HOW WELL DOES NORTH CAROLINA PROTECT ENROLLEES IN HMOs? A REPORT CARD

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North Carolina earns a C-

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Issues	Grade	Recommendations
Marketing and Procedural Protections: *Positives:* Requires agents to be licensed; prohibits unfair and deceptive trade practices. *Negatives:* Does not prohibit selective marketing aimed at segmenting market; does not provide free-look period which would enable enrollee to cancel policy if not satisfied.	B	Department should require health carriers to change marketing strategy if the marketing materials, taken as a whole, suggest efforts to segment the risk to attract only healthy enrollees. HMOs should be required to provide 10 day free-look period.
Covered Benefits: *Positives:* Some mandated benefits. *Negatives:* NC one of only two states that does not establish minimum benefit package by statute; some HMOs exclude coverage of mental health services (unless purchased separately as rider); most exclude therapy services unless expected to show significant improvement in short time period; HMOs deny emergency room coverage unless condition later confirmed to be an emergency.	C-	Mental health and substance abuse services should be offered in parity with other medical services. Carriers should be required to cover services rendered in an emergency room if the enrollee had a reasonable belief that an emergency existed (prudent layperson standard). DOI should assess the need for expanded coverage of therapy services.
Quality assurance standards: *Positives:* Carriers required to establish quality assurance system which includes mechanisms to measure, assess and improve processes and outcomes of health care. The quality management tools must include procedures to identify and take corrective action on quality problems, whether provider specific or systemwide. *Negatives:* Quality assurance system required by the state is minimal, for example, not required to analyze underutilization, not required to monitor enrollee satisfaction or conduct special quality of care studies, not required to undergo external quality of care evaluations. With the exception of doctors, carriers not required to report providers who show persistent quality of care problems to appropriate licensing agencies.	C-	Internal quality assurance systems should be enhanced. For example, carriers should be required to monitor underutilization, member satisfaction, special focused quality of care studies. Carriers should report any licensed provider who has shown persistent quality of care problems to licensing agency. DOI should have the authority to require carriers to undergo an external quality assessment if sufficient quality of care concerns are raised. Carriers should report adverse patient outcomes, malpractice suits, disenrollment data, complaints filed with the plan, and information about grievances to the state. Carriers should be required to coordinate and communicate with public health agencies to improve health of community.

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Access standards: *Positives:* HMOs required to establish internal access targets to ensure adequacy and accessibility of provider networks, including such measures as provider-patient ratios (for primary care and specialists), driving distance or time, average/expected waiting times, ability of the plan to cover emergency services on a 24 hour, 7 day/week basis, etc. *Negatives:* State has not established minimum provider-to-patient ratios, maximum travel or time standards, maximum appointment wait times, no guarantee of choice of providers (primary care or specialists). Current requirements for what HMOs must include in internal access guidelines are minimal. HMOs not required to report internal access standards to DOI, or to report how well it meets its own guidelines. Neither the access standards or carrier's performance available to the public. Women not allowed to use OB/GYNs as primary care provider. HMOs not required to have system to ensure continuity of care for individuals with ongoing medical needs (for example, when provider leaves the plan) or to facilitate access to specialists when individuals have complex medical needs. HMOs can exclude providers most likely to treat high-cost patients to discourage unhealthy patients from joining plan.	C-	Carriers should be required to report their internal access targets and how well carriers met these goals DOI on an annual basis. Requirements for what should be included in access plans should be enhanced. Access information and carriers' provider panels should be made available to prospective purchasers. Alternatively, NC should establish minimum access standards. Enrollees should have a guaranteed choice of at least three primary care providers and two specialists within reasonable travel time. Carriers should be required to pay for care provided outside the network (as well as reasonable travel costs) if insufficient providers within network. Carriers should be required to have procedures to allow certain individuals to continue care with their provider until alternative appropriate arrangements can be made. Carriers should be required to include OB/GYNs as primary care providers. Department should study the referral and gatekeeper arrangements that carriers currently use to care for the chronically ill and those with complex medical needs and should be given the authority to adopt regulations to address this issue if needed. Carriers should be prohibited from discriminating against certain providers who are likely to treat high-risk patients.
Consumer participation: *Positives:* DOI has taken steps to seek input from consumer organizations in drafting new legislation. *Negatives:* Compared to other states, North Carolina consumers have relatively few official avenues to participate in the governance of the HMOs in this state. For example, North Carolina laws do not require enrollee representation on HMO governing boards, nor do they give enrollees the opportunity to participate in policy and operation matters.	D-	Require plans to establish mechanisms so that consumers can give input into policy and operation of the plan. The state should establish a Managed Care Policy Board, including consumers, providers, purchasers, carriers and health service researchers and public health representatives. The Board would funnel problems and suggestions to the Department of Insurance, help the Department develop an annual guide comparing different health plans, recommend what, if any, additional information should be collected, and suggest changes in the Department's regulations and oversight procedures.

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Utilization review procedures: *Positives:* NC requires that utilization review systems include procedures to evaluate clinical necessity based on objective, clinically appropriate standards developed with provider input, time frames for making utilization review decisions, mechanisms to ensure that decisions are reviewed by clinical peers, and free telephone access to members and providers to the utilization review entity. Carriers must have procedures to notify the providers and enrollees of the review requirements. Utilization reviewers may not be reimbursed based on the amount saved through the utilization review process. *Negatives:* Utilization review protocols not available to enrollees or providers (see data section below); carriers not required to assess the effectiveness and efficiency of its utilization review program or to coordinate utilization review activities with other medical management activities.	B	Utilization review requirements should be enhanced. Carriers should be required to disclose utilization review clinical protocol to providers, enrollees, and prospective enrollees upon request.
Complaint and grievance systems: *Positives:* NC has detailed requirements for appeals of noncertifications (i.e., decisions not to approve or reduce coverage of certain services), including 30 day time limits for most appeals or shorter time period for expedited appeals. *Negatives:* No specific appeal provisions for other types of appeals (quality of care, access). Carriers not required to provide two levels of appeals or to allow enrollee to attend hearing and cross examine witnesses. Appeals process often difficult to understand.	C-	The state should establish minimum due process requirements which all carriers must follow for all types of appeals. State should implement Ombuds system to enable enrollees resolve disputes.
Provider contract provisions: *Positives:* NC currently prohibits a carrier's utilization review, quality assurance or sanctioning policies from interfering with providers' right to provide information to patients. Provider contracts must have provisions which prohibit providers from discriminating against members. Provider contracts must be approved in advance by the Commissioner, carriers may not assign to intermediaries their legal responsibility to monitor and oversee health services offered to enrollees. *Negatives:* NC laws do not prohibit plans from sanctioning providers who file appeals on behalf of patients, who file complaints with regulatory or	C-	NC should amend its current anti-gag clause provision to provide greater protections for providers who appeal on a patient's behalf, file complaints with regulatory or accreditation bodies, provide information about financial incentives to their patients, or help patients pick their health plan. NC should ensure that all carriers have an appeals mechanism for providers who have had their practice privileges in the plan reduced, suspended or terminated. This will help ensure that providers, for example, those who have higher utilization rates because they treat a disproportionate number of patients with complex medical needs, are not inappropriately sanctioned.

Issues	Grade	Recommendations
accreditation agencies, provide information about the provider's financial incentives, or who assist patients in choosing a health plan. Further, NC laws do not require carriers to provide an appeal remedy to providers who are sanctioned or not allowed to participate in a plan.		

Data collection requirements and methods to provide relevant information to the public:

Positives: N.C. collects extensive financial information. *Negatives:* Public information that is available about plans is sparse. Consumers can copy DOI data on file for $.50/page. Carriers are required to submit financial information, but little information about utilization of specific services, accessibility of services, consumer satisfaction, the adequacy of the carrier's process for delivering care or health care outcomes. Nor does the state require plans to disclose information about financial risk sharing arrangements, drug formularies, treatment of specific conditions, coverage of experimental or investigation procedures, or the clinical review criteria used to review the medical necessity of a particular condition or disease. Carriers are not currently required to provide prospective enrollees with a copy of their evidence of coverage.	D-	Carriers should be required to submit HEDIS data to the state. The DOI should be able to require carriers to submit different or additional data for special health issues. Carriers should be required to submit a record of the number and types of complaints filed within the plan, and to submit their annual utilization review and appeal activity reports. DOI should require carriers to independently audit the data if the state has reason to suspect its reliability. Carriers should also be required to provide prospective enrollees, upon request, information about their drug formularies, treatment protocols for specific cases, treatments or procedures considered experimental, and underlying utilization review clinical protocol. In addition, plans should be required to give prospective enrollees copies of the Evidence of Coverage, which contains more detailed information about the benefits included and excluded. Information provided to enrollees or prospective enrollees should be understandable. DOI or an independent nonprofit agency should be required to develop an annual consumer guide for health plan selection.

Financial solvency requirements:

Positives: NC has extensive financial solvency requirements. Like most states, NC has provisions governing net worth, minimum deposits, reinsurance agreements, hold harmless clauses, and provisions requiring providers to continue coverage in the event of insolvency. Further, the laws provide that in the event of HMO insolvency, the Commissioner shall ensure that the enrollees of the insolvent HMO will be offered other insurance or health coverage without any medical underwriting. *Negatives:* none.	A	None.

Issues	Grade	Recommendations
Oversight of premium rates: *Positives*: North Carolina requires all premium rate adjustments to be filed with the Commissioner for approval prior to use. In addition, the statute sets out specific requirements for how frequently the rates can be adjusted. **Negatives:** none.	A	None.
Credentialing standards: *Positives:* NC has extensive credentialing verification requirements, for both individual providers and institutions. *Negatives:* carriers not required to visit physician's offices prior to credentialing; carriers not required to disclose selection standards to providers or to allow providers to appeal if the carriers deny the provider the right to participate in the plan.	B-	Carriers should be required to disclose selection standards to providers. Carriers should be required to allow provider's appeal if provider denied right to participate in the plan.
Accountability and enforcement: *Positives:* The Department generally does a good job enforcing current laws. *Negatives:* DOI failed to track problems over time; did a more thorough job monitoring network adequacy and accessibility in the past; did not follow up with carriers that failed to submit some of the required reports to the state; did not consistently include same information in the Market Practices and Market Compliance Examination reports. The Department lacked the staff needed to monitor the growing managed care industry; DOI's enforcement mechanisms are limited to egregious violations of the law.	B-	DOI should standardize market conduct examinations, and track problems over time. Collect more detailed information about the number and nature of complaints it receives. Have the authority to require plans to correct all types of problems. Department should deem compliance with certain licensing requirements if plan is accredited by agency that has the same or higher standards (as determined by the Department). State should increase staff to match growth in industry and prepare annual report comparing selected aspects of different plans. Carriers should be required to submit comparable data and DOI should monitor plans to ensure required data is submitted.

Explanations to the grading system:

A = North Carolina provides all or substantially all of the consumer protections afforded in other states or proposed by the National Association of Insurance Commissioners in model legislation.

B = North Carolina provides most of the consumer protections provided in other states or proposed by the National Association of Insurance Commissioners, although some protections may be missing.

C = North Carolina has some consumer protections in the area; the laws are not comprehensive and are missing significant protections for consumers.

D = North Carolina has minimal or no protections in the area.

OVERALL GRADE: C-

Introduction

This research is a summary of a larger analysis of the adequacy of North Carolina's consumer protections in the managed care market. The issue of how well the state of North Carolina protects consumers in managed care is especially relevant given the rapid increase in the numbers of individuals who receive health care through a managed care program. Almost one million North Carolinians were enrolled in full-service HMOs by the end of 1996. By the end of 1995, nearly three-quarters of the insured population in the United States received their medical care from some type of managed care organization. This research was funded in part by a grant from the Robert Wood Johnson Foundation Reforming States Initiative.

Managed care, including Health Maintenance Organizations, Preferred Provider Organizations (PPOs), and Point-of-Service plans (POS) integrate, to varying degrees, the financing and organization of a health care delivery system. More tightly developed forms of managed care, such as HMOs, are also characterized by the use of primary care gatekeepers to manage patient care and payment systems which shift part or all of the costs of care to the health care providers (through capitation, withholds or bonuses).

Health maintenance organizations are the focus of this study. The study is limited to the state's oversight of HMOs (and to a lesser extent, POS plans) for a number of reasons: first, HMOs are a radical departure from the traditional fee-for-service indemnity model that characterized most people's health care coverage for the latter part of this century. Individuals no longer have total freedom to choose health care providers. Enrollees can only choose from among the providers listed in the provider network; and access to specialists is further limited. Second, HMOs shift the risk of caring for the patient onto the providers through capitation, withholds or bonuses--which may provide an incentive to providers to withhold necessary care. Thus, the risk to consumers may be greater within an HMO system than within PPOs or other forms of managed care. Third, the state collects more information about HMOs than about traditional managed indemnity plans or PPOs. PPOs, for example, only need to be registered with the state, whereas HMOs need to be licensed and undergo much more extensive evaluation by the Department of Insurance (DOI). Thus, there are more data available to examine the working of HMOs than with other forms of managed care plans.

Health maintenance organizations (HMOs) and other forms of managed care are subject to many different, and often complementary, systems to protect consumers. Consumer protections are typically designed to protect consumers from harm, ensure the efficient operation of the market, or set minimum quality standards. Consumer protection mechanisms exist in both the public and private sectors and include, for example, state and federal regulations, voluntary accreditation organizations, purchasers exerting pressures to extract greater consumer protections and the media acting as a "watchdog." Protections have been implemented on both a reactive and proactive basis to both remedy past problems and to prevent them in the future.

Although a variety of mechanisms are needed to adequately protect consumers in managed care, this study focuses on the state's role for three reasons: First, the federal government has historically left regulation of insurance to the state. Second, the state has set up an extensive regulatory structure in North Carolina and has therefore assumed the responsibility of ensuring that consumers are protected from harm. Third, the alternative systems of oversight are not as well developed in North Carolina as in other parts of the nation. Market-based systems to ensure quality, such as voluntary accreditation by the National Committee for Quality Assurance (NCQA), are not prevalent in North Carolina; only six of the carriers have obtained NCQA accreditation. Eleven of the carriers reported that they collected data for the Health Plan Employer Data Information Set (HEDIS), but only five of the plans submitted the data to NCQA to be released to the public as part of the NCQA *Quality Compass* project. Further, the NCQA charges between $800 and $3,200 to purchase the information, depending on the number of plans requested. The data, therefore, are out of reach for most consumers. For these reasons, this research focuses on state-level oversight of HMOs.

HMOs Are Growing Rapidly in North Carolina

North Carolina has experienced an explosion in the growth of HMOs and managed care companies. Between June 1994 and November 1996, the number of licensed full-service HMOs grew from 10 to 23, with several HMOs license applications pending review. As the number of licensed plans increased, so did the number of people enrolled in managed care plans. Enrollment in HMOs grew steadily in the early part of this decade, with annual increases of between 50,000 and 100,000 people. Beginning in about 1994, the HMO enrollment started to escalate, with the largest jump occurring between 1995 and 1996. There were 954,967 people enrolled in full service HMOs or POS plans by the end of 1996.

This report is based on an analysis of North Carolina HMO laws, a comparison of North Carolina laws to consumer protections enacted in other states or proposed by the National Association of Insurance Commissioners, a review of the practices of the six largest HMOs in North Carolina, and an analysis of the Department of Insurance's enforcement of current laws.

In general, the North Carolina Department of Insurance does a relatively good job enforcing current state HMO laws. However, North Carolina lacks an adequate array of laws to ensure that consumers are fully protected. For example, compared to other states or model acts proposed by the National Association of Insurance Commissioners, North Carolina has less extensive consumer protections in the areas of access standards, quality assurance systems, complaint and grievance procedures, data collection and information disclosed to the public, provider protections and consumer participation mechanisms.

The information that is available to consumers about competing plans is relatively sparse. Consumers can obtain financial information about the operation of the plans, but little information about consumer satisfaction, the adequacy of the carrier's process for delivering care or health care outcomes. Nor does the state require plans to disclose information about financial risk sharing arrangements,

drug formularies, treatment of specific conditions, coverage of experimental or investigation procedures or the clinical review criteria used to review the medical necessity of a particular treatment or service. This information is especially useful for individuals with special health care needs who need to choose from competing health plans. Unlike most other states, North Carolina has no requirements to involve consumers in HMO governance or operation. Similarly, North Carolina provides few protections to providers.

An analysis of the six largest HMOs in North Carolina uncovered several problems. In general, all of the plans covered basic health care services, including physicians' services, hospitalizations, some preventive care and some ancillary services. However, the benefit packages were not all comprehensive. Some of the carriers excluded any mental health coverage (unless purchased separately as a rider), and all of the carriers limited therapy services to conditions which were expected to show significant improvement on a short-term basis. The Certificates of Coverage (the member handbook) which should explain the covered benefits and exclusions were sometimes incomplete and often confusing. Plans used technical language which made some of the descriptions of covered or excluded services unintelligible. Further, the appeals mechanisms were not uniform across plans; several failed to provide adequate due process protections.

Limited information was available about the accessibility of network providers or services, or access to plan personnel. Although carriers are required to establish internal access guidelines, they are not currently required to report this information, or how well the carriers are meeting their own performance targets, to the state.

The six HMOs appeared to be doing a good job of establishing internal quality assurance and utilization review systems. All of the plans had more extensive systems for monitoring quality than required under state regulation. However, little information was available about the quality of care provided by the plans (structure, process or quality measures). Some of the plans report this information on a voluntary basis to the National Committee for Quality Assurance (NCQA), but the information is not readily available to consumers. Similarly, the plans all had extensive utilization review mechanisms especially geared at monitoring overutilization and inappropriate use of services. Information on overutilization was used by some of the carriers as grounds for sanctions. Utilization information was also used in determining whether providers received bonuses or whether some of their withheld compensation were returned. Only four of the six plans reported that they examined potential underuse of services. However, none of the plans reported that they looked at inappropriate underutilization of services in the provider evaluation process or to trigger provider sanctions.

The state collected extensive financial information from plans, as well as some enrollment and very limited utilization data. The usefulness of financial data was limited because two of the plans were not required to submit the same information as other carriers. The enrollment data was useful and helped provide information about the growth and stability of the plans. However, disenrollment data, which could highlight potential quality of care or access problems, was not

required to be reported. Information about consumer complaints, grievances filed against the plans, and malpractice claims could potentially provide useful information about the quality of a plan. However, the usefulness of this data was limited because carriers were not required to submit the information (internal complaints), the required reports were not collected (grievances), or the state failed to collect detailed enough information to be able to discern the nature of the underlying problems (malpractice information).

Overall, the Department of Insurance appeared to be doing a good job ensuring that the HMOs follow applicable state laws and regulations, but specific improvements are needed. For example, the DOI should do a better job of ensuring that member materials are complete and understandable. The Department failed to track problems over time–it did a more thorough job monitoring network adequacy and accessibility in the past than it does now, and it neglected to follow up with carriers that failed to submit some of the required reports to the state. In addition, the Department did not consistently include information in the Market Practices and Market Compliance Examination reports which could be useful to consumers, such as the number or nature of the internal consumer complaints filed with carriers, or the plan's compliance with its own accessibility standards. There was also some indication that the Department lacked the staff needed to properly monitor the growing managed care industry in the state. The Department of Insurance faces another problem which lessens its ability to enforce state laws and regulations: while North Carolina has many of the same regulatory enforcement mechanisms included in other states, most of the HMO enforcement mechanisms are limited to egregious violations of the law. The Department, therefore, lacks the authority to remedy less serious violations of the law.