewide PPO/primary care

physician managed care program (Key Advantage) for all employees. With Key Advantage and several HMO offerings, all state employees have been enrolled in a managed care program since 1992.

The state Medicaid program also has moved much of the Medicaid population into managed care. As of April, 1996, 372,818 Medicaid clients were eligible for managed care. Of this number, 201,402 recipients were enrolled in the Medallion program (primary case management program). Another 36,203 were enrolled in the Options HMO program (voluntary capitated managed care program), while 93,835 were enrolled in the Medallion II program (mandatory HMO coverage) that was implemented January 1, 1996, in Tidewater. The remaining 41,378 were in the process of being enrolled in one of these three programs. Additional Medicaid recipients will be enrolled in Medallion II as the program is implemented in other parts of the Commonwealth.

HMO Enrollments In Virginia Have More Than Doubled In The Past Six Years

The number of Virginians enrolled in HMOs has increased 140% since 1990. HMOs enrolled more than 1 million persons in 1995 providing coverage to one out of every six Virginians. As seen in Figure 4, much of Virginia's HMO enrollees live in Northern Virginia, the Hampton Roads area and Central Virginia. However, new managed care plans are developing in the Blue Ridge, Roanoke and Southwest Virginia areas which will increase further managed care's penetration in the Commonwealth.

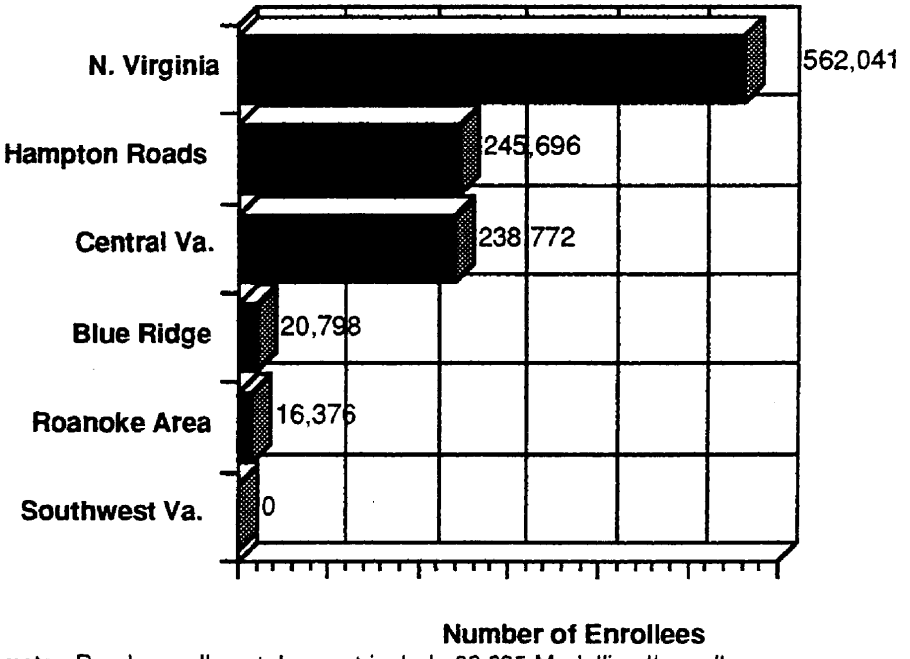
Some Providers And Patient Advocates Believe Managed Care Organizations Have Gone Too Far In Controlling Access To Care And Providers

While managed care enrollments have increased dramatically in recent years, some providers and patient advocates believe managed care organizations (MCOs) place too much emphasis on cost controls resulting in a diminution in the quality of care and inadequate access to necessary services and providers. Patients are most concerned with MCOs' requirement to utilize a primary care physician and to obtain a referral to receive care from specialty providers. Moreover, plan designs which require patients to see network providers to receive the highest benefits levels also bother managed care enrollees. Another

common complaint with MCOs is that patients have to endure the "hassle factor" in accessing care, getting questions answered, and resolving complaints.

Figure 4

HMO Enrollments in Virginia: 1995
(Total Enrollment: 1,083,683)



Note: Hampton Roads enrollment does not include 93,835 Medallion II enrollees.
Source: Virginia Association of HMOs

In the past, only a small percentage of providers' patients were enrolled in managed care plans; thus, participating in these programs did not have a major impact on a provider's practice. However, with the significant increases seen in managed care enrollments, managed care patients comprise a much larger percentage of a provider's practice. Providers' primary concerns are that: (i) managed care plans often "micro-manage" and "second-guess" the care recommended by the treating provider; (ii) there often is too much "administrative red tape" in getting services approved, making referrals and obtaining reimbursement; (iii) they often are pulled into the middle of resolving disputes between patients and the managed care entity; and (iv) some managed care organizations' provider contract provisions are inappropriate.

Legislation Has Been Passed in Virginia and Throughout the Nation to Address Patient and Provider Concerns About Managed Care

In response to the concerns voiced by patients and providers, legislation has been passed in many states, including Virginia, to provide additional protections for managed care enrollees and providers. "Any willing provider" laws, "freedom of choice" laws, minimum maternity length laws and patient/provider protection laws have been enacted in Virginia and several other states in an effort to strike a balance between the need to control costs and maintain access to quality care and providers. Virginia's laws and regulations are reviewed in Section III of this issue brief.

Senate Joint Resolution 67 Directs The Joint Commission On Health Care And The Bureau Of Insurance To Study The Appropriate Role Of State Agencies In Monitoring, Policing, And Regulating The Managed Care Industry

The regulatory oversight of traditional insurance products has remained relatively stable over the years and has focused primarily on: (i) licensing plans; (ii) monitoring the insurer's financial solvency; (iii) reviewing marketing and sales practices; and (iv) enforcing state insurance laws. While these functions are applicable to managed care plans, these entities (HMOs, PPOs, POS plans and others) also engage in activities such as making utilization review decisions, determining medical necessity, approving referrals for specialty care, and controlling access to certain providers, which are somewhat outside the scope of traditional state insurance regulation. These "patient care" and "quality of care" issues pose a different set of questions for regulators and bring into question the degree to which state oversight and regulation should focus on these functions of managed care entities.

In response to the dramatic growth in the number of Virginians in managed care plans, the varying nature of managed care entities (e.g., HMOs, PPOs, POS plans, and other risk bearing networks), the "patient care" and "quality of care" aspects of managed care plans, and the concerns of some managed care patients and providers, the General Assembly adopted Senate Joint Resolution 67, and directed the Joint Commission and the Bureau of Insurance to study the appropriate role of state agencies is overseeing the managed care industry.

This report was written by Joint Commission staff with input from the Bureau of Insurance. Section III provides an overview of the history of managed care legislation enacted in Virginia while Section IV outlines the current statutory and regulatory framework for managed care entities. Section V discusses specific concerns of some provider and patient advocates about Virginia's current oversight of managed care entities. Section VI provides an overview of how Virginia's oversight of managed care entities compares with other states. Section VII provides some overall conclusions, and Section VIII sets forth several policy options for consideration by the Joint Commission.

III.
History of Managed Care-Related Legislation in Virginia

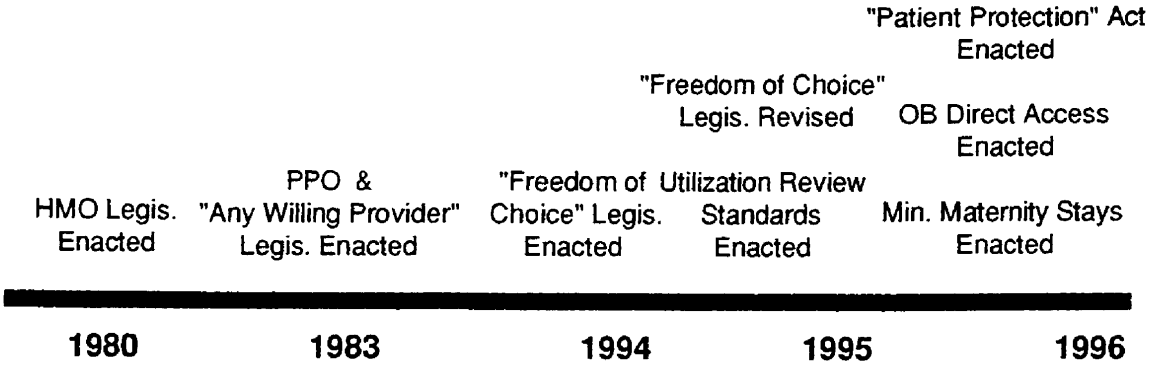
In reviewing the appropriate role of the agencies of the Commonwealth in monitoring the managed care industry, it is important to have a full understanding of the history of managed care-related legislation in Virginia and the current statutory and regulatory framework that currently exists.

Since The Enactment of The Health Maintenance Organization (HMO) Act in 1980, Virginia Has Passed A Number of Managed Care-Related Insurance Laws

Since the passage of the HMO Act (Chapter 43 of the Code of Virginia) in 1980, Virginia has passed a number of managed care-related insurance laws. While most of these laws apply to all types of comprehensive health insurance and not just managed care, they represent an important part of Virginia's current statutory and regulatory framework within which managed care plans and entities function. Figure 5 provides a historical illustration of the managed care-related legislation enacted in Virginia.

Figure 5

Legislative History of Managed Care in Virginia (1980 - 1996)



Source: Joint Commission on Health Care Staff Analysis

HMO Act of 1980: Chapter 43 of Title 38.2 of the Code of Virginia is referred to as the HMO Act. This law, which was passed in 1980, provides legislative authority for the establishment and operation of HMOs. Chapter 43 outlines all of the requirements that HMOs must meet to be licensed and to operate in Virginia, and specifies the Bureau of Insurance's role and responsibilities in regulating HMOs. Most of the regulatory and statutory requirements of HMOs are contained in Chapter 43. However, §38.2-4319, commonly referred to as the "HMO sweep-in" provisions, lists a number of other insurance laws that pertain to the operation of HMOs. Chapter 43 will be discussed in greater detail later in this section.

Preferred Provider Organization/Any Willing Provider Statute: In 1983, the General Assembly passed legislation authorizing the creation and operation of preferred provider organizations (PPOs). Included in this legislation was a provision (§38.2-3407) that requires PPOs to accept into their provider networks any provider willing to meet the terms and conditions established by the plan. This law, referred to as the "any willing provider" law, is seen as an important protection for providers wishing to participate in these provider networks. Conversely, PPO plans argue that this law reduces their ability to negotiate cost-effective provider contracts, adds unnecessary providers to their networks, and drives up health care costs. (The any willing provider law does not apply to HMOs.)

"Freedom of Choice" Legislation: The 1994 General Assembly passed legislation requiring health insurers and HMOs to permit enrollees to receive pharmacy and ancillary services from providers of their choice so long as the provider agrees to accept the plan's payment as reimbursement in full. This legislation expands the number of providers from whom enrollees can receive services and still obtain the highest level of benefits offered by their insurance coverage. In 1995, the General Assembly repealed the freedom of choice provisions that pertained to ancillary service providers.

Utilization Review Standards: The 1995 Session of the General Assembly passed House Bill 1973 which established standards for utilization review (UR) and for appeals of adverse utilization review decisions. Chapter 54 of Title 38.2 requires each entity performing utilization review to develop standards and

criteria that are objective, clinically valid and compatible with established principles of health care. Additionally, UR entities must establish their plans according to certain criteria, and must inform enrollees of their UR procedures. UR entities are required to be accessible to both patients and providers at least 40 hours per week during normal business hours, and treating providers are required to be notified of any adverse UR decision within two working days of the decision. Decisions on expedited appeals must be rendered no later than one business day after receipt of all necessary information.

This legislation also requires UR entities to establish a method for reconsidering adverse decisions and to notify the treating provider of the reconsideration decision within 10 working days. In addition, UR entities must establish an appeals process for consideration of any final adverse decisions made by the entity and appealed by the patient or provider. The appeals process for considering the entity's final adverse decision must be conducted by a physician advisor who is 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. Further, the physician advisor who reviews the appeal shall: (i) not have participated in the adverse decision or any prior reconsideration thereof, (ii) not be employed by or a director of the UR entity, and (iii) be licensed to practice in Virginia or under a comparable licensing law of another state as a peer of the treating health care provider.

UR entities also are required to maintain records on their respective UR processes, the number of complaints received and the decisions made on each complaint.

Direct Access to Obstetricians/Gynecologists: In 1996, the General Assembly passed legislation requiring insurers, including HMOs, to permit females to have direct access to obstetrical-gynecological services without the necessity of a prior referral from a primary care physician. Services covered by this exception include: (i) an annual wellness examination and (ii) routine health care services incident to and rendered during the annual exam. Additional services can be provided during follow-up care or subsequent visits if there is consultation with the primary care provider.

This legislation was enacted in response to concerns from women and obstetricians that managed care plans were not providing adequate access to obstetrical care.

Minimum Length of Stay for Maternity Admissions: The 1996 General Assembly also passed legislation requiring insurers and HMOs to provide benefits for maternity inpatient admissions and subsequent postpartum home visits in accordance with the medical criteria outlined in the "Guidelines for Perinatal Care" or the "Standards for Obstetric-Gynecologic Services."

This legislation was passed to address concerns that managed care plans were discontinuing maternity benefits for enrollees prior to the time at which the attending physician felt it was appropriate for the mother to be discharged. Similar legislation has been passed in a number of states across the country.

"Patient Protection Act": This legislation, which was passed by the 1996 General Assembly, addressed a number of different concerns of providers and patients regarding the manner in which health insurers and HMOs establish and operate their provider networks. Section 38.2-3407.10 of the Code of Virginia requires carriers to:

* provide notice to the Department of Health Professions when developing a provider network and to furnish a provider application and the relevant terms and conditions to a provider upon request;
* provide certain information to their enrollees, including (i) a notice when the enrollee's primary care provider terminates participation in the network, and (ii) the right of an enrollee to continue health care services for up to 60 days after the primary care provider's notice of termination (except for termination for cause);
* notify providers at least 60 days prior to their termination from the network (except termination for cause), and notify primary care providers of the termination of specialty providers;
* provide purchasers: (i) a description of all types of payment arrangements the carrier uses to reimburse its providers, (ii) information about the terms of the plan in clear language, and (iii) a list of network providers at least once each year; and

* allow patients to receive care for up to 60 days from a terminated provider (except termination for cause) under certain circumstances.

The legislation also prohibits insurers/HMOs from including certain provisions in their provider contracts. Specifically, carriers cannot: (i) require a provider to indemnify a carrier for the carrier's negligence; (ii) require a provider to waive any right to seek legal redress against the carrier; or (iii) prohibit, impede or interfere in the discussion of medical treatment options between a patient and provider. Provider contracts shall permit and require the provider to discuss medical treatment options with the patient.

The second enactment clause of the "patient protection act" directs the Joint Commission on Health Care, in cooperation with the Bureau of Insurance, to study whether HMOs should be required to offer a "point-of-service" option to their enrollees. In addition, the Joint Commission is to study whether certain insurance laws should apply to other provider panels currently not subject to state insurance regulation. This study was presented to the Joint Commission at its October 28th meeting.

Virginia Has Been Recognized By A National Consumer Group As Having Some Of The Broadest Managed Care Consumer Protections In The Country

Families USA Foundation, a national consumer group, issued a report in July, 1996, entitled "HMO Consumers At Risk: States to the Rescue." In this publication, Virginia was cited as one of seven states across the nation which have adopted extensive protections for HMO consumers. The other six states were Georgia, Kansas, Maine, New York, Rhode Island, and West Virginia. This recognition appears to be due in large part to the legislation passed during the 1996 session. A more detailed analysis of the Families USA report is presented in Section VI of this issue brief.

IV.
Virginia's Current Statutory and Regulatory Oversight of Managed Care

Some State Insurance Laws Apply To Only A Portion Of The Insurance Marketplace.

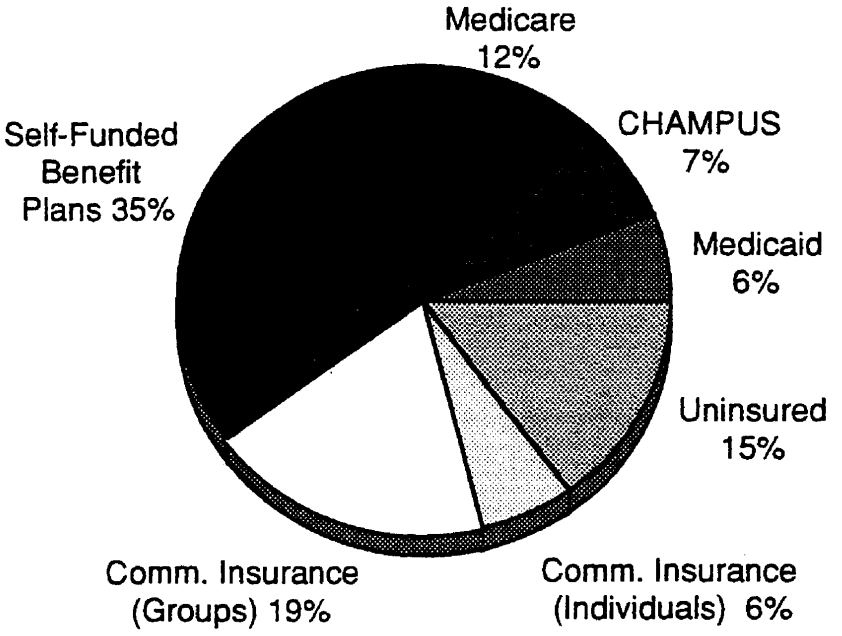
All insurers and HMOs operating in the state have to be licensed and must meet the various licensing requirements included in the Code of Virginia. However, in reviewing the current statutory and regulatory oversight of managed care, it is important to recognize that some of Virginia's insurance laws and regulations (e.g., mandated insurance benefits) apply only to the commercial insurance or "fully-insured" portion of the marketplace. Self-funded plans, typically large employer groups, are not subject to state insurance regulation because of an exemption provided through the Employee Retirement Income Security Act (ERISA). Other publicly funded health insurance programs such as Medicare and CHAMPUS are subject to federal laws and regulations. While states have some discretion in the design of their respective Medicaid programs, the federal government also plays a major role in how this program is administered.

Accordingly, as illustrated in Figure 6, many of the Commonwealth's insurance laws and regulations in Virginia affect only about 25% of Virginians (approximately 19% in commercial *group* insurance and 9% in commercial *individual* insurance). It is within this context that Virginia's oversight of managed care is discussed and analyzed in this report.

Another important consideration regarding an individual's source of health insurance coverage is that, depending on the sponsor of the coverage, a covered enrollee may or may not receive support from the sponsor in understanding and utilizing their coverage. Recipients of publicly funded benefits can obtain assistance from the appropriate public agency. Large employers often provide assistance to employees who have problems with their insurance carrier. Conversely, enrollees working for employers that do not have the resources to provide assistance, as well as enrollees who purchase coverage on their own, likely have no support and must navigate through insurance problems by themselves.

Figure 6

Health Insurance Status of Virginia's Population: 1992



Source: Virginia Commonwealth University, Survey Research Laboratory, U.S. Health Care Financing Administration, CHAMPUS Staff, Joint Commission on Health Care Staff

Several State Agencies Have A Role In Overseeing Managed Care Plans And Programs

A number of state agencies have responsibilities for overseeing various aspects of managed care. Figure 7 identifies these agencies and provides a brief description of their responsibilities.

The following paragraphs detail the various responsibilities of the state agencies with managed care oversight responsibilities.

The State Corporation Commission's Bureau of Insurance Regulates HMOs and Other Insurers Which Offer Managed Care Products

The State Corporation Commission's Bureau of Insurance (Bureau) is the state agency which regulates the insurance industry, including HMOs and other carriers which offer managed care products. Through its regulatory role, the

Bureau oversees many aspects of insurers and HMOs. Chapter 43 of Title 38.2 of the Code of Virginia specifies the current responsibilities of the Bureau in regulating HMOs. In addition to the statutory authority provided in the Code, the Bureau issues various sets of regulations which must be followed by HMOs and/or other carriers. Figure 8 illustrates the HMO oversight functions of the Bureau as provided in the Code of Virginia.

Figure 7

Managed Care Oversight Functions Of State Agencies

State Agency	Primary Oversight Function
State Corporation Commission Insurance)	Overall responsibility for regulation of (Bureau of HMOs and other insurance carriers
Department of Health	Authority to review HMOs' quality of health care services, HMO enrollee complaint systems, and HMOs' annual statements
Office of the Attorney General	Represents consumers (including health care consumers) before governmental commissions, agencies and departments; enforces state anti-trust laws; provides legal counsel to state agencies involved in health-related functions
Department of Health Professions	Licenses and regulates various health professionals; maintains listing of provider networks being developed by managed care organizations
Department of Medical Assistance Services	Contracts with and monitors HMOs participating in the Medallion II and Options programs for Medicaid recipients
Department of Personnel and Training	Contracts with and monitors HMOs and the state's self-funded preferred provider organization program for the state employee health benefits program

Source: Joint Commission on Health Care Staff Analysis

Figure 8

Key Responsibilities Of The State Corporation Commission's Bureau Of Insurance In Regulating HMOs

Code Section	Regulatory Function
38.2-4302, 4318	Issues HMO license; ensures HMOs meet certain licensure conditions; renews HMO licenses
38.2-4306	Reviews and approves evidences of coverage issued by HMOs
38.2-4308	Reviews and approves HMOs' enrollees' complaint system
38.2-4310, 4317, 4317.1	Establishes financial solvency requirements for HMOs; enforces certain provisions should an HMO become insolvent
38.2-4315	Performs market conduct examinations of HMOs at least once every five years, may examine the affairs of providers with whom the HMO contracts
38.2-4316	Suspends or revokes HMO license for various reasons
38.2-4319*	Issue cease & desist orders; injunctive authority

* **Note** Section 38.2-4319 provides authority to the Bureau of Insurance by reference to other sections of insurance law included in the Code of Virginia.

Source: Joint Commission on Health Care Staff Analysis of the Code of Virginia

The Bureau of Insurance Believes Its Most Important Regulatory Role Is Licensing Plans, And Overseeing Plans' Financial Solvency, Marketing, Advertising and Sales Activities, And Compliance With State Laws

As noted earlier in this issue brief, licensing plans; regulating the solvency of insurance plans; reviewing plans' marketing, advertising and sales practices; and ensuring compliance with state laws have been important roles for insurance regulators for many years. These functions provide important consumer protections, and are considered by the Bureau as its most important regulatory responsibilities. Much of the Bureau's expertise, efforts, and resources are devoted to these functions.

Approval of HMO Evidences of Coverage: In this capacity, the Bureau ensures that: (i) the evidence of coverage contains no false or misleading information; (ii) all aspects of the coverage are clear and understandable; (iii) the benefits and limitations/exclusions are clearly stated; (iv) there is a clear description of the HMO's process for resolving enrollee complaints; and (v) other statutory requirements are met.

Approval of HMOs' Complaint System: The Bureau reviews and approves each HMO's enrollee complaint system (written complaints) prior to issuing a license. The Bureau also receives annual reports from the HMOs on the number and types of complaints, the causes underlying the complaints filed, and the number, amount, and disposition of malpractice claims settled or adjudicated during the year by the HMO and any of its health care providers.

Bureau staff indicate that the annual reports are received from the HMOs and reviewed to ensure that the HMOs, in fact, are administering a complaint system as indicated in the plan description submitted to the Bureau. However, the Bureau does not review the complaints to determine if, in the Bureau's judgment, the complaint was resolved appropriately.

Market Conduct Examinations: As with all insurers, the Bureau conducts market conduct examinations on HMOs and other managed care carriers. These exams are conducted on HMOs at least once every five years, and include a review of many aspects of a managed care entity/HMO's operation. As provided in § 38.2-1317.1, the Bureau examines such matters as the conduct of business in the marketplace, results of financial statement analyses and ratios, changes in ownership, actuarial opinions and compliance with all applicable state insurance/HMO laws.

In conducting the market exams, the Bureau ensures that the managed care entity/HMO is conducting its business in accordance with its plan descriptions, evidences of coverage, and other written documents. The Bureau also makes certain that the entity has established necessary procedures for complying with various state requirements. However, the Bureau's review does not include an assessment of whether an HMO or other entity is making appropriate, quality-driven decisions on issues such as medical necessity determinations, utilization

review, access to providers, etc. As will be discussed later, this is an item of concern with some providers and patient advocates.

The Bureau Ensures HMOs Meet Several Requirements Included In Chapter 43 Of Title 38.2

In addition to the regulatory responsibilities of the Bureau that are outlined in Chapter 43 of Title 38.2, the HMO Act also places several requirements on HMOs. Figure 9 identifies the key mandates of the act that pertain to HMOs.

Other Managed Care Products Are Subject To Less Oversight and Regulation By The Bureau Of Insurance

Much of the regulation and oversight that the Bureau provides for HMOs also applies to other insurers, including carriers which offer managed care products such as preferred provider organizations and point-of-service plans. These carriers must comply with various statutory and regulatory provisions including financial solvency requirements, marketing and sales restrictions, unfair trade practices prohibitions, utilization review requirements, mandated benefits, etc. However, several provisions are applicable only to HMOs and do not extend to other carriers offering managed care products. These provisions include: (i) annual reports of HMO enrollee complaints, (ii) enrollee involvement in the HMO's matters of policy and operation, (iii) examination by the State Health Commissioner on the quality of health care services provided by the HMO and its contracted providers (discussed later), and (iv) tighter restrictions on the issuance of a HMO license.

Depending on how they are organized and operated, there are other types of provider panels which contract with employers and carriers to provide managed care services that are subject to even less, and, perhaps, no state regulation. The degree to which these entities exist and should be subject to state insurance regulation is being studied by the Joint Commission pursuant to House Bill 1393 of the 1996 Session of the General Assembly.

Figure 9

Key Mandates of the HMO Act (Chapter 43 of Title 38.2)

Code Section	HMO Requirement
38.2-4304	HMO governing body must establish mechanism for enrollees to participate in policy and operation matters
38.2-4306	Evidences of coverage must include certain information, including a description of the HMO's method of resolving enrollees' complaints, and a list of providers
38.2-4307	HMOs must submit annual statements with information on its financial balance, number of enrollees, and any material changes in previously submitted information
38.2-4308 (A)	HMOs must establish a complaint system for resolution of written complaints after consultation with State Health Commissioner and approval of State Corporation Commission
38.2-4308 (B)	HMOs must submit annual complaint report which must include: description of complaint process; total number of complaints; compilation of underlying causes for complaints; and the number, amount, and disposition of malpractice claims settled or adjudicated by the HMO and any of its providers
38.2-4311	HMOs must submit a list of health care providers with whom it contracts; list must be updated quarterly
38.2-4312	HMOs are prohibited from engaging in certain practices, including: knowingly providing false information; canceling an enrollee's coverage due to health status; discriminating against providers on basis of race, creed, color, sex or religion
38.2-4312.1	HMOs cannot prohibit persons from receiving pharmacy services from a provider of their choice as long as the provider accepts reimbursement as payment in full (this law applies to all health insurers)
38.2-4319*	HMOs must comply with several other laws, including: unfair trade practices (38.2-500 et. seq.), the patient protection act (38.2-3407.10), mandated benefits (38.2-3418.1, et. seq.) and utilization review standards (38.2-5400 et. seq.)

* **Note** Section 38.2-4319 requires HMOs to comply with various other insurance laws by reference to other sections of the Code of Virginia.

Source: Joint Commission on Health Care Staff Analysis of the Code of Virginia

The Code of Virginia Stipulates That The Bureau of Insurance Has No Authority To Resolve Controversies Arising Out Of Certain Insurance Laws

In several sections of the Code of Virginia, the insurance laws stipulate that the Bureau of Insurance shall have no authority to adjudicate controversies arising out of a particular provision of law. For example, this language appears in §38.2-3407(B) ("any willing provider" law), §38.2-3407.6 (exclusion of podiatrists from provider networks), §38.2-3407.7 (pharmacy "freedom of choice" law), §38.2-3407.10(L) ("patient protection act"), and certain aspects of the utilization review standard requirements contained §38.2-5400 et. seq. The HMO regulations promulgated by the Bureau also state that the Bureau does not have authority to adjudicate controversies between an HMO and its enrollees.

In most of these instances, the Bureau requested that this language be added to the legislation to preclude it from getting involved in contractual disputes between health plans and their contracting providers or in quality of care judgments. The Bureau feels the language included in these sections is needed to distinguish between appropriate regulatory functions and other activities that are not within the traditional scope of insurance regulation. However, as will be discussed later, there are some provider groups and patient advocates who believe the Bureau should play a more active role in adjudicating such controversies.

The Consumer Services Section of the Bureau of Insurance's Life And Health Division Responds To Complaints Filed By Health Insurance Consumers

The Consumer Services Section of the Bureau of Insurance receives complaints from consumers of various types of insurance, including life and health insurance. While there is no legislation in the Code of Virginia requiring this service, the Consumer Services Section provides assistance to consumers who have complaints about their insurance carrier. This section does not handle complaints from providers or insurance agents.

The Consumer Services Section does not adjudicate consumer complaints nor does it have the authority to do so. Rather, the section facilitates responses from the carriers, and advocates on behalf of the consumer. If the Bureau finds a violation of insurance laws in the course of advocating for a consumer, a separate

investigation or review of the matter is undertaken, and enforcement actions are taken, if necessary.

Bureau of Insurance statistics for the 12 month period from July, 1995 through June, 1996, indicate that a total of 3,382 complaints were received by the Consumer Services Section of the Life and Health Division. It is estimated that approximately 1,656 (49%) of these complaints were from health insurance consumers.

The State Health Commissioner Has Authority To Oversee Certain Aspects Of HMOs' Operations

The HMO Act (Chapter 43 of Title 38.2) references the State Health Commissioner in several sections of the act, and provides certain authority to the State Health Commissioner in overseeing the operations of HMOs. This authority does not extend to other insurance carriers which offer managed care products. The provisions of the HMO Act that pertain to the State Health Commissioner are outlined below.

* Section 38.2-4307 (A) stipulates that HMOs must send a copy of their annual statements to the State Health Commissioner (Commissioner).
* Section 38.2-4308 requires HMOs to consult with the Commissioner in establishing their complaint system for handling written complaints, requires HMOs to send a copy of their annual complaint report to the Commissioner, and provides that the Commissioner "may" examine the complaint system.
* Section 38.2-4315 (B) provides that the Commissioner "may" examine the quality of health care services of HMOs or providers with whom the HMO contracts, and "may" administer oaths to and examine officers and agents of the HMO and the principals of the providers concerning their business.
* Section 38.2-4316 states that the State Corporation Commission may suspend or revoke an HMO's license for several reasons, including receiving certification from the State Health Commissioner ". . . that the health maintenance organization is unable to fulfill its obligations to furnish quality health care services as set forth in its health care plan

consistent with prevailing medical care standards and practices in the Commonwealth."

Some of the above-noted Code provisions are somewhat vague and do not provide specific direction as to the role that DOH should be playing in monitoring HMOs. There are no regulations that amplify or clarify the department's role; and, until recently, there has been little interaction between the Bureau and DOH with respect to the department's authority. As previously noted, DOH has no authority to review or monitor aspects of other health insurance carriers offering managed care products.

To Date, The Department Of Health Has Exercised Very Little Of Its Authority In Monitoring The Operations Of HMOs

In the past, the Department of Health (DOH) has not exercised the authority provided in the Code for overseeing certain aspects of HMOs' operations. The word "may" that appears in §38.2-4315 (B) likely is one reason why the department has not taken a very active role in reviewing the quality of HMOs' health care services. The department has reviewed the complaint systems developed by HMOs and the annual complaint reports, but the reviews essentially have been a "paper exercise" with little impact. The department has received only five complaints on HMO operations which were referred by the Bureau of Insurance and local health departments. There is no authority to act on the complaints the department receives.

The Department Of Health Has Initiated A Collaborative Process With The Bureau Of Insurance To Take A More Active Role In The Oversight Of HMOs

Within the last few months, DOH, under the direction of the new State Health Commissioner, has taken steps to increase the department's role in overseeing certain aspects of HMOs' operations. The department has initiated discussions with the Bureau of Insurance and has drafted a "memorandum of understanding" between the department and the Bureau which outlines the expanded role of the department and how this role will be coordinated with the Bureau's activities. The "memorandum of understanding," which still is being finalized, contains the following key provisions:

* DOH will participate in the Bureau's market conduct examinations to review and approve HMOs' complaint systems;
* DOH will monitor the licensure status of HMOs' providers to ensure compliance with state licensing laws; any violations will be reported to the Bureau;
* DOH will review HMOs' quality assurance and utilization review programs;
* DOH will review the number and types of providers in HMO networks to assure enrollees have adequate access to care; and
* DOH will conduct system level, administrative reviews (not case by case investigations) of consumer/provider complaints.

The department also has hired a consultant to help in identifying the most appropriate role for the agency to take in monitoring managed care. The department's principal focus will be on quality of care issues rather than the more traditional regulatory functions (e.g., solvency, marketing and sales, etc.). The department hopes to shape its new, enhanced role within the next few months, and will be working with the Bureau and other state agencies to ensure its new role is in concert with these agencies' managed care responsibilities and functions.

The Office Of The Attorney General Does Not Have A Direct Oversight Role Specific To The Managed Care Industry

As provided in §2.1-133.1 of the Code of Virginia, there is a Division of Consumer Counsel within the Office of the Attorney General (OAG). While this division does not have a direct role in overseeing managed care, it does represent consumers (including health insurance consumers) before governmental commissions, agencies and departments, including the State Corporation Commission. The division handles only major consumer cases which affect numerous subscribers and does not get involved in individual health insurance complaints. These types of complaints are referred to the Consumer Services Section of the Bureau of Insurance. The OAG's Division of Consumer Counsel also studies issues related to the enforcement of the Commonwealth's consumer laws.

The OAG also enforces the state's anti-trust laws which may involve health insurance companies or managed care entities. Providing legal counsel to state agencies, including those involved in health care licensing, purchasing and regulation, also is a role of the OAG.

The Department Of Health Professions Licenses And Regulates Health Care Professionals But Has A Very Limited Role Specific To Managed Care

The various licensing boards of the Department of Health Professions (DHP) license and regulate health care professionals. The licensure and regulatory activities of DHP concentrate on the professional competency of the individual provider and do not have any special focus on managed care. As provided in §38.2-3410 (B)(1), carriers file a notice with the department of any provider panels being developed in the Commonwealth.

DHP Study of Utilization Review Agents: In response to a request from the group "Virginians for Mental Health Equity (VMHE)," the Board of Health Professions agreed to undertake a study to address three primary questions regarding utilization review (UR) agents: (i) should UR agents who make medical necessity determinations be required to hold valid Virginia licenses in their respective professions; (ii) are the decisions and recommendations relating to these agents' duties subject to disciplinary action by their respective health regulatory board; and (iii) what other methods, if any, are available which could assure that decisions made on medical necessity are made responsibly and with professional accountability.

The chief concern cited in the request for the study is that UR agents serve as "gatekeepers" to individuals' access to health care. Other than through civil means, there is no statutory provision for individual accountability. VMHE argues that since current applicable laws contain no enforcement provisions, there is little accountability for third party companies which employ UR agents. The study is underway now, and DHP staff indicate that it likely will be concluded sometime in 1997.

Department of Medical Assistance Services Contracts With And Monitors HMOs Participating In The Medallion II and Options Medicaid Programs

The Department of Medical Assistance Services (DMAS) contracts with and monitors the HMOs which participate in two of Medicaid's managed care programs, Options and Medallion II. The DMAS contracts include a number of requirements that HMOs must adhere to in order to provide services to Medicaid recipients, including several that relate to the quality of care provided by the HMO. HMOs must: (i) submit encounter data to DMAS for analysis; (ii) have marketing and other recipient information approved by DMAS; (iii) have a complaint/grievance procedure for recipients and submit information on complaints received; and (iv) meet certain access and network provider minimum requirements.

Medicaid Quality of Care Reviews: DMAS has taken several steps to help assure Medicaid recipients receive quality health care. DMAS administers an appeals process for recipients who have complaints that are not resolved by the HMO. If necessary to resolve the dispute/complaint, DMAS has the authority to require the HMO to take certain corrective actions. In addition to its appeals process, DMAS also contracts with the Virginia Health Quality Center (VHQC) and the Williamson Institute at Virginia Commonwealth University to assist the department in monitoring the quality of care received by Medicaid recipients. VHQC reviews certain recipient complaints dealing with quality of care issues and reviews certain encounter data. The Williamson Institute conducts recipient satisfaction surveys and performs quality of care assessments by studying certain medical conditions. Currently, the Williamson Institute is studying the quality of care Medicaid recipients with pediatric asthma and hypertension are receiving.

Department of Personnel And Training Requires HMOs And Other Program Administrators Participating In State Employee Health Benefits Program To Meet Certain Requirements

Like DMAS, the Department of Personnel and Training (DPT) does not have a role in *regulating* managed care entities, but does require plans participating in the state employee benefits program to meet certain requirements. To be a participating HMO, plans are selected through a procurement process which evaluates each plan on several factors, including: (i)

the accessibility and capabilities of their provider networks, (ii) their quality assurance and complaint systems, (iii) their customer service capabilities, and (iv) their utilization review procedures. Plans which do not meet contractual requirements can be penalized by DPT or eliminated as a program offering.

In each state agency, a benefits administrator assists employees with various health insurance issues. In addition, the Office of Health Benefits Programs at the Department of Personnel and Training (DPT) works with the agency benefits administrators to resolve employee complaints. DPT also works with the HMOs and other program administrators to resolve employee problems.

In Addition To State Oversight And Regulation, There Are Other Governmental And Private Entities Which Oversee Or Monitor HMOs

In addition to state oversight, there are other governmental and private entities which impact the operation of HMOs and some other managed care plans.

Federal HMO Act: The Federal HMO Act includes consumer protection standards for managed care plans seeking federal certification. These standards include benefits coverage, access to care, physician participation in developing medical policy, utilization review processes, and financial solvency.

Social Security Act: Section 1876 of the Social Security Act establishes standards for health plans with Medicare managed care risk contracts. This law includes many of the same consumer protections provided in the Federal HMO Act.

Utilization Review Accreditation Commission (URAC): The URAC is an independent non-profit accrediting body that reviews and accredits utilization review organizations. HMOs and other plans which elect to seek URAC accreditation must meet a number of criteria and requirements.

National Committee for Quality Assurance (NCQA): NCQA is an independent non-profit organization that assesses a managed care plan's quality of care and quality management through a stringent accreditation process.

Health plans can voluntarily seek NCQA accreditation. Many employers and other managed care purchasers require their managed care plans to seek NCQA certification.

V.
Provider/Consumer Concerns Regarding Managed Care Oversight In Virginia

Some Provider Groups And Patient Advocates Have Expressed Concern That Additional Protections Are Needed For Managed Care Enrollees

While a number of laws have been passed in recent years to provide protections for managed care consumers and providers, and several state agencies are involved to varying degrees in the oversight of managed care plans, some provider groups (principally physicians and other health professionals) and patient advocates believe additional protections are needed for both providers and managed care patients.

Three Primary Concerns: The issues raised by these provider groups and patient advocates can be capsulated in three primary concerns about the state's current oversight of managed care. These three concerns are outlined below.

1. The Commonwealth needs to take a more aggressive posture in overseeing managed care plans and enforcing current insurance laws.
2. There is a need for an independent appeals process for patients and providers to have various types of complaints against managed care plans heard and resolved. This process could function either as an ombudsman program which facilitates or advocates on behalf of complainants, or, preferably, has authority to adjudicate and resolve the complaint.
3. Additional consumer information on managed care plans regarding quality of care, the size and composition of provider networks, grievance procedures, customer satisfaction, accreditation status and other pertinent matters is needed to better inform patients about these plans.

For each of the three primary concerns identified above, a discussion of the concern is provided along with a summary of the thoughts and reactions of the Bureau of Insurance, the managed care industry, and the business community, where applicable.

Concern # 1: Provider Groups and Patient Advocates Believe More Enforcement of Current Insurance Laws Is Needed

Some providers and patient advocates feel that while the Commonwealth has passed a number of laws expanding patient and provider rights in managed care settings, enforcement of some of these laws is lacking and needs to be strengthened. As an example, the state's "any willing provider" law prohibits preferred provider organization plans from excluding any provider willing to meet the terms and conditions of the plan. However, the statute also states that the State Corporation Commission shall have no authority to adjudicate controversies arising from this law. Some providers and patient advocates feel that this provision effectively makes the law unenforceable, and, as a result, numerous violations are occurring.

A similar example of the need for more enforcement identified by some providers and patient advocates is the recently enacted Patient Protection Act (§38.2-3410). While this law provides a number of protections for providers and consumers, the State Corporation Commission has no authority to adjudicate controversies arising out of the law. As noted in Section IV of this report, similar language appears in other sections of the Code including limitations on the Commission's authority to adjudicate certain controversies arising out of the utilization review standards law (§38.2-5400, et. seq.).

Another area in which some providers and patient advocates believe additional enforcement is needed is in reviewing the appropriateness of managed care plans' medical necessity determinations, resolution of consumer complaints, and overall quality of care. During market conduct examinations, the Bureau of Insurance reviews managed care organizations' operations to ensure the plans have the required processes in place and that they comply with insurance laws; however, the Bureau does not pass judgment on the appropriateness of the decisions made by the plan in carrying out the required process. Provider and patient advocates believe such a review should be conducted by a state agency or other entity to assure patients receive quality care.

The Bureau of Insurance Believes Its Current Regulatory Role Is Appropriate

Officials at the Bureau believe its current regulatory role is appropriate, and that it should focus its oversight primarily on plans' licensure, financial solvency, marketing and sales conduct, and compliance with state insurance laws. The Bureau believes it should not become involved in settling contractual disputes between plans and providers nor should it be reviewing and passing judgment on the appropriateness of medical decisions made by managed care plans. With respect to contractual disputes, the Bureau feels providers should seek redress through the courts in the same manner other contractual disputes are settled. Regarding the medical decisions made by managed care plans, the Bureau's position is that, as an insurance regulator, it would not be appropriate for it to make decisions on medical matters; moreover, they do not have the expertise on staff to make such determinations. If such determinations are to be made, the Bureau feels it would be more appropriate to locate this responsibility in an agency with medical expertise such as the Department of Health.

The Insurance And Business Communities Believe Current Oversight Of Managed Care Is Appropriate

The insurance industry, including HMOs and the business community, which represents major purchasers of managed care services, believe the current level and type of managed care oversight, regulation and enforcement is appropriate. They argue that managed care already is heavily regulated and that additional regulation and oversight would result in "micro-management" of the industry and higher costs. The HMO industry asserts that it is regulated far more than any other insurance-related activity and that further oversight and enforcement would seriously hamper its ability to administer cost-effective products.

Insurance industry and business community representatives also point to other governmental oversight (i.e., federal regulation) and private accreditation and review entities (e.g., NCQA and URAC) as additional reasons why further state oversight and enforcement is not necessary. Lastly, they argue that the marketplace itself pushes managed care plans to meet consumer and provider needs, and, if a plan does not meet these needs, it will not survive.

Concern #2: An Independent Appeals/Dispute Resolution Process Is Needed To Facilitate Resolution And/Or Adjudicate Patient And Provider Complaints

The most pressing need identified by some provider groups and patient advocates is an independent appeals process or some other mechanism for resolving patient and provider disputes with managed care entities. The responsible entity could be a state agency, or the responsibility could be contracted out to a private entity. While health plans are required to have consumer complaint processes, these are thought to be subject to bias on the part of the plan and often do not provide an objective review of the issue. The court system also provides a means for adjudicating complaints; however, this is considered to be beyond the financial means of many consumers due to the cost involved in pursuing resolution through the courts. In addition, the legal process often is thought to be too lengthy and inefficient.

Advocates of an independent appeals process state that enrollees often get frustrated trying to resolve issues with managed care plans. They contend that the problem often can be resolved simply by getting "the right people to talk to one another" and to verify the facts of a given situation. Very often, matters are resolved by a provider or patient providing additional or corrected information to the plan. In some cases, the problem is simply a misunderstanding of the facts, and once the misunderstanding is resolved, the problem, too, is resolved.

Patient and Provider Complaints: The appeals/dispute resolution process envisioned by providers and patient advocates would allow both providers and consumers to have managed care disputes and complaints reviewed by a state entity or other independent entity. Consumer complaints would include such matters as: (i) medical necessity determinations; (ii) utilization review decisions; (iii) benefit denials; (iv) access to certain providers; (v) billing/claims adjudication problems; and (vi) administrative/record-keeping problems. Examples of provider complaints that would be reviewed through the process would include such issues as: (i) alleged violations of the "any willing provider" law and laws dealing with health plan networks and mandated access to certain providers (e.g., direct access to OBGYN); (ii) reimbursement complaints (e.g., "down-coding" of provider submitted claims); and (iii) contractual disputes.

Two Possible Approaches: Ombudsman or Adjudicatory Authority: There are two possible approaches to establishing an independent appeals/dispute resolution process. The first approach would be an "ombudsman" type of program wherein the state agency or independent entity would advocate on behalf of the patient or provider and facilitate resolution of the complaint, but would not have any authority to adjudicate the complaint. The second approach would involve adjudicatory authority which would empower the entity to enforce a resolution to the complaint. Those advocating such a process believe the latter approach, one with adjudicatory authority, would be the better approach.

The Virginia Health Quality Center Administers An Appeals/Complaint Process For Medicare Enrollees Enrolled In Medicare Risk HMOs; Medicaid Recipients Can Appeal HMO Disputes To The Department Of Medical Assistance Services

As part of its peer review responsibilities for the Medicare program, the Virginia Health Quality Center (VHQC) administers an appeals/complaint process for Medicare enrollees enrolled in Medicare risk HMOs. Such a process is required by the U.S. Health Care Financing Administration. The VHQC receives and reviews written complaints from beneficiaries on the quality of medical care they receive. Many of the reviews involve care received from providers as opposed to complaints about the plans. If necessary, the VHQC has the authority to require an "improvement action" on a provider, and can impose sanctions through HCFA.

The VHQC believes that if an appeals/complaint process is implemented in Virginia for all managed care enrollees, the Commonwealth should conduct a competitive bidding process to select an appropriate entity to administer such a process.

As noted earlier, the Department of Medical Assistance Services administers an appeals process for Medicaid recipients. This process is in addition to the internal appeals/grievance procedures HMOs are required to administer. The VHQC assists DMAS in this process by reviewing certain quality of care complaints and making recommendations to the department for resolving the issue.

Consumer Rights Organizations Recommend Appeals Processes For Managed Care Enrollees

An independent appeals/complaint review process is recommended by some consumer rights organizations. The Center for Health Care Rights, a non-profit organization dedicated to ensuring that health care consumers obtain high quality medical care, recommended in its 1995 report "Consumer Protections in State HMO Laws" that states should provide "funding for independent non-profit ombudsman programs to provide free information, counseling and legal assistance to HMO enrollees."

The Public Policy and Education Fund of New York, in cooperation with the Citizens Fund, published "The Managed Care Consumers' Bill of Rights" in 1995. The document includes 10 consumer rights, one of which is that consumers should have the right to "an external appeals process, with the decision made by a neutral third party." The external appeals process should include a "Patients Advocate Office" which functions as an ombudsman program to advocate for enrollees.

The Bureau Of Insurance Believes That The Need For An Independent Appeals Process Is No Greater For Managed Care Than For Any Other Type Of Insurance, And That Such A Process At The Bureau Would Require Extensive New Resources

The Bureau indicated that there are more protections for managed care enrollees than for enrollees of any other kind of insurance. In addition, the grievance procedures provided by the HMOs and the complaint review process at the Bureau provide consumers with an appeals process. The Bureau believes that the need for an independent appeals process is no greater for managed care enrollees than for any other line of insurance. Moreover, the Bureau believes that if the complaints relate primarily to quality of care issues, an agency with medical expertise would be better suited to administer such a process. If the Bureau were to be charged with administering such a program, it believes significant new resources would be necessary.

Managed Care Organizations And The Business Community Believe An Independent Appeals Process Is Not Needed

Managed care organizations and the business community contend that an independent appeals/complaint review process is not needed and would add unnecessary costs to health care. These groups cite the existence of appeal and grievance procedures by the plans and the Consumer Services Section of the Bureau as providing adequate avenues of appeal for managed care enrollees. These groups also point to the utilization review standards in §38.2-5400 et. seq. of the Code as providing an independent appeals process for utilization review decisions and medical necessity determinations. In addition, they argue that these provisions and those included in the patient protection act were enacted very recently, and that before enacting an additional appeals process, these laws should be given an opportunity to have an impact in the marketplace.

Concern #3: Additional Consumer Information On Managed Care Organizations Is Needed

Providers and patient advocates stress the need to have additional consumer information available on managed care organizations to assist enrollees in selecting their managed care plan. Information on how providers are selected for inclusion in plan networks, quality of care outcomes, patient satisfaction rates, complaint adjudication, and health plan "report cards" are needed by consumers.

There Is General Agreement Among All Parties That Additional Consumer Information On Health Plans Would Be Helpful

The need for additional consumer information on health plans, including managed care plans, is recognized by all segments of the health care marketplace. Information on quality of care is needed not only on health plans but all providers.

There currently is much activity in the marketplace to produce this type of information. The National Committee on Quality Assurance (NCQA) has developed a standardized set of health plan data called the Health Employer Data and Information Set (HEDIS). HEDIS is designed to produce information

on HMOs on a wide range of variables, including quality of care measurements. NCQA just recently announced the establishment of a national database for purchasers and consumers on the quality of managed care plans. The "Quality Compass," which just became available, integrates and summarizes NCQA accreditation information and HEDIS data. It also will allow plans to compare their performance against regional and national databases.

The August issue of "Consumer Reports" provided an assessment of 37 HMOs based on a survey of 20,000 subscribers. In Virginia, the Richmond Area Business Group on Health has been working with Virginia HMOs to produce HEDIS data for analysis and publication.

The Commonwealth also has recognized the need for additional consumer information on health plans and other providers. In legislation passed by the 1996 Session of the General Assembly, the Department of Health (DOH) now coordinates the statewide cost and quality data collection and analysis functions formerly administered by the Virginia Health Services Cost Review Council. Through a contract with DOH, Virginia Health Information (VHI), a private, non-profit entity will be responsible for producing data projects for consumers and purchasers. VHI's Board of Directors, which is composed of representatives of hospitals, health plans, nursing homes, physicians, consumers, the business community and state government currently is developing a strategic plan to identify data projects that should be pursued in order to produce meaningful information for consumers and purchasers. Part of the strategic plan will address the kinds of information that consumers and purchasers want on health plans.

As required in § 32.1-276.4(B)(6), VHI will present its strategic plan to the Board of Health, the Governor and the 1997 Session of the General Assembly outlining specific data projects and data elements it believes will produce valuable and useful data on health plans and other providers. The strategic plan should provide direction on the kinds of information that should be generated to respond to the concerns of providers and patient advocates for more information on health plans.

VI.
Managed Care Oversight And Regulation In Other States

National Governors' Association Assesses States' Role In Oversight Of Managed Care Entities

A recent report by the National Governors' Association (NGA) indicated that licensure statutes and regulations in all 50 states regulate marketing activities; require basic benefits; protect consumers against insolvency; and require consumer grievance systems, quality assurance plans, and external quality audits. Few state statutes: (i) set explicit standards for access, such as provider-to-population ratios, referral requirements, or maximum distance or appointment waiting times; (ii) limit provider risk-sharing arrangements; (iii) survey enrollee satisfaction; (iv) prohibit "self-dealing" (i.e., doing business with entities in which providers have financial interests); or (v) establish specific quality standards.

Virginia's Statutory And Regulatory Requirements For HMOs Are Similar In Many Respects To Those In Other States

As noted earlier in this report, the issue of managed care protections for providers and consumers applies to plans other than HMOs. However, in assessing how Virginia's insurance laws compare with other states, the only analysis of other states' laws available for review focused on HMO laws only.

The Center for Health Care Rights (CHCR) published a report in November, 1995, which analyzed the HMO laws in all 50 states. The report, entitled "Consumer Protections in State HMO Laws," summarizes the statutory and regulatory requirements that states place on HMOs. The report analyzes HMO laws according to the following 10 broad categories:

* marketing/enrollment;
* access and benefits;
* quality;
* grievance/complaint procedures;

* data collection by HMOs;
* information provided to enrollees/available to the public;
* HMO enrollee participation/governance;
* protections against conflict of interest;
* insolvency protections; and
* penalties for HMOs violating state laws.

Within these 10 broad categories, state HMO laws are compared across approximately 70 different specific provisions. One caution noted in the CHCR report that warrants mentioning here is that the report simply assesses what laws are "on the books" and does not address the degree to which the laws are enforced or how effectively they are administered by the state regulatory entity. Nonetheless, a review of the CHCR report indicates that Virginia's HMO laws and regulations are, for the most part, consistent with those found in other states across all categories. Virginia's strongest protections appear to be in the area of protection against financial insolvency.

The following paragraphs present information on certain laws or regulations pertinent to the issues raised in this issue brief that exist in a number of states but differ from those in place in Virginia.

Required Timeline for HMOs To Resolve Complaints: Of the 21 states which specify the time frame in which HMOs must resolve some or all types of enrollee grievances, Virginia's timeline (180 days) is at least twice as long as any of the other states. The timeframe ranges from 15 days in Vermont to 90 days in four other states.

Enrollees' Right To Complain To The State: CHCR also reports that 22 states provide HMO enrollees with the right to complain directly to the state. Of these states, 7 require the enrollee to exhaust the HMO's appeals process prior to taking the complaint to the state. In most states, persons direct their complaints to the insurance department. However, in a number of states the health department receives the complaints. In a few states, both the insurance and health departments receive complaints depending on the issues involved.

As previously noted, the Bureau of Insurance reviews enrollee complaints and advocates on behalf of the enrollee; however, there is no provision in the Code or HMO regulations that establishes this program. This may be the reason that Virginia is not listed in the CHCR report among those states with such a process.

Required Enrollee Participation on HMO Governing Boards: Virginia law (§38.2-4304 (B)) requires HMOs to establish a mechanism to provide enrollees with an opportunity to participate in matters of policy and operation through advisory panels, advisory referenda and other mechanisms. However, 15 states require HMOs to have a minimum number of enrollees serve on their respective governing boards.

Virginia Appears To Be One Of Seven States That Require An Independent Review Of Adverse Utilization Review Decisions

The CHCR report identifies only six states which require reviews of grievances or appeals by an entity independent of the HMO. It is difficult to determine exactly how these laws are administered. However, it appears that the process referred to in the CHCR report is an independent review of final adverse decisions made by the HMO. While Virginia is not listed as one of these states, the CHCR report was based on laws in effect prior to Virginia's utilization review (UR) standards law which requires an independent review of final adverse decisions. Based on the information contained in the CHCR report on these six states, it appears that Virginia's independent UR process would be included in this category.

Virginia Has Been Recognized As Having Some Of The Most Extensive HMO Consumer Protections In The Country

As noted earlier, Families, USA Foundation, a national consumer group, issued a report in July, 1996, entitled "HMO Consumers At Risk: States to the Rescue." In this publication, Virginia was cited as one of seven states across the nation which have adopted extensive protections for HMO consumers. The report assesses states' HMO laws according to 14 key consumer protections. Virginia was cited as being one of just a few states that have the best consumer protections in the following categories: (i) utilization review/referral provisions;

(ii) continuity of care following enrollment and provider contract termination; (iii) standards by which decisions to approve and deny care are made; and (iv) prohibition against "gag" rules.

Ombudsman Programs For Managed Care Enrollees Have Been Established In California, Florida, And Maryland

In Virginia, some provider groups and patient advocates believe an independent appeals process or ombudsman program is needed to resolve disputes between providers, managed care patients and managed care plans.

Ombudsman programs for managed care enrollees have been established in at least three states, California, Florida, and Maryland. The scope and structure of the programs vary considerably.

California: On July 15th of this year, three health foundations announced the establishment of a pilot ombudsman program to help managed care enrollees in the Sacramento area navigate through their plans and options. The Henry J. Kaiser Family Foundation, Sierra Health Foundation, and California Wellness Foundation are funding what is believed to be the first project of its kind in the nation with an initial award of $1.6 million for the first two years of a planned four-year, $4 million commitment. (BNA Managed Care Reporter, July 24, 1996).

The program will be administered by the Center for Health Care Rights and is expected to be in operation by March, 1997. The program will answer questions about managed care, and help resolve specific problems with managed care plans. While it will be an independent entity, it will work closely with HMOs, providers, consumer groups, and regulators. The focus of the program will be on managed care consumers, but the foundations expect inquiries from Medi-Cal beneficiaries (the California Medicaid program), Medicare recipients, consumers in preferred provider organizations and those in commercial HMOs.

Florida: In Florida, a volunteer Statewide Managed Care Ombudsman Committee was created within the Florida Agency for Health Care Administration to act as a consumer protection and advocacy organization on behalf of all health care consumers receiving services through managed care

programs in the state. The statewide committee oversees the activities of district committees throughout the state that work with consumers.

The statewide committee serves as a volunteer organization that assists the Florida Agency for Health Care Administration in the investigation and resolution of complaints. The agency promulgates regulations that specify how the statewide and district committees function. Travel expenses for the program come from a Health Maintenance Organization Quality Care Trust Fund. Other financing comes through grants, gifts, donations and other sources.

Maryland: Maryland established a Health Education and Advocacy Unit within the Office of the Attorney General (OAG) in 1986. Originally established to assist consumers with billing and medical claims problems, the unit's role has moved more to mediating health insurance consumer disputes with health plans and providers (e.g., physicians, hospitals, etc.). The unit does not have adjudicatory power; cases are referred to other sections of the OAG for enforcement action if necessary. The unit has only two full-time staff members; an additional 12-15 volunteers do most of the mediation work for consumers. The volunteers include retired nurses, dentists and former physician office managers. The annual budget of the unit is approximately $100,000, and is funded out of the OAG's budget.

Officials at the Maryland program estimate that the unit handles approximately 1,000 complaints each year, and successfully resolves about 80% of the complaints. In 1995, the unit generated approximately $500,000 in direct savings to consumers through billing corrections, etc.

VII.
Conclusions

The Growth Of Managed Care Has Raised New Questions About The Appropriate Role Of Insurance Regulators And Other State Agencies

The growth of managed care has raised new issues that states are having to address in terms of what role state agencies should play in overseeing this segment of the health insurance marketplace. The traditional insurance regulatory role of licensing plans, overseeing plans' financial solvency, reviewing marketing and sales conduct, and ensuring compliance with state insurance laws remains a critical function of the state. However, managed care's impact on the type, extent and quality of care that managed care enrollees receive raises new questions about the degree to which state regulators and other agencies should oversee these aspects of managed care health insurance plans. Like all other states, Virginia is searching for the proper balance between providing consumer protections and maintaining an effective marketplace that encourages innovation and the efficient delivery of quality care.

Virginia Has Passed A Number Of Managed Care-Related Insurance Laws To Provide Protections For Enrollees And Providers

As noted in Section II of this issue brief, Virginia has passed a number of managed care-related laws which provide protections for consumers and providers. As a result of the most recent laws, Virginia is cited in one consumer publication as having passed some of the broadest protections in the country.

Virginia's Insurance Laws And Regulations For HMOs Are Similar To Those In Other States; A Few Variations Exist

For the most part, Virginia's HMO insurance laws and regulations are similar to those in most other states, and provide many of the same protections. With respect to the issues discussed in this study, three laws exist in several other states that the General Assembly may want to consider enacting. First, while the Bureau of Insurance's Consumer Services Section advocates on behalf of insurance consumers, there is no provision in the Code to require this service. Twenty-two states specify in their respective laws that consumers can complain directly to the state. Most of these states also require HMOs to notify their

enrollees of the right to complain to the state. Second, the length of time given HMOs for resolving consumer complaints (180 days) is quite long compared to other states. The General Assembly may want to consider shortening this period. Third, Virginia law requires HMOs to provide a mechanism for enrollees to participate in policy and operation matters. The General Assembly may want to consider requiring HMOs, and perhaps other plans, to include a specific number of enrollees on its governing board, as is required in 15 states.

While Virginia Has Numerous Regulatory Requirements For HMOs; The Health Insurance Industry Administers Other Managed Care Products That Are Not Monitored As Closely As HMOs

HMOs represent the highest form of managed care, however, there are numerous other managed care products available in the marketplace that include a primary care physician component, requirements for referrals for specialty care, utilization review, etc. These plans are not subject to several of Virginia's managed care protections which apply only to HMOs (e.g., certain grievance procedure requirements, quality of care review by the Department of Health, enrollee participation in policy matters). The National Governors' Association (NGA) report referenced earlier suggests that states consider adopting rules and requirements that apply to managed care "functions" or "products" as opposed to specific managed care organizations (e.g., HMOs).

In this context, the General Assembly may want to consider extending some of the HMO requirements to other managed care products. Moreover, the degree to which changes are made in the way the Commonwealth oversees managed care as a result of this study, consideration should be given to the appropriateness of applying any potential changes to other managed care products, and not just HMOs. It should be noted; however, that additional oversight of other managed care products likely would require additional resources at the Bureau of Insurance and other affected agencies.

Until Very Recently, The Health Department Has Exercised Very Little Of The Authority Provided In The HMO Act; Consideration Should Be Given To Clarifying Its Role In Overseeing Managed Care

The State Health Commissioner is authorized to review the quality of care of HMOs and other aspects such as HMOs' complaint systems. Until recently, the Department of Health (DOH) has not taken an active role in this area. Under the new Commissioner, DOH has begun working with the Bureau of Insurance and other entities to exercise the department's authority. The General Assembly may want to consider providing more specific direction in the Code to clarify what DOH's role and responsibilities should be in reviewing certain quality aspects of managed care plans. Consideration also should be given to changing the word "may" to "shall" in §38.2-4308 (C) regarding reviews of HMOs' complaint systems, and in §38.2-4315 (B) to ensure that DOH plays a role in reviewing the quality aspects of managed care.

There Is Disagreement Among Interested Parties Regarding Several Aspects Of The State's Role In Monitoring Managed Care

Some provider groups and patient advocates assert that the Commonwealth needs to take a more active role in enforcing many of the insurance laws dealing with managed care. Specifically, they believe the Bureau of Insurance should have broader authority to investigate and adjudicate disputes that providers and patients have with their managed care health plans. Additionally, these groups feel strongly that an independent appeals process or ombudsman program is needed to assist consumers and providers resolve disputes with managed care plans.

The Bureau of Insurance believes that the current authority provided in the Code as well as its regulatory and enforcement activities are appropriate. Moreover, the Bureau feels that the sections of the Code which limit its authority to adjudicate controversies arising from certain laws is proper. The Bureau has serious concerns about assuming a more prominent role in areas related to contractual disputes and the quality of medical care provided by health plans.

The insurance industry, including HMOs, and the business community believe the current statutory and regulatory framework in Virginia is appropriate

and provides adequate protections to consumers and providers. They feel that, particularly in view of the laws passed during the past two years, Virginia should wait to see the impact of these laws prior to enacting any additional regulatory measures.

The Department of Health's (DOH) current efforts to formulate a more active role in overseeing certain aspects regarding the quality of care provided by HMOs is a positive step toward identifying an appropriate role for the Commonwealth. The department is coordinating their efforts with the Bureau of Insurance and other agencies such as the Department of Medical Assistance Services. The work of DOH will touch on many of the issues raised in this issue brief. The General Assembly may want to consider having the Department of Health, in cooperation with the Bureau of Insurance, report on the results of their current review, and recommend any changes in the Commonwealth's role they feel are necessary prior to enacting any additional statutory requirements.

Given the importance of these issues and the significant divergence of opinion among the interested parties, the Joint Commission may want to consider appointing a subcommittee to hear testimony from the various interest groups, and obtain additional information on whether additional enforcement actions and an independent appeals process are needed.

Additional Consumer Information On Health Plans Will Assist Consumers Make Informed Decisions When Selecting Managed Care Plans And Will Provide Valuable Information On The Quality Of Health Plans

There is general agreement among all parties that additional consumer information on various aspects of health plans would be beneficial to consumers and purchasers. There already is a move in this direction as evidenced by the publication of HEDIS data by the National Committee on Quality Assurance, the Richmond Area Business Group on Health's HEDIS project with several Virginia HMOs, and the strategic plan being developed by Virginia Health Information. The Commonwealth should continue to support and monitor these projects. To further these efforts, the General Assembly may want to consider requesting the Bureau of Insurance and the Department of Health to coordinate a process whereby the Bureau would provide DOH with information received from HMOs on various aspects of their complaint process. This information, along with any

other appropriate plan data, could be included in health plan publications that VHI may produce in the future.

VIII.
Policy Options

The following options are offered for consideration by the Joint Commission on Health Care. These policy options do not represent the universe of alternative directions that the Joint Commission may wish to pursue; rather, they provide a range of options. They are not mutually exclusive, and one or more can be pursued simultaneously. In considering options that involve Chapter 43 (HMO Act), the Joint Commission may want to consider applying any potential changes to other managed care plans as well.

Option I: Maintain status quo

Under Option I, no specific actions would be recommended by the Joint Commission to the 1997 Session of the General Assembly. Option I recognizes that Virginia has passed a number of managed care-related laws in the past few years that provide protections to consumers and providers; and that the current role of the Commonwealth's agencies in monitoring managed care is appropriate.

Option II: Introduce Legislation To Codify The Bureau Of Insurance's Current Consumer Complaint Review Process

Option II would codify the current complaint review process administered by the Bureau of Insurance. This Option is not intended to expand the current scope of issues reviewed by the program, it simply would establish statutory authority for the program as done in other states. The legislation could also require health plans to provide information to their enrollees on the availability of the process.

Option III: Introduce Legislation To Change The Word "May" To "Shall" In Section 38.2-4308(C) Regarding Review Of HMOs' Complaint Systems And In Section 38.2-4315 (B) Regarding The State Health Commissioner's Examination Of HMOs' Quality Of Health Care Services; Other Sections Of Chapter 43 Involving The State Health Commissioner Would Be Clarified

Option III would require, rather than allow, the State Corporation Commission or the State Health Commissioner to examine HMOs' complaint systems, and would require the State Health Commissioner to examine the quality of care provided by HMOs and the providers with whom the HMO contracts. In addition, this Option would clarify other provisions of Chapter 43 regarding the State Health Commissioner's role in overseeing HMOs.

Option IV: Introduce Legislation To Require HMOs To Appoint A Certain Number Of Enrollees To Their Respective Governing Boards And Request The Commissioner Of Insurance To Shorten The 180 Day Timeframe For HMOs To Resolve Enrollee Complaints

Option IV would revise the HMO Act to require HMOs to appoint a certain number of enrollees to their respective governing boards as done in several other states. This would give enrollees a direct voice on important policy matters. The current 180 day requirement for HMOs to resolve enrollee complaints is in the HMO regulations. Option IV would request the Commissioner of Insurance to shorten this time period (e.g., 90 days) to expedite resolution of these complaints.

Option V: Request The State Health Commissioner, In Cooperation With The Bureau Of Insurance, To Report To The Joint Commission And The General Assembly The Results And Recommendations Of The Department's Evaluation Of Its Role In Overseeing The Quality Of Health Care Services Provided By HMOs; And Request Department of Health Professions To Report To Joint Commission The Results Of Its Utilization Review Agent Study

The Department of Health currently is re-evaluating what its role should be in reviewing the quality of health care services provided by HMOs. Option V would direct the Department, in cooperation with the Bureau of Insurance, to report to the Joint Commission and the General Assembly the results of the Department's evaluation and recommendations for revising its current oversight role. In addition, the Department of Health Professions would report the findings and recommendations of its study of utilization review agents to the Joint Commission

Option VI: Request The Department Of Health (DOH) To Provide Virginia Health Information, Inc. (VHI) Information On HMOs' Complaint Processes Received Pursuant To Section 38.2-4308(B) For Inclusion In VHI's Health Plan Publications

Providers and patient advocates state that additional consumer information on managed care plans is needed. Virginia Health Information (VHI) is developing a strategic plan to respond to this need. This Option would request DOH to provide to VHI information it receives from HMOs on their complaint processes. As a result, consumers would have information on each HMO's complaint process, the number of complaints HMOs receive, and the underlying causes of the complaints.

Option VII: Introduce Legislation To Extend Certain Provisions Of Chapter 43 Which Currently Pertain Only To HMOs To Other Managed Care Products

As noted in this issue brief, managed care involves products and entities other than HMOs. Some managed care products include many of the same provisions as HMOs (e.g., primary care physician component, referral requirements, utilization review and medical necessity determinations). These managed care products are not subject to some of the statutory and regulatory requirements with which HMOs must comply. Option VII would extend certain requirements of Chapter 43 (e.g., review of the quality of health care services provided by the plan and its contracting providers by the State Health Commissioner, and grievance and complaint system requirements) to these other managed care products. Under this Option, it may also be appropriate to extend some of these requirements to other types of provider panels pending the findings of the study of these panels being conducted pursuant to House Bill 1393.

Option VIII: Establish A Subcommittee Of The Joint Commission To Review Further Two Key Issues Raised In This Study: (I) Whether An Independent Appeals/Ombudsman Program Is Needed, And, If So, How Such A Program Should Be Funded; And (II) Whether The Bureau Of Insurance's Regulatory And Enforcement Authority And Activities Should Be Strengthened

There is considerable disagreement among the key stakeholders on two key issues of this study: (i) whether an independent appeals/ombudsman program is needed for managed care enrollees and providers, and, if so, how the program should be funded; and (ii) whether the regulatory and enforcement authority of the Bureau of Insurance needs to be strengthened. Option VIII would call for the establishment of a Joint Commission subcommittee to hear testimony and review additional information from the Bureau of Insurance, managed care entities, and provider and patient advocates on these two issues. The subcommittee then could make recommendations to the full Joint Commission on what actions, if any, should be pursued.

APPENDIX A

SENATE JOINT RESOLUTION NO. 67

Directing the Joint Commission on Health Care and the State Corporation Commission's Bureau of Insurance to study the appropriate role of the agencies of the Commonwealth in monitoring, policing, and regulating the managed care industry.

Agreed to by the Senate, February 27, 1996
Agreed to by the House of Delegates, February 23, 1996

WHEREAS, the health care industry is undergoing sweeping change in an effort to decrease health care costs; and

WHEREAS, the marketplace is determined to maximize cost-saving efficiencies through various forms of managed care; and

WHEREAS, purchasers and beneficiaries of managed care health insurance plans are seeking safeguards to ensure the protection of elements of the health care delivery system including, but not limited to, the integrity of the provider-patient relationship, the right of patient privacy, the freedom to choose a health care provider, and the viability of the individual and small group practices of health care providers in underserved areas; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Joint Commission on Health Care and the Bureau of Insurance be directed to jointly study the appropriate role of the agencies of the Commonwealth of Virginia in monitoring, policing, and regulating the managed care industry.

The Joint Commission on Health Care and the State Corporation Commission's Bureau of Insurance shall complete their work in time to submit their findings and recommendations to the Governor and the 1997 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

APPENDIX B

Joint Commission on Health Care

Summary of Public Comments on Draft Issue Brief 4:
Study of the Commonwealth's Role in
Oversight of the Managed Care Industry

Comments regarding the Health Insurance Reform in Virginia Issue Brief were received from 25 interested parties:

13 Providers/Provider Groups

Sharon Alperstein, LCSW, ACSW
Community Pharmacy Coalition
Independent Pharmacists
Medical Society of Virginia
NeuroPsychiatric Services/Greater Washington
Psychiatric Society of Virginia
Sheldon M. Retchin, MD
Donald M. Switz, MD
Virginia Association of Durable Medical Equipment Companies
Virginia Hospital & Healthcare Association
Virginia Optometric Association
Virginia Pharmacists Association
Virginians for Mental Health Equity

Three Insurers/Managed Care Organizations

BlueCross BlueShield of the National Capital Area
Trigon BlueCross BlueShield
Virginia Association of Health Maintenance Organizations

Two Business Organizations

The Virginia Chamber of Commerce
Virginia Manufacturers Association

Three Consumer Groups

American Association of Retired Persons
Virginia Poverty Law Center
(Virginians for Mental Health Equity also listed under providers)

Four state/local government agencies

Department of Medical Assistance Services
Department of Health
Northern Virginia Aging Network
State Corporation Commission Bureau of Insurance

Virginia Health Quality Center

Policy Options Presented in Issue Brief

The following options are offered for consideration by the Joint Commission on Health Care. These policy options do not represent the universe of alternative directions that the Joint Commission may wish to pursue; rather, they provide a range of options. They are not mutually exclusive, and one or more can be pursued simultaneously. In considering options that involve Chapter 43 (HMO Act), the Joint Commission may want to consider applying any potential changes to other managed care plans as well.

Option I: Maintain status quo

Under Option I, no specific actions would be recommended by the Joint Commission to the 1997 Session of the General Assembly. Option I recognizes that Virginia has passed a number of managed care-related laws in the past few years that provide protections to consumers and providers; and that the current role of the Commonwealth's agencies in monitoring managed care is appropriate.

Option II: Introduce Legislation To Codify The Bureau Of Insurance's Current Consumer Complaint Review Process

Option II would codify the current complaint review process administered by the Bureau of Insurance. This Option is not intended to expand the current

scope of issues reviewed by the program, it simply would establish statutory authority for the program as done in other states. The legislation could also require health plans to provide information to their enrollees on the availability of the process.

Option III: Introduce Legislation To Change The Word "May" To "Shall" In Section 38.2-4308(C) Regarding Review Of HMOs' Complaint Systems And In Section 38.2-4315 (B) Regarding The State Health Commissioner's Examination Of HMOs' Quality Of Health Care Services; Other Sections Of Chapter 43 Involving The State Health Commissioner Would Be Clarified

Option III would require, rather than allow, the State Corporation Commission or the State Health Commissioner to examine HMOs' complaint systems, and would require the State Health Commissioner to examine the quality of care provided by HMOs and the providers with whom the HMO contracts. In addition, this Option would clarify other provisions of Chapter 43 regarding the State Health Commissioner's role in overseeing HMOs.

Option IV: Introduce Legislation To Require HMOs To Appoint A Certain Number Of Enrollees To Their Respective Governing Boards And Request The Commissioner Of Insurance To Shorten The 180 Day Timeframe For HMOs To Resolve Enrollee Complaints

Option IV would revise the HMO Act to require HMOs to appoint a certain number of enrollees to their respective governing boards as done in several other states. This would give enrollees a direct voice on important policy matters. The current 180 day requirement for HMOs to resolve enrollee complaints is in the HMO regulations. Option IV would request the Commissioner of Insurance to shorten this time period (e.g., 90 days) to expedite resolution of these complaints.

Option V: Request The State Health Commissioner, In Cooperation With The Bureau Of Insurance, To Report To The Joint Commission And The General Assembly The Results And Recommendations Of The Department's Evaluation Of Its Role In Overseeing The Quality Of Health Care Services Provided By HMOs; And Request Department of Health Professions To Report To Joint Commission The Results Of Its Utilization Review Agent Study

The Department of Health currently is re-evaluating what its role should be in reviewing the quality of health care services provided by HMOs. Option V would direct the Department, in cooperation with the Bureau of Insurance, to report to the Joint Commission and the General Assembly the results of the Department's evaluation and recommendations for revising its current oversight role. In addition, the Department of Health Professions would report the findings and recommendations of its study of utilization review agents to the Joint Commission

Option VI: Request The Department Of Health (DOH) To Provide Virginia Health Information, Inc. (VHI) Information On HMOs' Complaint Processes Received Pursuant To Section 38.2-4308(B) For Inclusion In VHI's Health Plan Publications

Providers and patient advocates state that additional consumer information on managed care plans is needed. Virginia Health Information (VHI) is developing a strategic plan to respond to this need. This Option would request DOH to provide to VHI information it receives from HMOs on their complaint processes. As a result, consumers would have information on each HMO's complaint process, the number of complaints HMOs receive, and the underlying causes of the complaints.

Option VII: Introduce Legislation To Extend Certain Provisions Of Chapter 43 Which Currently Pertain Only To HMOs To Other Managed Care Products

As noted in this issue brief, managed care involves products and entities other than HMOs. Some managed care products include many of the same provisions as HMOs (e.g., primary care physician component, referral requirements, utilization review and medical necessity determinations). These managed care products are not subject to some of the statutory and regulatory requirements with which HMOs must comply. Option VII would extend certain requirements of Chapter 43 (e.g., review of the quality of health care services provided by the plan and its contracting providers by the State Health Commissioner, and grievance and complaint system requirements) to these other managed care products. Under this Option, it may also be appropriate to extend some of these requirements to other types of provider panels pending the

findings of the study of these panels being conducted pursuant to House Bill 1393.

Option VIII: Establish A Subcommittee Of The Joint Commission To Review Further Two Key Issues Raised In This Study: (I) Whether An Independent Appeals/Ombudsman Program Is Needed, And, If So, How Such A Program Should Be Funded; And (II) Whether The Bureau Of Insurance's Regulatory And Enforcement Authority And Activities Should Be Strengthened

There is considerable disagreement among the key stakeholders on two key issues of this study: (i) whether an independent appeals/ombudsman program is needed for managed care enrollees and providers, and, if so, how the program should be funded; and (ii) whether the regulatory and enforcement authority of the Bureau of Insurance needs to be strengthened. Option VIII would call for the establishment of a Joint Commission subcommittee to hear testimony and review additional information from the Bureau of Insurance, managed care entities, and provider and patient advocates on these two issues. The subcommittee then could make recommendations to the full Joint Commission on what actions, if any, should be pursued.

Summary of Comments

Overall, provider groups and consumer groups generally supported implementing several of the Options, including: codifying the Bureau of Insurance's complaint review process; mandating the Department of Health's role in reviewing HMOs' quality of care; shortening the length of time for HMOs to resolve enrollees' complaints; extending provisions of Chapter 43 to other managed care products; implementing an appeals/ombudsman program; and strengthening the Bureau of Insurance's regulatory authority.

The insurance industry commented that current regulation and oversight are appropriate; additional regulatory oversight is not necessary; the appeals/ombudsman process is not needed; and the state should not regulate who serves on plans' governing boards.

The business community generally commented that current oversight of managed care is appropriate; the appeals/ombudsman process is not needed; codifying the Bureau's complaint process is not necessary; and additional information on managed care plans is needed.

Summary of Individual Public Comments

Sharon Alperstein, LCSW, ACSW

Sharon Alperstein did not comment specifically on the issue brief or policy options. Ms. Alperstein expressed concern that the time restraints and limitations imposed by managed care insurance companies create obstacles and interfere with delivering quality treatment for patients with mental disorders.

Community Pharmacy Coalition

Cynthia L. W. Warriner, Legislative Liaison, stated that they opposed Option I and supported Options IV, VI, VII and VIII. She recommended that consumers have greater input into employers' purchasing decisions.

Independent Pharmacists

Wyatt B. Durrette, Jr., Attorney with Durrette, Irvin & Bradshaw, submitted comments on behalf of the Independent Pharmacists. Mr. Durrette did not comment specifically on the issue brief or policy options. He stated that certain aspects of managed care adversely affect millions of

Virginians, thousands of Virginia businesses, and Virginia state government. He also submitted a copy of a document sent to the Board of Pharmacy regarding the Board's study of the community pharmacy's workplace.

Medical Society of Virginia

Madeline I. Wade expressed opposition to Option I. Ms. Wade expressed support for Option II and stated that it should be expanded to include provider complaints. She also expressed support for Option III. Ms. Wade expressed that she does not believe it is necessary to impose requirements on who participates in HMOs' governing boards and supported shortening the 180 day timeframe for resolving complaints (Option IV). She also felt that regulation should be streamlined in one entity or clear duties should be assigned to multiple entities; some functions could be handled more efficiently by a private entity. Ms. Wade stated that is was critical for the regulatory entity to have authority to address specific complaints and not just systematic issues; the regulatory entity also needs the authority to impose sanctions.

She expressed strong support for Option VII. She suggested that an interim approach would be to charge the Department of Health with reviewing complaints under current authority. Ms Wade indicated that the regulatory authority of the Bureau should be strengthened.

NeuroPsychiatric Services of Greater Washington

Joseph J. Palombi, M.D., commented in support of Options III and VIII.

Psychiatric Society of Virginia

Prakash Ettigi, M.D., President, commented in opposition to Option I. He expressed support for Option II but stated that it was insufficient to fully address the problems. Dr. Ettigi expressed support for Options III, IV, V, VI, VII and VIII and emphasized strengthening the Bureau's enforcement and regulatory authority.

Sheldon M. Retchin, MD (President of MCV Associated Physicians)

Dr. Retchin commented that the report should have addressed the impact of managed care on academic health centers. He expressed concern about the "selection issues" due to HMOs not being subject to the "any willing provider" law.

Donald M. Switz, MD (MCV Associated Physicians)

Dr. Switz commented in support of Options II, III, IV and VIII.

Virginia Association of Durable Medical Equipment Companies

Doug Ellis, Sam Clay and Cynthia L. W. Warriner submitted comments in support of Option IV. They supported Option VI for expanding consumer information on HMOs' complaint processes. They expressed strong support for the independent appeals/ombudsman program in Option VIII. They also support efforts to provide additional consumer information.

Virginia Hospital & Healthcare Association

Katharine M. Webb, Senior Vice President, stated that they did not endorse any specific policy options, but expressed support for actions that would facilitate and expedite interagency efforts to assess and report on the quality of health plans. Further, she stated that any recommendations implemented pursuant to the interagency efforts mentioned above should apply to managed care functions performed by any type of health plan and not solely HMOs.

Virginia Optometric Association

Bruce B. Keeney, Sr. expressed support for legislative proposals that impose stringent enforcement and severe penalties for plans which ignore provider panel requirements, and suggested that legislation permitting managed care patients to have direct access to ophthalmologists and optometrists be enacted.

Virginia Pharmacists Association

Rebecca P. Snead suggested that more provider input into policy guidelines developed by plans might eliminate some of the need for the appeals process.

Virginians for Mental Health Equity

Mark E. Rubin commented that Option I was not sufficient. Mr. Rubin suggested that Option II would ensure that the Bureau of Insurance continues to be accessible to consumers; however, without statutory

authority to resolve problems, their effectiveness is limited. He expressed support for Option III. In Option IV, he stated that requiring consumers to serve on HMOs' governing boards is a step in the right direction, but not a solution. Further, Mr. Rubin commented in support of Options V, VI, VII and VIII. Mr. Rubin requested that the Joint Commission not delay acting on policy options and noted that individuals pay a share of premiums and should be considered "purchasers."

BlueCross BlueShield of the National Capital Area

Gail M. Thompson stated that managed care is highly regulated and there was no need for additional regulation. Ms. Thompson expressed a need to assess the effectiveness of 1996 legislation prior to enacting additional laws. She felt that there was adequate statutory authority for the Department of Health to monitor HMOs. She expressed opposition to the state mandating certain representatives on plans' governing boards. She suggested that managed care entities, products and techniques need to be better defined. Ms. Thompson expressed opposition for the independent appeals/ombudsman process and stated that adequate processes already exist.

Trigon BlueCross BlueShield

Wilda M. Ferguson commented in support of Option I and stated that oversight by state agencies and others is sufficient. She expressed strong opposition to the appeals/ombudsman process and recommended that the Joint Commission review the Department of Health's study recommendations before proposing any legislation. Further, she stated that she opposed the state regulating who serves on plans' governing boards.

Virginia Association of Health Maintenance Organizations (VAHMO)

Mark C. Pratt stated that VAHMO believes the marketplace is responsive and is meeting the challenge of balancing consumer protections and the need for efficient plans. He stated that HMOs are subjected to more oversight than other forms of managed care. Further, he stated that the current oversight includes state and federal agencies as well as private entities. He suggested that all risk bearing entities engaged in health care delivery should be subject to similar oversight. Mr. Pratt expressed strong opposition to the appeals/ombudsman process involving adjudicatory authority. He also expressed that purchasers and consumers should be provided more and better information on managed care products.

Virginia Chamber of Commerce

Sandra D. Bowen, Senior Vice President, commented that the current oversight by public and private entities is appropriate and sufficient. She stated that the Bureau of Insurance exercises an appropriate level of regulation. Ms. Bowen also commented that the General Assembly should not consider codifying the Bureau's complaint process or changing the Department of Health's authority until after receiving the report from the Department of Health on its current study. She stated that there was no need for an independent appeals/ombudsman process and would support Option VIII if it included a review of other activities in the private sector. Further, she stated that purchasers and consumers need additional information on all components of the health care system and Virginia Health Information should have access to all information on health plans in the public sector.

Virginia Manufacturers Association

Robert P. Kyle, Vice President, commented that the draft report leaves the impression that HMOs and managed care are synonymous, ignores the fundamental question: has managed care adversely affected quality of care?, and does not adequately highlight where business has pressed insurers to be more responsive to employer and consumer concerns. Mr. Kyle expressed support for Option I and expressed opposition to codifying the Bureau's review process and requiring the Department of Health to review HMOs' quality of care. Further, Mr. Kyle expressed opposition to Option IV and support for Option V. He stated that all state agencies should share information with Virginia Health Information, and recommended examining the necessity of current requirements before imposing them on other managed care plans. Mr. Kyle expressed opposition to the appeals/ombudsman process and is satisfied that the marketplace will discipline plans more effectively than more regulation.

American Association of Retired Persons

Mary Madge, Chair of the AARP State Legislative Committee, expressed opposition to Option I. She expressed support for Option II, III, IV, V, VII and VIII.

The Virginia Poverty Law Center

Jill A. Hanken, Staff Attorney, commented in support of Option II and III, and supported the independent appeals/ombudsman process. She

recommended reducing the timeframe for resolving complaints and requiring clear notification to consumers on avenues available for complaint resolution.

Department of Medical Assistance Services

Joseph M. Teefey, Director, stated that the report should clarify that the Virginia Health Quality Center rarely receives complaints dealing with the quality of care; complaints are handled by the Department's enrollment broker. Further, he felt that the report understates the Department's extensive "quality assurance" program.

Department of Health

Randolph L. Gordon, State Health Commissioner, commented that the oversight of quality across all payors, not just HMOs, is a critical public health role. He stated that DOH would work with the Bureau of Insurance to coordinate its role if the Bureau's complaint process is codified. Dr. Gordon recommended not changing "may" to "shall" at this time; and stated it is best to proceed with caution. He requested time to consult with affected parties and permit industry to prepare for change. He supported actions to require enrollees to serve on governing boards to strengthen enrollee involvement. Dr. Gordon expressed support for phasing in a shorter timeframe for resolving HMO complaints and will report results of the Department of Health's study of its oversight role to the Joint Commission. He committed to making appropriate health plan information available to Virginia Health Information and strongly supported extending certain provisions of Chapter 43 to other managed care products. Further, he stated that DOH was planning to study including either an appeals or ombudsman process in their responsibilities for examining HMO complaint systems.

Northern Virginia Aging Network

Erica F. Wood, Legislative Chair, expressed opposition to Option I and expressed concurrence with Options III, IV, V, VI, VII and VIII. She also stated that the State Health Commissioner should have a primary role in addressing complaints.

State Corporation Commission Bureau of Insurance

Alfred W. Gross, Commissioner of Insurance, commented that serious consideration be given to Option I and indicated that more time is needed

to see how the change enacted in 1996 will affect the enrollees in managed care plans. Commissioner Gross recommended that rather than codify the Bureau's complaint review process (Option II), that the notice required on insurers' policies advising policyholders of the Bureau's complaint process be clarified and that the notice be required for HMO and health services plans. Commissioner Gross commented that he had no objection with Option IV and recommended that the enrollees selected to serve on the respective governing boards of the HMOs be enrollees that are not employed by or affiliated with that HMO. Commissioner Gross preferred Option V over Option III and recommended that a study would allow the Bureau and the Department of Health to distinguish their respective roles and to make recommendations for legislation to be enacted in 1998. Regarding Option VI, the Commissioner noted that the Bureau traditionally has opposed the concept of releasing complaint statistics, but was not registering opposition to this option. Regarding Option VII and VIII, the Commissioner recommended a study resolution rather than possibly premature legislation.

Virginia Health Quality Center

Sally S. Cook, MD., commented that the report should clarify that VHQC believes the state should conduct a competitive bid to identify an appropriate entity for administering an appeals/ombudsman process. Further, she stated that the report should be revised to indicate a bidding process should be used to develop and report health care information.

JOINT COMMISSION ON HEALTH CARE

Director

Jane Norwood Kusiak

Senior Health Policy Analyst

Patrick W. Finnerty

Office Manager

Mamie V. White