CONSULTANT'S REPORT ON THE TENNESSEE PATIENT ADVOCACY ACT OF 1997

Prepared by:
RESEARCH & PLANNING CONSULTANTS, INC.
7600 Chevy Chase Drive, Suite 500
Austin, Texas 78752
(512) 371-8100

February 19, 1998

TABLE OF CONTENTS

CONSULTANT'S REPORT ON THE TENNESSEE PATIENT PROTECTION ACT
EXECUTIVE SUMMARY

Research & Planning Consultants (RPC) was commissioned by the Special Committee of the Tennessee Legislature to study the Patient Protection Act of 1997. The study began in late October of 1997 and was scheduled to be completed by the end of January 1998. The role of the consultant was to provide the Committee professional and technical expertise in conducting an evaluation study and written report to the Committee that evaluates the health care, commercial and financial aspects and other issues addressed in the "Patient Advocacy Act of 1997", including "any willing provider" provisions.

Specifically, the scope of the consultant's assignment included addressing the following issues:

(a) If Tennessee moves to an open panel (any willing provider) model, what fiscal impact would there be to the TennCare program? What fiscal impact would there be to private insurance policy holders? If there is an impact, where is it (specialist, primary care, cap-rate, HMOs, etc.)

(b) To what extent would the provisions of the act increase provider participation in managed care, and patient choice of health care providers?

(c) Are the regulatory mechanisms for health-care insurance companies in the State of Tennessee adequate to protect consumers?

(d) The extent to which patient choice and access to health care providers in Tennessee varies depending on whether one lives in a rural or urban area.

In fulfilling that role, RPC conducted research on all the important aspects of the Act. The research effort included:

- Gathering information and opinions from stakeholders on all sides of the issues both at the Committee hearings and through interviews

- Literature research on topics addressed in the Act including "any willing provider" and "patient protection initiatives"
- Telephone surveys of Tennessee hospitals and specialty physicians
- Collection and analysis of data covering other states' experience with any willing provider provisions and patient protection initiatives and
- Collection, processing, and analysis of data specific to Tennessee and the TennCare program including provider files, provider lists, enrollee materials, financial data, and utilization data.

The bibliography and list of persons interviewed can be found in Appendix 2-B. The results of the study are summarized below and in presented in detail in the body of the report.

(a) If Tennessee moves to an open panel (any willing provider) model, what fiscal impact would there be to the TennCare program? What fiscal impact would there be to to private insurance policy holders? If there is an impact, where is it (specialist, primary care, cap-rate, HMO's, etc.)

RPC found that there would be a fiscal impact on the TennCare program and private insurance policy holders if Tennessee adopts an "any willing provider" (AWP) requirement that applies to the TennCare managed care organizations and to private (non-self-insured) HMOs. The best estimate for the fiscal impact is a six percent (6%) increase in premium costs for TennCare and private HMOs subject to state regulation. In annual dollar terms ($1998) we estimate additional costs to managed care plans of approximately $98 million for TennCare, $9.4 million for the government employees benefit plan, and $83.6 million for privately insured employers.

The basis for the estimated additional costs is the difference in the premium costs of health plan with closed and open panels of providers. These insurance products include broad panel preferred provider organizations (PPOs) and, to a lesser degree, HMO's with a point of service option (POS). We adjusted (downward) the premium difference between the broad PPO product and the closed HMO product to estimate the additional cost to health plans of the AWP provision. The adjustment reflects the possible impact of some adverse selection in PPOs compared to HMOs.

Our percentage estimate of the financial impact of the AWP provision in this study is less than in prior published studies we reviewed. RPC found the other studies were based mainly on actuarial models and untested assumptions. The prior studies made little or no use of actual market transactions as a reality check on their results.

Who will bear the increased costs the AWP provisions would create in the TennCare program is a decision for the Legislature. TennCare premiums are set by legislative appropriations rather than by market forces. RPC found that the TennCare MCOs are likely to experience cost increases similar to those in private MCOs. How the TennCare MCOs respond: charging the State more, reducing service levels or dropping out of the program will depend on whether the Legislature covers the additional costs with higher appropriations or forces the MCOs to absorb the costs. Our cost estimate for TennCare assumes the Legislature funds the additional costs.

(b) To what extent would the provisions of the act increase provider participation in managed care and patient choice of health care providers?

The focus of this part of the study was the TennCare program. The TennCare population has less choice of plan type than do others in managed care. While individuals and their employers can select plans with a broader choice of providers by paying the additional cost, TennCare enrollees do not have the economic means to make a similar choice.

RPC answered this question by first identifying the areas where choice of provider was most constrained in the TennCare program. These areas have both a geographic and provider dimension. Geographically, citizens of Tennessee who live in rural areas have much less choice of physicians than do those living in urban areas (see (d) below). The choice is least for specialist physicians.

RPC obtained data from the Tennessee Department of Health on licensed physician providers by speciality residing in Tennessee. The Bureau of TennCare provided current lists of participating physicians from the TennCare MCOs. RPC created databases from the state file and the MCO lists of providers. RPC selected five types of specialists and identified licensed physicians in those specialties who do not contract with in any TennCare

plan. The specialties are: cardiology, obstetrics/gynecology, oncology, ophthalmology, and orthopedic surgery. We surveyed the non-participating specialists using a two-tiered approach. First, we drew a 30 percent sample from all non-participating specialists and attempted to interview each of them by telephone. Second, we identified counties without a TennCare physician in these specialties. We called all the physicians in the selected specialities in those counties.

Based on the survey we conclude that few, if any, physicians in the selected specialties have been excluded from TennCare MCOs. Virtually all specialists who are not currently participating in the plans are not willing to join them at current reimbursement rates. The AWP provision will not Improve access and choice in the rural and underserved counties for TennCare enrollees.

(c) Are the regulatory mechanisms for health-care insurance companies in the State of Tennessee adequate to protect consumers?

RPC reviewed Tennessee's current regulatory mechanisms for protecting consumers enrolled in MCOs. To gauge their adequacy, RPC

- Studied Tennessee's current regulations,
- Identified the distribution of regulatory responsibility between agencies,
- Talked to consumer advocacy groups,
- Analyzed current model legislation and national standards and
- Compared the relevant laws of other states.

This information allowed us to determine Tennessee's strengths and weaknesses within a context of national discussions and activities in this area. RPC found that many consumer, government, and academic groups have concerns regarding patient protections and are studying the situation. Many state legislatures are also currently in the process of studying the issues and proposing new regulations, and many new patient protection laws have been passed since 1995.

Tennessee is still an immature market for commercial managed care plans

compared to states like California, New York and Minnesota. The current regulatory environment reflects the stage of development of the market. Tennessee has regulations that are adequate in several areas but needs more regulation in other important aspects of patient protections.

Tennessee, like many other states, splits regulation of managed care between the departments regulating health and regulating insurance. One the health side, much of the regulation and effort is focused on quality of care and program administration, while the insurance side primarily focuses on financial oversight. The Tennessee Department of Commerce and Insurance (TDCI) appears to be doing an adequate job of financial monitoring but is not as adequate in monitoring complaints, as they are currently unable to create detailed reports on consumer complaints, while the Bureau of TennCare at the Department of Health has a variety of information about complaints made by TennCare enrollees. The interest groups RPC spoke to all want to see the state enact more managed care standards; areas commonly mentioned were access to care, availability and disclosure of information, adequacy of networks, and strong complaint procedures.

Many national groups have proposed standards and model laws. These usually revolve around several main themes: access to providers, adequacy of provider networks, complaint and appeal procedures, access to emergency services, disclosure of information, provider protections and quality assurance plans. The National Committee for Quality Assurance (NCQA) is at the forefront of the quality improvement movement with its widely-respected accreditation process and performance measurements.

Our major recommendations for Tennessee are as follows:

1) Allow direct access to specialists in certain circumstances,
2) Allow continuity of physician care in certain circumstances,
3) Adopt standards for adequacy of provider networks,
4) Adopt certain provider protections,
5) Ban financial arrangements that directly limit care,
6) Adopt standards for complaint and appeal procedures and
7) Require comprehensive data reporting.

One way that states can accomplish many of the recommendations is to require that

all health plans be accredited by the NCQA. This would be similar to requiring that all hospitals obtain accreditation by the Joint Commission for the Accreditation of Health Care Organizations (JCAHO).

(d) The extent to which patient choice and access to health care providers in Tennessee varies depending on whether one lives in a rural or urban area.

The same databases used in the analysis of (b) above were used to construct ratios of providers to population in rural and urban counties. All physicians were included, without regard to their participation in TennCare.

The statistics confirm that rural and urban areas of Tennessee differ dramatically in the amount of choice of and access to physicians they enjoy. Large areas of the state have no local access to some physician specialties. For all physician specialties we examined in this study, urban residents have at least twice as many providers to choose from as rural residents.

These differences are due to where physicians have chosen to locate their practices because of economics or other factors. Managed care plans do not make these decisions for physicians. Development and application of access standards for health plans, particularly as applied to specialists, must take into account the great geographic diversity that exists in Tennessee. Standards set with reference to urban areas will be inherently unattainable in many rural areas. Unless separate standards are developed for rural areas, access standards could have the unintended result of causing health plans to drop rural counties from their service areas.

CHAPTER 1.

THE COST IMPACT OF THE "ANY WILLING PROVIDER" PROVISION

The first set of questions in the scope of the study is:

(a) If Tennessee moves to an open panel (any willing provider) model, what fiscal impact would there be to the TennCare program? What fiscal impact would there be to private insurance policy holders? If there is an impact, where is it (specialist, primary care, cap-rate, HMO's, etc.)?

The operations of managed care plans in Tennessee will be affected if the any willing provider (AWP) provisions of the Tennessee Patient Protection Act are implemented. The cost impacts are discussed below. Because the provision of health coverage is a business, some basic economic relationships come into play. These basic relationships are summarized in Figure 1-1. The first equation states that a health insurer's profit is the difference between premium revenue obtained from plan participants and the medical and administrative costs that the insurer incurs. Profit is needed to maintain the insurer in business; without profits the business will eventually exit the health insurance market. In private markets the tradeoff between higher premiums and reduced level of services and/or reduced profits and market exit will be determined by the interplay of market forces.

In markets where premiums are legislatively determined, as in TennCare, the tradeoff is a matter of policy. The state may choose to fund increased costs or may choose to force the businesses to adjust to higher costs through reducing profits, reducing services or leaving the market. These tradeoffs are illustrated in the lower half of Figure 1-1.

This study found that AWP would generate additional costs for managed care organizations in the TennCare program and in the private sector. The additional costs are summarized in Figure 1-2 for three groups of MCOs: the TennCare Program; the state employees' health benefit plan; and enrollees in private HMO plans that are not self-insured. The estimated impact is six percent (6%) of the HMO premium for each group.

FIGURE 1-1
Basic Economic Relationships for Health Insurance Business

Profit Equation		
Premium Revenue -- (Medical Costs + Administrative Costs) = Profit		
Adjustments to Higher Costs		
	Private Market	**Administrative**
Higher Premiums	Supply/Demand	Appropriation
Lower Provider Reimbursement	Supply/Demand	Supply/Demand
Reduced Service Level	Supply/Demand	State Contract
Reduced Profit	Supply/Demand	Funding Level and Costs
Market Exit	Supply/Demand	Funding Level and Costs

Source: Research & Planning Consultants

The premium impact on the state employees health plan and the private health plans are identical and based on the rates in the state benefits plan. The premium impact on TennCare is based on the 1997 average per member per month (PMPM) premium paid by the TennCare program to the TennCare MCOs, $113. The reasons and evidence for a six percent increase in premium cost are in the following sections of this chapter. State government and private employers will receive higher premium quotes from their insurers. Negotiation between plans and potential customers may result in some tradeoffs resulting in smaller increases in premiums and some reduction in services offered. Employers that have the option to self-insure through ERISA and avoid the added cost may do so. The Legislature decides the rates for the TennCare MCOs. The cost impact shown in Figure 1-2 assumes the costs will be passed through as premium increases to all three groups.

Figure 1-3 shows an estimate of the Tennessee population by insurance coverage. The estimate was developed using information on TennCare enrollment, the percentage of the population in Medicare, the percentage of people uninsured, the percentage of privately insured in self-funded plans, and the distribution of commercially insured people in indemnity plans, PPO, points of service plans, and traditional HMOs. The number of people in the state employees health benefit plan shown in Figure 1-2 is taken from 1997 enrollment information from the Tennessee Department of Insurance.

FIGURE 1-2

Estimated Annual Cost Impact of "Any Willing Provider" Provision Tennessee Patient Protection Act of 1997

Affected Group	Approximate Number Affected	Additional PMPM	Additional Cost
TennCare	1,200,000	$6.78	$97,632,000
State/Local Government Employees	72,000	$10.93	$9,439,546
Private Employees	637,700	$10.93	$83,605,531
Total	1,909,700		$190,677,077

Break Down of Estimated Cost

Affected Group	Administrative Costs (28.2%)	Provider costs (71.8%)	Total
TennCare	$27,568,000	$70,064,000	$97,632,000
State/Local Government Employees	$2,665,408	$6,771,138	$9,436,546
Private Employees	$23,607,365	$59,998,166	$83,605,531
Total	$53,840,773	$136,833,304	$190,674,077

Research & Planning Consultants. February 1998

FIGURE 1-3
Estimate of Insurance Coverage
Tennessee Population 1996

	Number	Percent
Total Population	5,300,000	100.0%
TennCare	1,200,000	22.6%
Medicare	636,000	12.0%
Commercial	3,130,732	59.1%
Self-Insured*	901,000	17.0%
Indemnity	169,388	3.2%
POS	29,733	0.6%
PPO	445,094	8.4%
HMO	257,686	4.9%
Other Commercial	2,229,732	42.1%
Indemnity	419,190	7.9%
POS	73,581	1.4%
PPO	1,101,488	20.8%
HMO	637,703	12.0%
Uninsured	333,268	6.3%

*Includes 226,000 State and local government workers. Approximately 72,000 are in HMOs, the remainder in PPOs.

Sources: Tennessee Department of Insurance, AAHP. Research & Planning Consultants

Basis for Cost Estimate

The cost estimate for the AWP provision of the Tennessee Patient Advocacy Act is based on the premium cost difference between closed panel HMOs and broader access managed care products, primarily preferred provider organizations (PPOs) and secondarily, HMOs with an out of network or point of service option (POS). RPC gathered comparative data from a variety of sources including the Tennessee state employee benefit plan. The data are summarized in Figure 1-4. The percentage savings of the closed HMO product compared with the more open PPO product is graphed in Figure 1-5. In this data, closed panel HMOs cost between 7.4 and 11 percent less than plans that offer either a broader network (PPO) or a point of service option. The high estimate includes both

FIGURE 1-4
Cost Comparison of Traditional HMO and PPO or POS Plan
Tennessee State Employee Benefit Plan-1998

	Single Premium	Employee Share	Employer Share
Basic Plan	$197.51	$39.50	$158.01
HMO #1	$186.84	$28.83	$158.01
HMO #2	$188.05	$30.04	$158.01
HMO #3	$173.22	$15.21	$158.01
HMO #4	$179.89	$21.88	$158.01
HMO #5	$185.35	$27.33	$158.01
HMO #6	$182.20	$24.19	$158.01
HMO #7	$173.11	$15.10	$158.01
HMO #8	$188.05	$30.04	$158.01
HMO Average	$182.09	$24.08	$158.01
%HMO Savings	8.5%	64.1%	0.0%

Source: Tennessee Division of Insurance Administration

Managed Care Savings Compared to Unmanaged Fee-for-Service under Alternative Forms of

IPA HMO	23.0%
POS/PPO	12.0%
%HMO Savings	11.0%

Source: Sheils, et al June 1995.

Average Monthly Single Premium for HMO and POS Plans - 1996

HMOs	$141.89
POS Plans	$152.39
%HMO Savings	7.4%

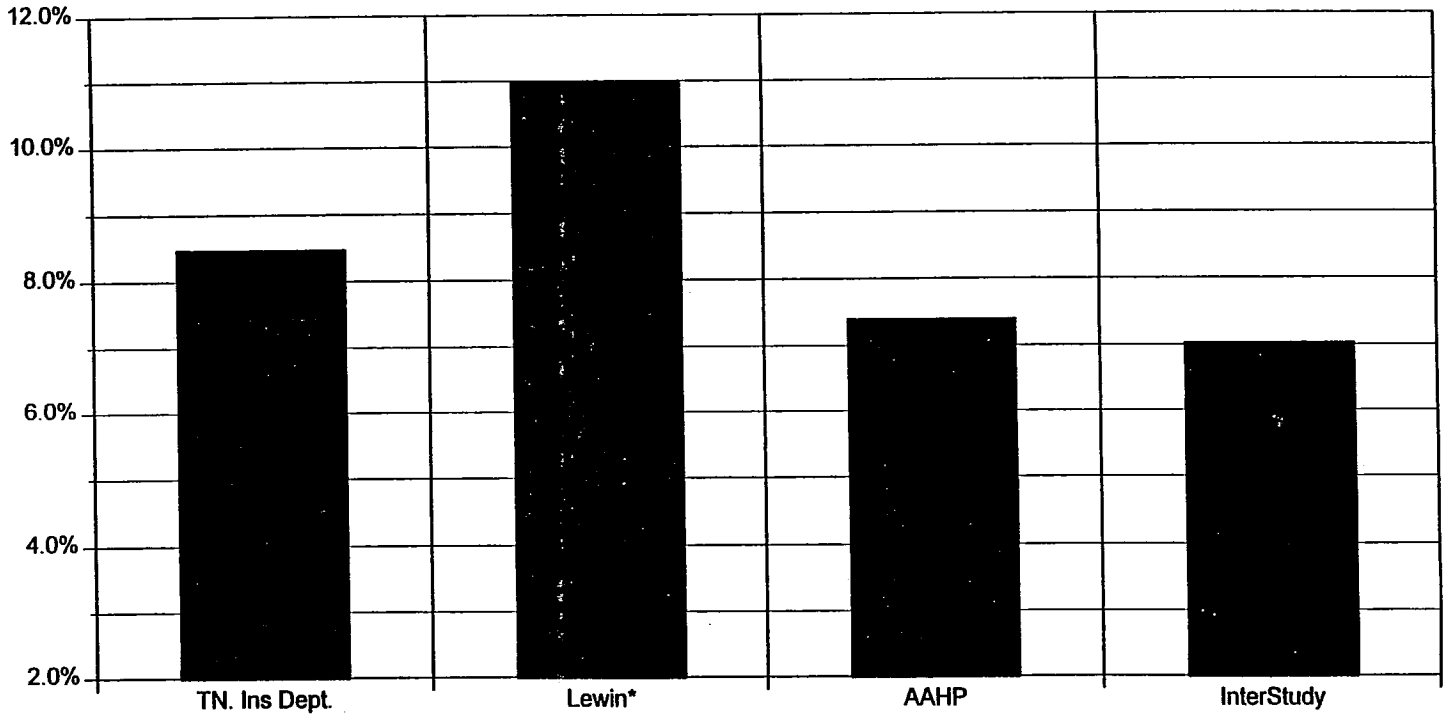
Source: AAHP

Average Monthly Single Premium for Traditional and Open-Ended HMO

Traditional HMO	142.97
Open-Ended	153.01
% Savings	7.0%

Source: InterStudy. Competitive Edge. December 1997

Market Value of Expanded Choice
% Saving Closed HMO vs PPO/Open HMO



* Estimates are based upon total expenditures including out-of-pocket costs and administrative costs for plans with comparable patient cost sharing requirements.
Other estimates reflect premium difference only.

Sources: Tennessee Department of Finance and Administration
Sheils, et al June 1995.
AAHP 1998
InterStudy, December 1997

premium costs and out of pocket costs (deductibles and co-pays). The other estimates are differences in premium only.

The cost differences shown in Figures 1-4 and 1-5 are a reasonable basis for estimating the cost of an AWP provision. The goal of AWP is to expand the choice of participants in a managed care health plan. The managed care plans currently offer products with that expanded choice and have placed a competitive price on that benefit as shown in Figure 1-5. The six percent cost placed on the Tennessee AWP provision is less than the premium differentials shown in Figure 1-5. The estimate for AWP is less because the amount of choice available to enrollees will be less than in plans that offer out of network options. Under AWP, providers must still be on the panel of providers, although the panel will be larger than under a closed panel HMO. Therefore we have used an estimate that does not factor in additional out of pocket costs (the 11% value in Figure 1-5) and which is below the cost estimate of the PPO plan. The use of a market-based approach to estimating the cost of an open panel requirement is sound because it reflects actual transactions that are occurring between competing managed care plans, employers and enrollees.

As noted above, there are differences other than the premium between a closed panel HMO and the more open products with which they are compared in Figures 1-4 and 1-5. These differences include differentials in co-pays, cost of out-of-network services, and annual out-of-pocket maximums. The cost estimate we used for the AWP provision focuses on the premium difference. The reason for this focus is that the groups affected are currently choosing the less costly option (closed panel HMO) for their health benefits. If that choice is no longer open to them because of an open panel requirement, they could be expected to minimize the cost impact to their health costs. This impact is best represented by the premium difference.

In private plans there is the possibility that the closed panel HMOs are selected by the relatively more healthy. Adverse selection of the open panel products used as a comparison is a possibility. However, by including only the premium difference and discounting it somewhat (6% vs. 8.4% in the state plan), the estimate used in this study is reasonable.

Comparison to Other Estimates of AWP Costs

There have been other studies of the impacts of an AWP law on health care costs and published critiques of those studies. The upper portion of Figure 1-6 provides some information about the studies including the sponsor. The lower portion of Figure 1-6 contains information on two published critiques of the cost studies. Some of these studies (Atkins and Wyatt) are based on actuarial cost models of managed care organizations. They have been criticized as based on unsupported assumptions (Simon). The Shiels (Lewin) study is based on identifying a relationship between AWP and growth of HMO penetration. Ohsfeldt, et al, have criticized this approach because it fails to consider the possibility of reverse causation, i.e., that the AWP law could be passed because HMO penetration was low. Marsteller, et al, note that "these studies' empirical methods range from non-random surveys of actuaries' opinions to multiple regression models with inferences based on coefficients that were not significant at conventional confidence levels."[1]

Of the studies listed in Figure 1-6, only the Arthur Andersen study for the State of Florida House of Representatives focused on the impact of AWP on a Medicaid managed care proposal. In Florida, the estimate was developed for a proposed Medicaid managed care initiative, the Florida Health Security Plan. The question was the amount of savings Florida could achieve through the initiative and how an AWP provision would affect the savings. The Andersen study concluded that AWP laws that applied to both primary care physicians and specialists would raise costs in both the Florida Health Security Program and the private sector by 15%. (Page 33). However in an earlier section of the report (p. 17), Andersen estimated the revenue loss to the program from the AWP provision to be 7% of acute care service cost, including 2% in additional administrative costs.[2] This

---

[1]Marsteller, Jill A., Randall B. Bovbjerg, Diana K. Verrilli, Len Nichols. "The Resurgence of Selective Contracting Restrictions". *Journal of Health Politics, Policy and Law*. October 1997.

[2]RPC contacted the authors of the report to request an explanation of the difference between the two estimates. While the authors attempted to be cooperative, they were unable to explain the reason for the 15% estimate. The substance of the report supports the 7% estimate.

estimate is roughly in line with the estimate RPC is using for the TennCare Program and private HMO plans that would be subject to the Tennessee AWP law. Although the Arthur Andersen study for Florida is not based on methods materially different from the Atkins and Wyatt studies, it was at least not produced under insurance industry sponsorship.

The critics of these studies fail to define any better approaches and do not offer any independent analysis of their own. We have found no studies that conclude that AWP would not raise costs at all. That includes the articles cited in Figure 1-6 that criticize the other studies.[3]

RPC's approach differs from the AWP cost estimates shown in Figure 1-6 by basing our estimate on market measures for the cost of choice, rather than relying on actuarial models and assumptions employed in the Atkins and Wyatt studies. We choose to rely on a market-based approach because it is grounded on real transactions that are occurring between competing MCOs and employers. The market approach prevents the adoption of an unrealistic estimate of the cost of AWP that implies loss of all or more than all the managed care cost savings compared with unmanaged indemnity insurance.

[3]Simon. P. 4. "To reiterate, the basic premise of the Atkinson study -- that AWP may increase network costs by increasing participation rates -- is not without merit."
Ohsfeldt, et al. P. 8. "While AWP (and FOC) laws are likely to reduce managed care growth and increase costs..."

FIGURE 1-6
COST STUDIES OF ANY WILLING PROVIDER LAWS AND CRITQUES OF THE STUDIES

Title	Date	Author	Sponsor	Method	Conclusion
Cost Analysis of State Legislative Mandates on Six Managed Health Care Practices	June 7, 1991	The Wyatt Company	Health Insurance Association of America	MCO Survey Actuarial Cost Model	Administrative costs increase between 34% and 52% Claims cost increase between 8.8% and 14.2%
The Cost Impact of "Any Willing Provider" Legislation	June 27, 1994	Atkinson & Company	Group Health Association of America	Update of Wyatt study	Insurance premiums increase between 9.1% and 28.7%
Flordia Health Security Program Actuarial Report	1994	Authur Andersen & Co.	Florida House of Representatives	Actuarial	Additional cost of 15% to Florida Health Security Program and Private Sector under broad AWP
The Cost of Legislative Restrictions on contracting Practices: The Cost to Governments, Employers and Families	June 21, 1995	Lewin - VHI, Inc.	Healthcare Leadership Council Alliance for Managed Care Health Ins Assn of America	Regression model of HMO Penetration	Reduced HMO enrollment associated with AWP raises private health spending by $74.7 billion over 1996 through 2002 period.
Cost Estimate Related to the Impact of an "Any-Willing-provider" Requirement in the State of Washington	1997	Arthur Andersen, LLP	Coalition for Affordable Healthcare	Acturial impact household, businesses and state gov.	Sponsor provided assumption of 12% premium increase. Cost in 1998 estimated at $175 million.
Critiques of AWP Studies					
Review of "The Cost Impact of Any Willing Provider Legislation"	July 1994	Carol J. Simon, PhD	Center for Health Policy Research, American Medical Association	Critique of Atkinson study	Projected increases in provider participation rates are too high. "Model" of administrative costs over simplified. No basis for "model" of provider discounts....the empirical analysis is so fundamentally flawed that it lends no credible support to the propositions.
The Spread of Any Willing Provider Laws	January 1997	Robert J. Ohsfeldt, PhD et al	University of Alabama at Birmingham	Analysis of reasons for enactment of AWP laws	Wyatt and Atkinson assume network expansions and fixed proportion administrative costs. Lewin finding fails to account for reasons for enactment of legislation.

As part of this study, RPC proposed to examine data from other states to learn if there was any information relevant to Tennessee (RPC proposal page 8). There is a lack of cost data with which to do a purely statistical comparison either of the states with and without AWP or states before and after adopting AWP.[4] That situation remains largely true for this study as well. However, in late 1997 InterStudy Publications published the Regional Market Analysis volume of their Competitive Edge series.[5] In the December and past volumes of the *Regional Market Analysis* InterStudy has presented information on HMO market penetration and enrollment, HMO reimbursement methods, population insurance coverage data, and physician and hospital data. The Regional Market Analysis volume presents data on HMOs by urban (metropolitan statistical area) markets. The December 1997 InterStudy Regional Market Analysis included more information on HMO finance measures than had been included in earlier volumes.

RPC believes the InterStudy data is reliable and objective. InterStudy has published data on HMOs for 25 years. Their data is used by people inside and outside the HMO industry to do market research. InterStudy data has been used extensively in academic studies[6] and cited by trade publications in the health insurance and provider industries[7].

---

[4]Hellinger, Fred J. "Any-Willing-Provider and Freedom-Of-Choice Laws: An Economic Assessment", *Health Affairs*, Volume 14, Number 4. Page 297-302.

Marsteller, Jill A., Randall B. Bovbjerg, Diana K. Verrilli, and Len Nichols. "The Resurgence of Selective Contracting Restrictions". *Journal of Health Politics, Policy and Law*, October 1997.

[5]InterStudy Publications. *The InterStudy Competitive Edge Part III: Regional Market Analysis*. December 1997. St. Paul, Minnesota.

[6]Burns, Lawton R; Gloria J. Bazzoli; Linda Dynan; Douglas R. Wholey. "Managed care, market stages, and integrated delivery systems: Is there a relationship?" *Health Affairs*, Nov/Dec 1997, pp. 204-218.

Christianson, Jon B; Roger D. Feldman; Douglas R. Wholey. "HMO mergers: Estimating impact on premiums and costs." Health Affairs, Nov/Dec 1997, pp. 133-141.

[7]Conrad, Douglas; Thomas Wickizer; Charles Maynard; Theodore Klastorin; et al. "Managing care, incentives, and information: An exploratory look inside the 'black box' of hospital efficiency." *Health Services Research*, Aug. 1996, pp. 235-259.

"Putting managed care in its place." *Hospitals & Health Networks*, Jan. 5, 1998, pp. 34-35.

InterStudy obtains the information and data they publish from regularly conducted surveys of HMOs and from government sources such as HMO financial reports to state insurance boards. InterStudy compiles the data and checks it for consistency. InterStudy adjusts the data for the response rate to the survey. Some finance information was obtained through the survey including average premium, administrative and medical cost (InterStudy, page iv). Other financial information was obtained from state insurance filings. "Data from the filings were matched with HMO survey data and estimates of MSA coverage were applied to the financial information. Duplicate filings were eliminated from the analysis; information from filings that provided data for several HMOs was allocated across the HMOs in proportion to enrollment. Results for each MSA were then aggregated and ratios were calculated. This yields a MSA-level database that reflects financial performance of HMOs as a whole within each market." (InterStudy, page 8).

RPC analyzed the InterStudy data on HMO finances to learn if they show any systematic relationships between HMO costs and premiums and whether a state has adopted an AWP provision applicable to commercial HMOs. It would not be surprising to find that there are no relationships or inconsistent relationships between AWP and HMO financial characteristics. That is the case because in most jurisdictions where AWP exists it is limited to only a specific provider group (pharmacy). In some states with broader AWP laws, the application of the law has been stayed by legal challenges under ERISA (Arkansas).

To do meaningful analysis we need a reasonable number of observations in the Wth and Without AWP categories. For that reason RPC divided the states into two groups: those with some AWP laws applicable to commercial HMOs and those that have none. The basis for the classification of the states is the 1997 article by Ohsfeldt, et al, shown in Figure 1-6. In the appendix to that article the authors list states based on whether or not they have AWP laws that are applicable to HMOs. RPC used the same classification with the following exceptions:

- Louisiana is shown as having AWP, but the law applies only to Medicaid.
- Washington State is shown to have AWP, but repealed the requirement in 1995.

Since the InterStudy data are from 1997, we put Washington in the No AWP group. The state classification used in the analyses along with the number of markets in each state is shown in Figure 1-7. Markets with less than 5% HMO penetration are excluded from the analysis because less complete data were reported for those markets and because the financial data can be heavily influenced by start-up factors.

Figure 1-8 shows averages for several variables for markets in states with AWP and with No AWP. Average data for the seven markets in Tennessee included in the InterStudy data are shown separately.

The Tennessee data are also a component of the No AWP averages displayed. For some variables, HMO's in states with and without some type of AWP law are about equal. This is true for HMO penetration, and medical expenses after adjustment for practice cost differences.

Some variables appear to be related to the existence of AWP. HMOs in markets with some type of AWP law have, on average, higher administrative costs, higher revenues from commercial payers, and higher premiums for individuals in traditional HMOs. RPC performed some simple regression modeling on the data. The regression analysis showed that some observed relationships were statistically significant (i.e., they could not have occurred by chance with more than a 5 percent probability.) The results of the regression analysis are shown in Figure 1-9. The regression analysis shows that premiums in traditional closed panel HMOs tend to be higher in markets subject to AWP laws. The results also show that administrative costs are higher in markets operating with AWP laws.

FIGURE 1-7

Classification of States by Any Willing Provider Law Applicable to Commercial HMOs

Any Willing Provider Law

State	AWP Applicable to	# of Markets
Alabama	Pharmacy	4
Arkansas	Pharmacy, Phy, Hosp	2
Connecticut	Pharmacy	6
Delaware	Pharmacy	2
Florida	Pharmacy	15
Georgia	Pharmacy, Phy, Hosp	3
Idaho	Pharmacy, Phy, Hosp	0
Illinois	Phy Pharmacy	6
Indiana	Pharmacy, Phy, Hosp	9
Kansas	Pharmacy	3
Kentucky	Phy, Hosp	2
Massachusetts	Pharmacy	10
Michigan	Pharmacy, Phy, Hosp	7
Minnesota	Pharmacy	4
Mississippi	Pharmacy	0
New Hampshire	Pharmacy	2
New Jersey	Pharmacy	8
New Mexico	Pharmacy, Phy	3
New York	Pharmacy	12
North Carolina	Pharmacy	9
North Dakota	Pharmacy	1
Oklahoma	Pharmacy	2
Oregon	Pharmacy	4
Pennsylvina	Phy	11
South Carolina	Pharmacy	5
South Dakota	Pharmacy	0
Texas	Pharmacy, Phy, Hosp	16
Virginia	Pharmacy, Hosp	4
Wyoming	Pharmacy, Phy, Hosp	0
Total 29		150

No Any Willing Provider Law

State	# of Markets
Alaska	0
Arizona	4
California	25
Colorado	7
District of Columbia	1
Hawaii	1
Iowa	5
Louisianna	4
Maine	3
Maryland	3
Missouri	5
Montana	1
Nebraska	2
Nevada	2
Ohio	8
Rhode Island	1
Tennessee	7
Utah	2
Vermont	1
Washington	8
West Virgina	4
Wisconsin	10
22	104

Sources: "The Spread of Any Willing Provider Laws", Ohsfeldt et al. January 1997
InterStudy Competitive Edge. Part III: Regional Market Analysis. December 1997

FIGURE 1-8
Summary Information from Interstudy Data
Markets with AWP and Without AWP

	Total	With AWP	With Out AWP	Tennessee
1995 HMO Market Penetration	18.72%	16.90%	21.29%	12.76%
1997 HMO Market Penetration	26.01%	24.93%	27.59%	15.44%
Index of Competition	0.58	0.58	0.59	0.64
HMO Commercial Revenue PMPM	120.33	122.35	117.43	115.71
HMO Administrative Expenses % of Total	14.73%	15.46%	13.69%	18.96%
HMO Administrative Expenses PMPM	20.23	21.32	18.66	22.57
HMO Medical Expenses % of Total Revenue	91.06%	90.73%	91.54%	97.00%
HMO Medical Expenses PMPM - Unadjusted	126.17	125.60	126.98	115.70
HMO Medical Expenses PMPM - Adjusted	130.71	130.52	130.97	128.70
HMO Operating Margin % of Total Revenue	-5.80%	-6.19%	-5.23%	-15.96%
Individual Premium in Traditional HMO PMPM	143.02	146.69	138.03	135.43

Sources: (1) InterStudy. Competitive Edge. Part III: Regional Market Analysis. December 1997
(2) Ohsfeldt et al, January 1997
(3) Health Care Financing Administration, November 1996
(4) Research & Planning Consultants

We caution readers against drawing any firm conclusions from our analysis of the InterStudy data. Regression shows correlation, but not causation. There are many factors other than AWP that could affect HMO financial data more than the existence of an AWP law. The analysis does not control for the effectiveness of a state's AWP law. What is known about the effectiveness of the laws is that in many jurisdictions that have adopted AWP, the law has not been fully implemented. An interpretation of these results that follows Ohsfeldt, et. al,[8] could lead to the conclusion that AWP laws tend to be passed in jurisdictions where providers are more powerful politically than employers or MCOs. The association between AWP and higher premiums and administrative costs could then be explained by the relative difficulty MCOs have in those states due to other market and political conditions.

While the analysis of the HMO financial data alone cannot prove that AWP raises costs and premiums in markets where such laws exist, it is consistent with a finding that AWP results in higher premiums and costs.

Conclusion Regarding the Cost of AWP

The best basis for an estimate of the cost of an AWP provision on HMOs in Tennessee is premium difference between a closed panel HMO and a broad network PPO. This difference - somewhat more than 6% - reflects what actual markets have produced and offer to consumers. The review of market level data found that a conclusion of a 6% increase in premium costs is consistent with experience of markets that had adopted AWP laws.

[8]Ohsfeldt, Robert L., Michael A. Morrisey, Leonard Nelson and Victoria Johnson. "The Spread of Any Willing Provider Laws". University of Alabama at Birmingham. January 1997 (Draft). See in particular Page 8.

FIGURE 1-9

Regression Model Results for HMO Single Premium and Administrative Expenses in Markets With and Without Any Willing Provider Rules

Single Premium Traditional HMO

Dependent Variable	Premium ($PMPM)			
Number of Observations	229			
Degrees of Freedom	225			
R-Squared	0.303			
Independent Variables	Coefficient	Std Error	t-Stat	Prob
Index of Competition	-24.72	5.28	-4.68	<1%
Medicare Practice Expense	94.49	11.05	8.55	<1%
AWP	8.96	2.21	4.05	<1%
Dependent Variable	Ln ($PMPM)			
Number of Observations	229			
Degrees of Freedom	225			
R-Squared	0.285			
Independent Variables	Coefficient	Std Error	t-Stat	Prob
Index of Competition	-0.159	0.036	-4.403	<1%
Medicare Practice Expense	0.627	0.076	8.253	<1%
AWP	0.059	0.015	3.856	<1%

HMO Administrative Expenses

Dependent Variable	Admin. Expense($PMPM)			
Number of Observations	254			
Degrees of Freedom	249			
R-Squared	0.114			
Independent Variables	Coefficient	Std Error	t-Stat	Prob
Index of Competition	3.449	1.749	1.972	<5%
% Enrollees in Medicare	17.972	11.050	1.626	<11%
% Enrollees in Group	-2.169	1.651	-1.314	<20%
AWP	2.534	0.815	3.108	<1%
Dependent Variable	Ln (Adm. Expense)			
Number of Observations	254			
Degrees of Freedom	249			
R-Squared	0.119			
Independent Variables	Coefficient	Std Error	t-Stat	Prob
Index of Competition	0.204	0.084	2.434	<2%
% Enrollees in Medicare	0.708	0.245	2.891	<1%
% Enrollees in Group	-0.147	0.079	-1.857	<10%
AWP	0.125	0.039	3.207	<1%

Applicability to TennCare

The application of the market-based cost estimate for AWP to the TennCare Program could be questioned because TennCare payments to MCOs are not set by the market. The premium cost differences shown in Figure 1-5 are drawn from the commercial market and not from Medicaid managed care programs, which have different funding mechanisms. The Arthur Andersen analysis of the Florida Health Security Program, which included a Medicaid managed care initiative, concluded that the cost impact on the Medicaid market would be the same as in the commercial market (Andersen, p.33). To test the applicability of the commercial based cost estimate used in this study to TennCare, RPC examined data on the TennCare program from provider, MCO, and Tennessee State government sources.

The purpose of the analyses described below is to estimate the likely cost impact of AWP on TennCare MCOs. The private MCOs set their premium rates after taking into consideration increased medical and administrative costs. The rates for TennCare MCOs are set legislatively and administratively. Increasing costs for the MCOs without increasing rates may cause them to exit from TennCare. It is the Legislature's option whether to allow increased costs to be passed on to the State or be absorbed by the TennCare MCOs. The assumption underlying Figure 1-2 above is that the State will fund any cost increases to the TennCare plans due to AWP.

To examine the likely cost impact on the TennCare program it is first necessary to define the potential avenues through which costs might increase if MCOs were required to operate under AWP. Once those avenues are identified, information on the likely size of the impact can be examined. For some avenues of cost impact no data exist that, directly or indirectly, produce a quantified cost estimate. For those avenues RPC has used the best available evidence or made no estimate at all.

Figure 1-10 shows the potential avenues of cost impact on the TennCare program and the estimate of the size of the cost impact on the program. The figure also shows the primary sources of the information for the estimate or the other basis for the estimate if an estimate is made.

FIGURE 1-10
Avenues of Potential Cost Impact to the TennCare Program From "Any Willing Provider" Provisions

Avenue of Potential Cost Impact	Cost Estimate	Source(s) for Estimate
Loss of Exclusive Arrangements	$19 million	MCOs
Leveling of Reimbursement Rates		
Hospital Inpatient	$23 million	Tennessee Hospital Joint
Hospital Outpatient	$13 million	Tennessee Hospital Joint
Other Providers	Not Available	Not Available
Less Risk Sharing in Reimbursement	Not Available	Not Available
Increase Utilization	Not Available	Not Available
Shift in Market Bargaining Power	Not Available	Not Available
Administrative Costs	$27 million	Arthur Andersen Study; Analysis of InterStudy
Total Identified	$82 million	

Exclusive Arrangements

Some contractual arrangements between MCOs and providers (hospitals, physicians, pharmacies) explicitly involve exclusivity. In those agreements the MCO limits the number of providers in a market in exchange for more favorable terms from the selected provider. Exclusivity can be an important topic in the negotiation process between a provider and a health insurer.[9] One witness (Sandy Benson, 11/17/97 p. 2) testified to the Committee that exclusivity is not an explicit feature of managed care contracts in Tennessee, although it might be implied in precontracting discussions between the

[9]Howard T. Wall, III, Esq. "Managed Care Provider Agreements", National Health Lawyers Association Managed Care Law Institute. December 4-6, 1995.
St. Mary's Hospital v. Blue Cross and Blue Shield of Virginia, discussed in "Study of the Impact of Subsection B of Section 38.2-3407 of the Code of Virginia on the Commonwealth's Health Care Market Statute Pursuant to SJ 158 of 1995." Page 7-8.

provider and the MCO. However, another witness from an MCO (Ruth Allen, 11/17/97, p. 38) testified about negotiating discounts from hospitals in exchange for an exclusive arrangement. Some negotiated prices depend on exclusivity and some do not.

Besides agreements with explicit exclusivity provisions, some provider/MCO arrangements are exclusive by the nature of the relationship. One class of arrangements that falls into this category is capitated arrangements based on the total enrollment of an MCO in a defined area. The arrangement might be for all covered services as with Blue Cross Blue Shield's arrangement with Tennessee Health Partnership (THP). A capitated arrangement might also cover a few services such as services of a particular specialty.

A geographic capitated arrangement between a single provider or group of providers and the MCO is incompatible with AWP. The MCO could not continue to pay the capitated provider the agreed amount and reimburse other similar providers who come into the network under AWP.

The information on the additional cost that would be incurred from the loss of exclusive contracts and geographic capitated arrangements come from the MCOs that participate in the contracts. Blue Cross provided information on its estimate of the savings from its arrangement with THP. The estimate compares costs from the year before the agreement (1995) to 1996, the first year the agreement was in place. (See Figure 1-11). The estimated savings, according to Blue Cross, are around $14 million.

RPC estimated that the Blue Cross savings represents 75% of the amount attributable to arrangements that explicitly or inherently involve exclusivity. The estimated annual value of the exclusive arrangements in TennCare is $19 million, as shown in Figure 1-10.

FIGURE 1-11
BlueCross BlueShield Estimate of Cost Savings from BlueCare Global Capitation Arrangement

	1995 Open Network PMPM	1996 Closed PMPM	Closed Network Savings PMPM
Primary Care Services	$12.25	$8.31	$3.94
Speciality Physician Services	$17.96	$14.57	$3.39
Hospital Inpatient Services	$6.11	$3.19	$2.92
Total	$36.32	$26.07	$10.25
Approximate number of Members Affected	115,300		
Estimated Savings	$14,181,900		

Source: BlueCross BlueShield of Tennessee

Rate Reimbursement Variation

Under AWP laws an MCO must define terms and conditions with which it will contract with any qualified provider willing to accept the terms and conditions. Those terms and conditions must be applied to all providers in a given class without discrimination.[10] That law is a change from the current operating environment under which MCOs can contract on different terms with different providers based on their specific characteristics (price discrimination).

For commercial MCOs negotiation and price discrimination are common. How much negotiation occurs in TennCare contracting was the subject of some dispute between witnesses before the Committee. Witnesses supporting AWP testified that negotiation never occurs; a provider either accepts the terms offered or turns them down (Wayne

[10]Some state AWP laws allow at least a limited amount of negotiation and discrimination. The Virginia law reads in part: "Neither differences in prices among hospitals or other institutional providers produced by a process of individual negotiations with providers or based on market conditions, or price differences among providers in different geographical areas, shall be deemed unreasonable discrimination." (Subsection B, Sec. 38.2-3407)

Winfree, Carthage General Hospital, 10/27/97, p. 71). Some MCO representatives testified that negotiation was common, particularly with hospitals. (Sam Howard, Phoenix Health Care, 10/27/97 p. 11).

RPC conducted a telephone survey of Tennessee hospitals that contract with TennCare MCOs. The object of the survey was to learn how much negotiation occurs between hospitals and MCOs and the hospitals' general views about the contracting process in TennCare. The survey instrument may be found in Appendix 1-E. Because affiliated hospitals generally handle contracts through a central contracting point, the number of hospitals covered by the information gathered in the survey exceeds the number of interviews completed. RPC obtained completed interviews from 30 respondents representing 90 hospitals in Tennessee. The hospitals accounted for 350,000 TennCare patient days or about 56 percent of the total number of inpatient days.[11]

Figures 1-12 and 1-13 show responses to some key questions asked in the survey. With respect to negotiation of contracts, a majority (69%) of respondents said the contracts their hospitals had with TennCare MCOs had been signed with no negotiation. For those that offered a reason why no negotiation took place, the most frequent answer was that TennCare is tightly funded and that there was little room for negotiation. Most respondents (53.3%) said that they believed negotiation was relatively rare throughout the TennCare MCOs' dealings with other hospitals. This perception may inhibit hospitals from making counteroffers even where the MCO would negotiate. The survey also revealed that a substantial amount of negotiation does occur.

On the question about whether payment rates in the TennCare program varied from hospital to hospital, the most frequent response to the question was that rates were the same with few exceptions. However, at least as many respondents said rates differed among hospitals based on rural and urban differences or by geographic section of the state.

[11]Tennessee Department of Health's 1996 Joint Annual Report of hospitals.

FIGURE 1-12

Hospital Representatives' Response to Question Regarding Negotiation of Contracts with TennCare MCOs

Question: **Which contracts with TennCare MCOs you work with were entered into following negotiation between (Hospital) and the TennCare MCO?**

Respondent #	Negotiated	Not Negotiated	Total	Don't Know
1	3	1	4	
2				1
3	4	0	4	
4	0	4	4	
5				1
6	0	3	3	
7	0	3	3	
8	0	5	5	
9	1	4	5	
10	5	0	5	
11	1	1	2	
12	0	5	5	
13	0	5	5	
14	0	5	5	
15	0	1	1	1
16	0	1	1	
17	0	4	4	
18	5	0	5	
19	5	1	6	
20	1	4	5	
21	0	6	6	
22	0	2	2	
23	0	4	4	
24	0	4	4	
25	0	5	5	
26	4	1	5	
27	4	1	5	
28	0	4	4	
29	0	4	4	
30	2	0	2	
Totals	35	78	113	
Percent	31.0%	69.0%	100.0%	

Source: Research & Planning Consultants, 1998

FIGURE 1-13

Hospital Representatives' Response to Question Regarding Negotiation of Contracts with TennCare MCOs - Continued

Question: Which of the following comes closed to expressing your understanding of the negotiation that occurs between MCOs in the TennCare program and hospitals over reimbursement rates?

Response:	Number Responding	% Responding
Negotiation Never Occurs	3	10.0%
Negotiation Rarely Occurs	13	43.3%
Negotiation Occurs Frequently	9	30.0%
Negotiation Almost Always Occurs	3	10.0%
Did Not Answer/Know	2	6.7%
Total	30	100.0%

Question: Which of the following comes closed to expressing your understanding of the reimbursement rates hospitals across Tennessee receive from TennCare MCOs?

Response:	Number Responding	% Responding
The rates are all the same	0	0.0%
The rates are the same with few exceptions	11	36.7%
The rates differ most of the time	9	30.0%
Each hospital's rate is unique	4	13.3%
Did Not Answer/Know	6	20.0%
Total	30	100.0%

Source: Research & Planning Consultants, 1998

To the extent that terms for hospital services differ, costs to MCOs could increase if the uniform terms and conditions required by the AWP provision caused average hospital (and other provider) rates to increase. If MCOs wanted or needed to keep some higher priced providers in their networks for access, efficiency, popularity with enrollees, or other reasons, average rates would go up as providers now receiving lower rates of reimbursement are raised to the level needed to attract the desired provider. The alternative, setting the uniform rate at or below the current average rate, risks the loss of the more desirable participants in the network.

Analysis of Joint Annual Report of Hospitals Data

No readily available information will produce a direct estimate of the cost of leveling reimbursement rates among existing providers. RPC sought indirect evidence from the financial and utilization data available from the Tennessee Department of Health's Joint Annual Report of Hospitals. The 1996 Joint Annual Reports contains FY 96 data for Tennessee hospitals. The data include TennCare net inpatient revenue and TennCare inpatient days. Similar data are reported for Medicare and other payers. RPC used data from the Joint Annual Report to construct a per diem rate for hospitals that reported data for both TennCare net inpatient revenue and TennCare patient days. Psychiatric and rehabilitation hospitals were excluded from the group since their reimbursement rates would be different from the acute care facilities.

Figure 1-14 shows summary information from the Joint Annual Survey data for the TennCare inpatient hospital experience. The data are arranged in groups based on the calculated per diem rate. Figure 1-14 shows that the 18 hospitals with highest calculated per diem rate accounted for 31% of the TennCare patient days reported. The average cost of a TennCare inpatient day at a Tennessee hospital in 1996 was $696. However, more than 57 percent of the patient days cost less than the average. RPC used some additional information from the Joint Annual Report to learn if the variation in TennCare inpatient per diem rates was likely the result of differing contract terms.

FIGURE 1-14

Summary Data for TennCare Inpatient Hospital Utilization - 1996

Per Diem Group	# of Hospitals	TennCare Patient Days	Net Inpatient Revenue	Net Revenue Per Diem	Hospital Ave Per Diem
Highest 15%	18	192,033	$228,436,238	$1,190	$1,252
Middle 70%	84	360,625	$188,113,860	$522	$511
Lowest 15%	19	69,645	$16,691,688	$240	$215
Total	121	622,303	$433,241,786	$696	$575

Medicare pays for most inpatient hospital services under a uniform prospective payment system based on the diagnosis related group (DRG) of the hospital's patient discharge. A hospital's calculated per diem rate for the Medicare patient population would reflect that hospital's patient mix and service mix, but not different reimbursement terms. Figure 1-15 repeats some TennCare data shown in Figure 1-14 and adds similar data for the Medicare patients discharged from these hospitals. Two hospitals in the TennCare group (St. Judes Children's Research Hospital and the East Tennessee Children's Hospital) did not report any Medicare patients.

A common way to measure the variability in a data series is with the standard deviation statistic. The standard deviation measures how dispersed a data series is around its mean value. The higher the standard deviation the greater the dispersion. The standard deviations for the TennCare and Medicare per diem rates are shown in Figure 1-15. The standard deviation divided by the average value and expressed as a percentage is a measure of the relative variability in different series. Figure 1-15 shows that the variation in the TennCare per diem rates (65.4%) is almost double the variation in the Medicare per diem rates (35%).

One problem with the TennCare data is that the calculated per diem rates include payments to some hospitals for graduate medical education besides the amounts paid by the TennCare MCOs. These payments would raise the calculated per diem rates for these

hospitals and increase the measured variability in the data.[12]

FIGURE 1-15
Comparison of TennCare and Medicare Per Diem Rates for Tennessee Hospitals - 1996

All Hospitals	TennCare		Medicare	
	# of Hospital	Hospital Per Diem	# of Hospitals	Hospital Avg Per Diem
Highest 15%	18	$215	18	$1,549
Middle 70%	84	$511	84	$900
Lowest 15%	19	$215	17	$532
Total	121	$575	119	$946
Standard		$376		$331
% Standard		65.4%		35.0%

Middle 70% of Hospitals	TennCare		Medicare	
	# of Hospital	Hospital Per Diem	# of Hospitals	Hospital Avg Per Diem
Middle 70%	84	$511	84	$900
Standard		$143		$134
% Standard		28.1%		14.9%

Source: Tennessee Department of Health. Joint Annual Report of Hospitals
Research & Planning Consultants, 1998

[12]This problem exists in the 1996 Joint Annual Report. However for the 1997 Report, only TennCare MCO payments and enrollee co-payments will be included in net patient revenue. "Joint Annual Report of Hospitals Instructions/Definitions" 1996 and 1997.

To deal with this problem and others that may cause a hospital's calculated per diem rate to be an outlier, RPC focused on the middle 70% of the TennCare series and the Medicare series. This eliminates the 15% of hospitals with the highest per diem rate (which includes the teaching hospitals) and the 15% with the lowest per diem rate. The bottom part of Figure 1-15 shows the results of limiting the analysis to the middle 70%. Compared with the data for all the hospitals, the variability is less (as expected) for both the TennCare and Medicare data. The reduction in variability for TennCare was from 65.4% to 28.1% and for Medicare from 35% to 14.9%. However, the variability in TennCare rates is still about double the variation in Medicare rates. This difference supports a finding that there are some differences in hospital reimbursement in TennCare that are absent from Medicare.

RPC estimated the potential impact on TennCare by raising the per diem rates for the lower paid hospitals in the group by just enough to make the variability in the adjusted TennCare data equal to the variability in the Medicare data. Following the adjustment, RPC calculated the total cost of the 1996 patient days at the hospitals and compared that result with the amount actually reimbursed for those hospital days. Inpatient costs were 12% or $23 million higher after adjusting for the excess variability. This amount is shown in Figure 1-16.

The Joint Annual Report of Hospitals data also includes information on hospital outpatient revenues. The total net patient revenue from TennCare for hospital outpatient visits in 1996 was $199 million. Of that amount $108.3 million was paid to the 84 hospitals used in the inpatient analysis. If a similar percentage increase found for inpatient services is applied to outpatient services, TennCare net revenue for outpatient services would increase by $13 million at the hospitals included in the inpatient analysis.

There is no data available that would allow an estimate of the potential impact of a reimbursement leveling on physician costs.

Reimbursement Methods

Managed care plans often use a variety of reimbursement methods for providers depending on the providers' interests and abilities to assume some utilization risk for the

plan enrollees. This can take the form of capitation, risk pools, or withholds. Under the AWP law defining terms and conditions that include both fee schedule and capitation arrangement may still be possible. For example, PHP in one type of primary care physician contract uses a fee schedule until the physician has 200 members in his/her patient base. At that point the reimbursement moves to a capitated arrangement.[13] However, some flexibility in reimbursement method will be lost under AWP. Currently not all primary care physicians and few specialists are capitated in the TennCare program. An MCO could be expected to have a more difficult time introducing or expanding risk sharing in their networks if it has to be done uniformly across the entire network. A more likely result is that risk sharing arrangements that currently exist in the TennCare program involving providers will revert to a fee-for-service or fee schedule method of reimbursement.

There are no data that would allow an estimate of the potential impact of the loss of flexibility in reimbursement methods.

Utilization

With the loss of flexibility in reimbursement methods, particularly methods that involve provider risk sharing, utilization can be expected to increase. If providers have less incentive to control utilization because they are paid on a fee for service basis, utilization and costs will likely increase.

Although there will be some immediate impact on the TennCare Program from greater utilization, the long-term impact will likely be much greater. The TennCare MCOs will be hindered by the AWP law from culling from their networks providers whose practice patterns are considered inefficient. The utilization review methods that will remain in place will have less impact on practice patterns if providers know that deselection from the network is a more difficult step to undertake.

The immediate and future cost impacts of increased utilization cannot be estimated with available data.

---

[13]PHP Health Plans. Health Maintenance Organization Primary Care Physician Agreement. Commercial PCP Contract 12/01/96. Page 13.

FIGURE 1-16
Cost Impact of Adjusting TennCare Per Diem Rates for Excess Variability

	# of Hospitals	TennCare Patient Days	Net Inpatient Revenue	Net Revenue Per Diem	Hospital Avg Per Diem	Standard Deviation	% Standard Deviation
Prior to Adjustment	84	360,625	$188,113,860	$522	$511	$143	28.0%
After Adjustment	84	360,625	$210,780,372	$584	$578	$86	15.0%
Difference	0	0	$22,666,512	$63	$67	($57)	-13.1%
% Difference	0.0%	0.0%	12.0%	12.0%	13.1%	-39.7%	-46.6%

Source: Research & Planning Consultants

Relative Market Power

Under the AWP laws, the terms and conditions offered to providers by the insurance entities are less likely to be readily accepted by the provider. With selective contracting a provider faces at least the possibility that failure to accept means loss of access to the patients in the network. Under AWP, there is no reason not to reject or at least delay accepting an offer since access to the patient pool can be gained at any time by agreeing to the terms then in effect. If enough providers adopt a wait and see strategy, the insurance company may be forced to come back with a better offer to provide required access.

The immediate and future cost impacts of a shift of relative market power toward providers cannot be estimated with available data.

Administrative Costs

Administrative costs could be expected to rise under the AWP provisions of the Patient Advocacy Act for three reasons. First, the administrative cost to credential and recredential an expanded network will be higher. Second, claims processing costs will be increased because more providers will be submitting claims and requiring payment. Third, the Patient Advocacy Act (Section 6) provides for due process rights for providers who either are not credentialed by an insurance plan or are deselected from the plan.

There is no direct evidence from TennCare operations on the potential impact on administrative costs from the implementation of the AWP and due process provisions of the Patient Advocacy Act. Some indirect evidence is provided by the Arthur Andersen study for the Florida Legislature discussed earlier. Anderson estimated that administrative costs would increase by two percent (2%) of acute patient care services cost under the broad version of AWP then under consideration by Florida (Anderson p. 17). Andersen's actuarial study assumed that administrative costs were 15% of the total. Figure 1-17 applies those assumptions to the TennCare program to calculate the expected increase in administrative cost.

FIGURE 1-17
Calculation of Administrative Cost Impact on TennCare Program From Adoption of AWP Mandate

Arthur Andersen & Co Assumption

Administrative cost increase = 2% of acute care service costs. (Andersen page 17)

Acute care service cost = 85% of premium for MCO. (Andersen Exhibit 6 page 1)

Administrative cost increase = 2% X 85% = 1.7% of MCO premium.

Applied to TennCare:

MCO Average Premium (PMPM)	113
% Impact	0.017
Impact on PMPM	1.921
TennCare Enrollment	1,200,000
Administrative Cost Impact	27,662,400

RPC Analysis of InterStudy Data

Estimated Impact of AWP on Single Premium	8.96
Estimated Impact of AWP on Administrative Costs	2.53
% Premium Impact from Administrative Costs	28.2%
Total Estimate Impact on TennCare	97,632,000
Administrative Cost Impact	27,567,964

Sources: Arthur Andersen & Co. Florida Health Security Program Actuarial Report, 1994.
Research & Planning Consultants, 1998.

The analysis of the InterStudy financial data discussed above provides some corroborating evidence for the estimate based on the Author Andersen assumptions. That analysis showed that HMOs in markets with AWP laws that apply to HMOs had both higher HMO premiums and higher administrative costs. A comparison of the relationship between the higher administrative costs and the higher premium costs shows that the administrative costs account for about 28% of the total. Based on RPC's estimate of a total impact of 6%, the administrative cost portion is about 1.7%. The lower portion of Figure 1-17 shows the calculation of the administrative cost impact based on these figures.

The two indirect approaches to estimating the increased administrative costs yield very similar estimates of approximately $27.5 million.

Summary of Cost Impact of the Any Willing Provider Provision on the TennCare Program

The 6% cost increase to TennCare from implementation of the AWP provision is reasonable based on the identified avenues of cost impact and the quantification of the impacts for which some relevant data are available. Figure 1-10 above shows that nearly 85% of the estimated cost to the TennCare Program can be tied to a quantifiable source. The remaining 15% of the cost impact will arise through ways listed in Figure 1-10 that could not be quantified.

Policy Issue Raised for TennCare Program

The additional cost that the TennCare MCOs would face from the adoption of an AWP law raises a policy issue for the State's elected officials. The issue is whether the State would add funds to the program to cover the increased costs and keep TennCare operating at current levels of service. Alternatively, by not increasing funding, the State could force MCOs to absorb the increased costs. Figure 1-18 presents information on the net incomes of the TennCare MCOs for the period 1994 and projected through 1998. The financial data are from the National Association of Insurance Commissioners (NAIC) statements; the projection is from the Tennessee Department of Commerce and Insurance.

FIGURE 1-18
NET INCOME OF TENNCARE MCO'S

MCO	CY94	CY95	CY96	97 TO 9/30	Projected 1998	1/31/98 Enrollment
HealthNet	($13,785)	$0	$0	($14,988,916)	($16,668,725)	79,546
Healthsource	($328,283)	($745,041)	$718,622	$0	$0	---
Heritage	($35,670)	$3,896,470	$2,786,044	($9,114,678)	($11,062,362)	21,504
Memphis Managed Care	$929,097	($1,531,377)	($1,878,200)	($1,764,625)	($753,591)	48,132
OmniCare	($8,358,947)	($561,310)	($7,846,726)	$1,320,084	$3,459,866	44,244
Phoenix	$794,433	$740,475	$2,107,333	($2,927,711)	($842,921)	93,765
PHP	$13,296	($128,169)	$312,118	$564,886	$4,021,141	89,126
Prudential	($2,150,010)	($2,158,957)	$875,880	$1,292,294	$2,197,785	11,107
Access Med Plus	($15,347,367)	$18,047,233	$13,280,934	($584,335)	$10,784,237	290,491
VHP	($4,280,585)	($1,116,160)	$1,644,887	($361,873)	$2,117	11,365
Blue Care	($932,307)	($2,640,943)	($583,949)	($289,592)	$4,521,801	102,873
*Volunteer	($8,826,000)	($5,401,714)	$10,128,523	$3,104,035	$22,731,921	419,898
Total	**($38,536,128)**	**$8,400,507**	**$21,545,466**	**($23,750,431)**	**$18,391,269**	**1,212,051**

*Effective 11/1/96, Blue Cross/Blue Shield TennCare enrollment was transferred to Volunteer.

Source: (1) Tennessee Department of Commerce & Insurance
(2) Bureau of TennCare

The plan enrollment data are from January 31, 1998.

One MCO, Healthsouce, left the TennCare Program after 1996. Another MCO, HealthNet is merging with Phoenix. The 1998 projections include a 3% increase in capitation payments effective the third quarter of 1997 and assumes expenses will remain proportionate to expenses through September 30, 1997. Under these assumptions three of the ten remaining plans would continue to operate at a loss, the merged Phoenix/HealthNet, John Deere Heritage, and Memphis Managed Care. Together they represent 20 percent of TennCare enrollees. The projected net income of the other plans totals $47.7 million in 1998.

As a group the MCOs probably cannot absorb the projected cost increases associated with the AWP law. The plans in weak financial condition may exit the market if faced with additional unfunded mandates. The plans that remain in the program will need to reduce costs in other ways to offset the increased cost associated with the AWP law. This could happen in different ways depending on the market position of the MCO. Plans with relative less market clout are likely to reduce costs by setting provider rates low enough to maintain profitability. Many providers that would see reduced reimbursement may drop out of the plan. The MCO probably cannot maintain the same network and may have to reduce the areas it serves.

MCOs with a current strong market position, particularly MCOs that can tie access to commercial business to TennCare participation, will find their relative market position further enhanced. The open panel requirement will make available to any provider the large patient pool of the big MCOs. The incentive of a provider to work with a small MCO on low reimbursement terms is reduced if the provider can have access to the patient volume of the larger MCO. If enrollees have choice of MCO, they can be expected to select those with the most choice of providers, which will increasingly be the dominant MCO. The interaction of provider choice of MCOs to contract with and enrollee choice of plans with the widest provider networks will concentrate enrollment and provider participation in the largest plans.

The trend toward fewer MCO market participants would operate to a degree even

if the State decided to fund part or all of the cost of the open contracting mandate. The concentration process will be accelerated if plans must find ways to deal with higher costs that are not funded through premium increases.

If the Legislature chooses not to fund the cost increases for the TennCare Program arising from the AWP law, the consequences are likely to be opposite of those intended: less choice of plans for consumers because of fewer participating MCOs; fewer services for consumers because of the need to reduce costs; lower quality of care as networks are increasingly composed of providers who are willing to accept TennCare rates because of lack of alternative patients.

Managed Care's Future under Open Panel Mandate

The cost estimates presented are based on the current operation of HMOs in Tennessee, private HMOs and the TennCare HMOs. The AWP law will affect the future development of managed care in Tennessee as well. These future effects will be particularly important for the TennCare Program.

TennCare was set up in a very short time. A key concern for the TennCare MCOs was to develop networks that could serve the enrollees in the plans. In some cases, the networks could only be developed through requiring TennCare participation as a condition of participation in commercial MCO networks. There was little opportunity during the early years of the program for efficient network design; the concern was to have a network. The transition from scrambling to build a network to making it efficient and of high quality is just beginning for the TennCare program.

An AWP law will make network improvement more difficult for MCOs. Dr. Preston of Blue Cross described in his testimony (October 27, 1997, page 50 to 58) the next stage, as he sees it:

> "One of my goals as the medical director for Blue Cross is to actually create the infrastructure for quasi-integrated delivery systems for our managed care products. It will be necessary for me to identify individuals and institutions who have both the interests as well as qualifications to work with each other to promote the health of well defined populations as well as to provide care

to members when they are ill." (Page 51) Later in his testimony: "The problem with that is - if we're not allowed to define the networks and form these relationships, I don't think we'll ever be able to move to the next stage of managed care, which is the practitioners managing the care and the health care organizations representing the resource." (Page 55).

Managed care in Tennessee has not reached to stage of quasi-integrated delivery systems discussed by Dr. Preston. The consequences for some providers of MCOs attempting to move in that direction by purposefully limiting a network are among the reasons for the legislation's introduction. The AWP provisions of the Patient Protection Act will possibly freeze managed care and the TennCare program in the early stage of development. This effect of the law is likely to result in higher costs and lower quality of care in the long-run.

CHAPTER 2.
PATIENT ACCESS AND PROVIDER PARTICIPATION

This section of the report address two issues raised by the Committee for the consultant to address:

> **(b) To what extent would the provisions of the act increase provider participation in managed care, and patient choice of health care providers?**
>
> **(d) The extent to which patient choice and access to health care providers in Tennessee varies depending on whether one lives in a rural or urban center.**

These two issues are related because they deal with issues of access and choice. The first issue seeks to gauge provider reaction to the open panel requirement provisions of the Act. The second issue addresses the inherent differences that may exist for people living in rural and urban areas.

This part of the study focuses on the TennCare MCOs for two reasons. First, the TennCare population includes those most vulnerable to access problems. Lack of provider participation in TennCare will fall particularly hard on TennCare enrollees since their options to seek care outside the plan or choose a plan with wider choice is severely limited. It is also likely that access problems for TennCare would be more acute because provider reimbursement rates are lower than some other third party payers.

Second, more complete data were available by geographic area (county) for the TennCare Plans than for commercial plans. Much of the data was provided by the TennCare Bureau in electronic format. The Bureau also provided current directories of providers for the TennCare MCOs. This was the source for the participating specialist analysis that RPC performed.

Although an information request went out to both TennCare and Commercial HMOs, direct responses were received from a relatively small number of plans. The information request, mailing list, and list of respondents may be found in Appendix 1.

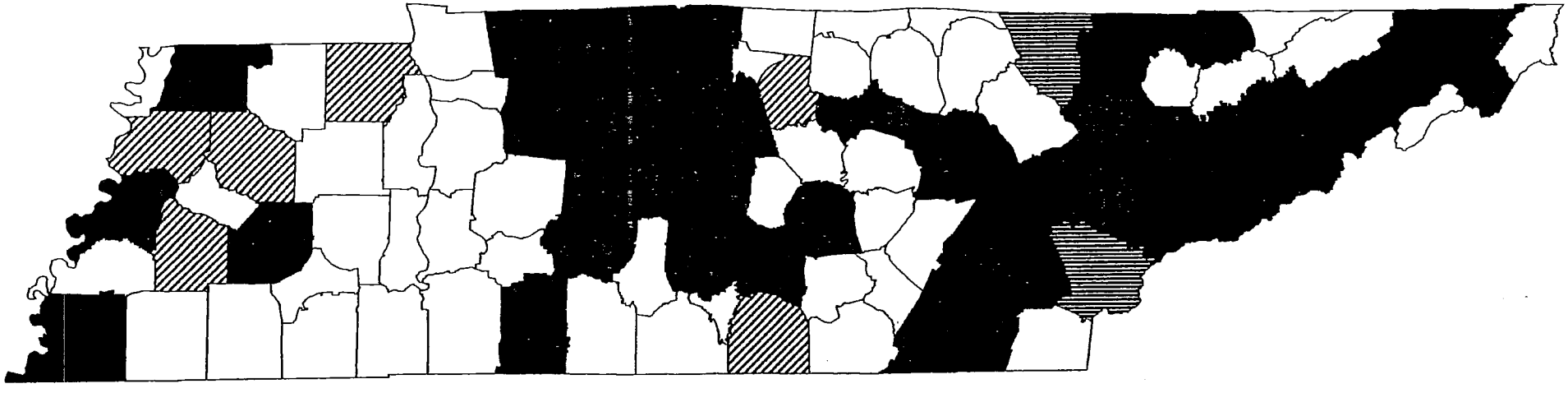
(b) To what extent would the provisions of the act increase provider participation in managed care, and patient choice of health care providers?

For issue (b), as it relates to the TennCare MCOs, RPC found that requiring TennCare MCOs to accept any qualified provider willing to accept the terms and conditions of the plan would not increase the participation of providers in some key specialities. We base this conclusion on a telephone survey specialist physicians who do not participate in TennCare plans.

We conducted the survey in two stages. In the first stage we used data obtained from the Tennessee Department of Health on licensed physicians in Tennessee to create a database of physician providers. The Department of Health data included physician name, speciality, office location, and phone number. As we received provider lists from the TennCare MCOs, we entered them into separate MCO databases. We matched the physicians on the MCO lists with those on the Department of Health list. In some cases a physician listed as a specialist by an MCO would not be on the state file under the same speciality. In such cases the physician was added to the state list for that speciality. Physicians in the MCO lists with multiple office locations were included in the MCO data files with the multiple locations. When they were matched with the state data, however, the extra office locations were not added to the state file.

Maps 1 through 5 on the following pages show information on five specialities: cardiology, obstetrics/gynecology, oncology, ophthalmology, and orthopedic surgery. Using the combined state file and the MCO files, RPC identified Tennessee counties that had various levels of coverage for these specialties. The maps label counties in **white** where no physician in that specialty has an office location. This information is also relevant to Issue (d). Counties that have specialists who participate in a TennCare MCO are shown in **green**. Counties that have no resident specialists but are served by at least one satellite office are shown in **blue**. Counties that have resident specialists who do not participate in TennCare are **yellow** if the county is served by a satellite office and **red** if no TennCare coverage is available in the county.

TennCare* Coverage by Cardiology Specialists

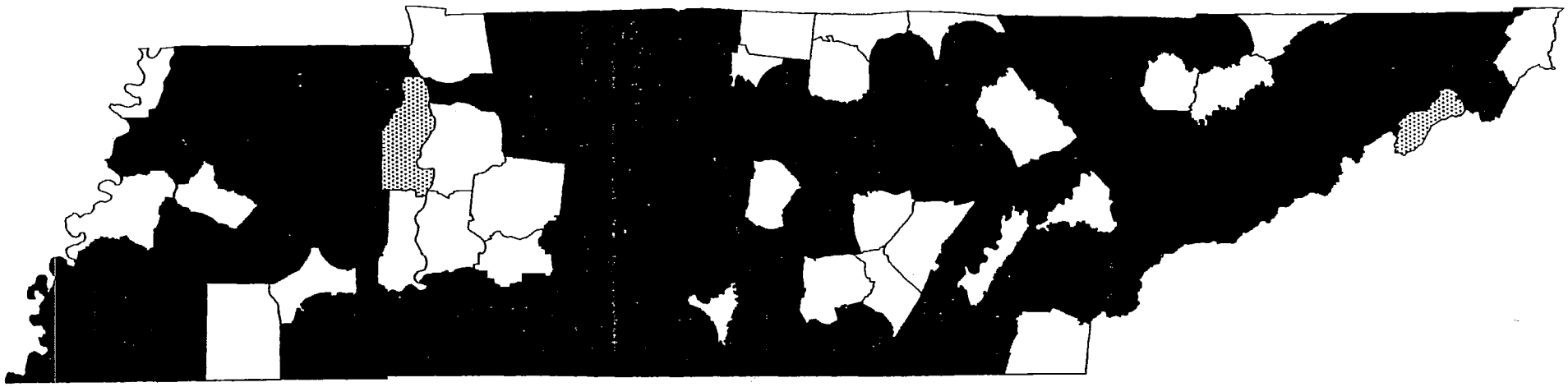


- Participating Cardiologists
- Participating Satellite Cardiologists
- Participating Satellite and Non-participating Resident Cardiologists
- No Participating Cardiologists/ Resident Non-participating
- No Cardiologists

* Includes All TennCare MCO's

Prepared by Research and Planning Consultants, Inc. 2/98

TennCare* Coverage by Obstetricians and Gynecology Specialists

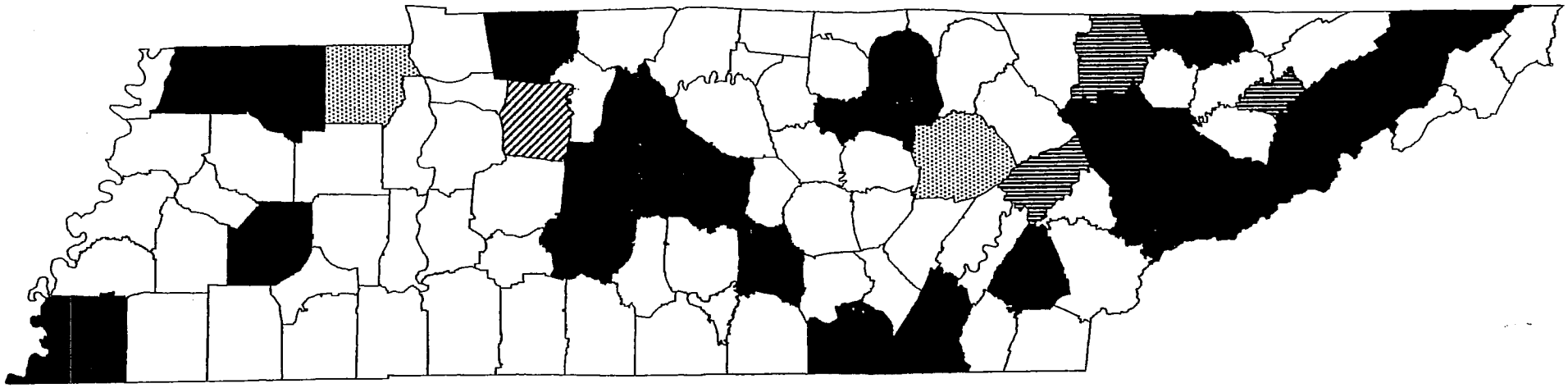


- Participating Obstetricians and Gynecologists
- Participating Satellite Obstetricians and Gynecologists
- Participating Satellite and Non-participating Resident Obstetricians and Gynecologists
- No Participating Obstetricians and Gynecologists/ Resident Non-participating
- No Obstetricians and Gynecologists

* Includes All TennCare MCO's

Prepared by Research and Planning Consultants, Inc. 2/98

TennCare* Coverage by Oncology Specialists

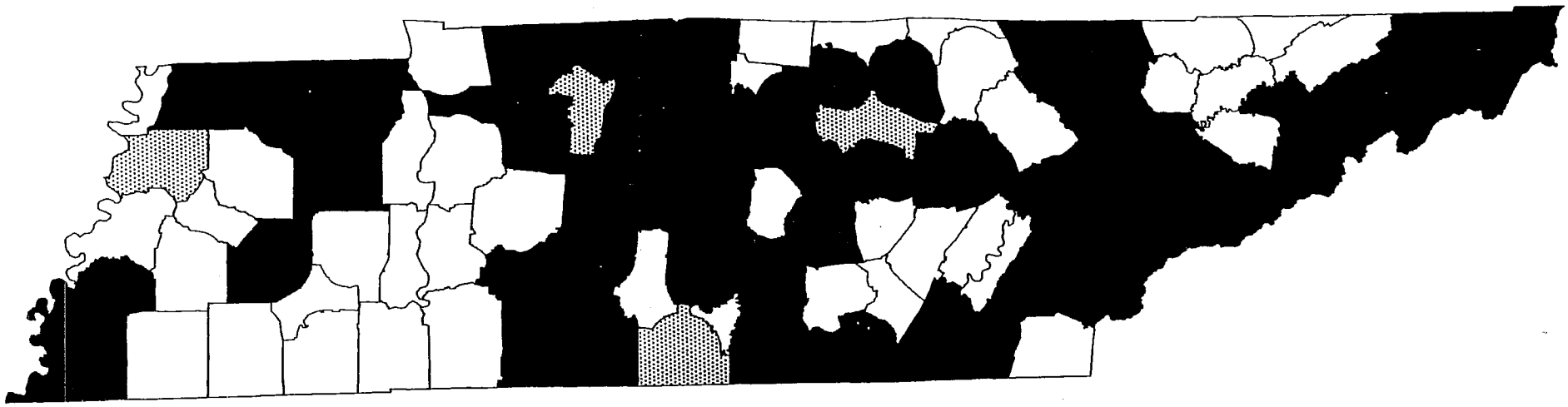


- Participating Oncologists
- Participating Satellite Oncologists
- Participating Satellite and Non-participating Resident Oncologists
- No Participating Oncologists/ Resident Non-participating
- No Oncologists

* Includes All TennCare MCO's

Prepared by Research and Planning Consultants, Inc. 2/98

TennCare* by Orthopedic Surgery Specialists

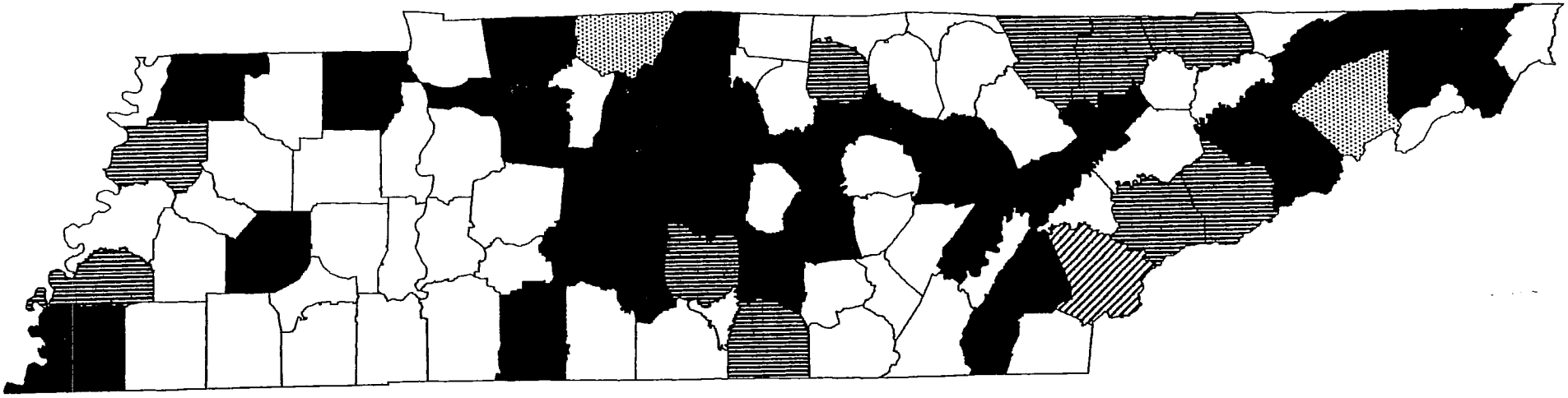


- Participating Orthopedic Surgeons
- Participating Satellite Orthopedic Surgeons
- Participating Satellite and Non-participating Resident Orthopedic Surgeons
- No Participating Orthopedic Surgeons/ Resident Non-participating
- No Orthopedic Surgeons

* Includes All TennCare MCO's

Prepared by Research and Planning Consultants, Inc. 2/98

TennCare* Coverage by Ophthalmology Specialists



- Participating Ophthalmologists
- Participating Satellite Ophthalmologists
- Participating Satellite and Non-participating Resident Ophthalmologists
- No Participating Ophthalmologists/ Resident Non-participating
- No Ophthalmologists

* Includes All TennCare MCO's

Prepared by Research and Planning Consultants, Inc. 2/98

The second phase of the analysis was a survey of specialist physicians who do not participate in TennCare. We compiled a list of physicians in each specialty who were not shown on any TennCare MCO provider list. A 30% random selection of such specialists was drawn and we tried to contact each physician by telephone. A fairly large percentage of the physicians proved to be unreachable either through bad telephone numbers, closed offices or other factors. The results for the physician offices that were contacted are shown in Figure 2-1. Some doctors we contacted were not currently in practice. The survey also found that some physicians participate in TennCare although they did not appear on any TennCare MCO provider lists.

For those physicians in practice and not currently participating in TennCare, the nearly unanimous response was that the specialist physicians were not willing to participate in TennCare. Many cited low reimbursement rates and restrictive guidelines as reasons for not participating.

FIGURE 2-1
Results of Doctors Contacted: 30% Random Sample of Specialty Doctors Not Participating in TennCare

Cardiology

Response	Number	Percent
Not in Practice	2	33%
Participating in TennCare	3	50%
Willing to Participate	0	0%
Unwilling to Participate	1	17%
Total	6	100%

Obstetrics and Gynecology

Response	Number	Percent
Not in Practice	4	14%
Participating in TennCare	4	14%
Willing to Participate	2	7%
Unwilling to Participate	18	64%
Total	28	100%

Oncology

Response	Number	Percent
Not in Practice	2	25%
Participating in TennCare	4	50%
Willing to Participate	0	0%
Unwilling to Participate	2	25%
Total	8	100%

Ophthalmology

Response	Number	Percent
Not in Practice	4	31%
Participating in TennCare	2	15%
Willing to Participate	0	0%
Unwilling to Participate	7	54%
Total	13	100%

Orthopedic Surgery

Response	Number	Percent
Not in Practice	4	17%
Participating in TennCare	2	9%
Willing to Participate	0	0%
Unwilling to Participate	17	74%
Total	23	100%

We conducted a second survey of specialty physicians in counties that have either no TennCare participating specialty physician or only a satellite TennCare specialist office. We attempted to contact all physicians in the five specialities in those counties. The results of the survey are shown in Figure 2-2. As was the case with the earlier survey, these physicians have little interest in participating in TennCare. Reasons for unwillingness to participate include administrative costs, low reimbursement rates, and problems associated with high-risk patients.

At current reimbursement rates specialty physicians in cardiology, obstetrics/gynecology, oncology, ophthalmology, and orthopedic surgery who are not currently participating in a TennCare plan would not affiliate with a plan if the network were opened up with an AWP law. None of these providers indicated they wanted to participate, but had been excluded from an MCO panel.

FIGURE 2-2
Results of Rural Specialty Doctors Contacted who do not Participate in TennCare

Cardiology

Response	Number	Percent
Not in Practice	0	0%
Participating in TennCare	0	0%
Willing to Participate	0	0%
Unwilling to Participate	1	100%
Total	1	100%

Obstetrics and Gynecology

Response	Number	Percent
Not in Practice	0	0%
Participating in TennCare	0	0%
Willing to Participate	0	0%
Unwilling to Participate	2	100
Total	2	100%

Oncology

Response	Number	Percent
Not in Practice	0	0%
Participating in TennCare	0	0%
Willing to Participate	0	0%
Unwilling to Participate	4	100%
Total	4	100%

Ophthalmology

Response	Number	Percent
Not in Practice	0	0%
Participating in TennCare	1	25%
Willing to Participate	0	0%
Unwilling to Participate	3	75%
Total	4	100%

Orthopedic Surgery

Response	Number	Percent
Not in Practice	0	0%
Participating in TennCare	1	14%
Willing to Participate	0	0%
Unwilling to Participate	6	86%
Total	7	100%

(d) The extent to which patient choice and access to health care providers in Tennessee varies depending on whether one lives in a rural or urban center.

Maps 1 through 5 provide some evidence of the geographic variation in access and choice of providers. Large areas of the State are undeserved simply because no physicians in certain specialties have chosen to locate there. This is further illustrated in the urban/rural comparisons provided by Figure 2-3. The urban/rural data below are based on the state physician files and county population estimates from the Tennessee Department of Health, Division of Information Resources. Urban counties were defined as those with a population of 50,000 or more. Rural and urban physician/population ratios are calculated by dividing the number of physicians by the population times one thousand. The physician to population ratio is one common method for measuring access to care and physician choice. By itself, the ratio does not capture all aspects of patient access such as physician office hours and his/her willingness to accept new patients. In Tennessee

mountains can make access even within a county difficult. The physician to population ratio analysis is only a first level indicator of the differences in access between urban and rural areas.

The physician to population ratio data for primary care physicians indicate that the Tennessee urban population has almost twice as much access as rural populations. While it is common for rural areas to have fewer doctors, for the five specialties used in this analysis, rural areas have only a fraction of the access available in urban areas. Among the specialities the differential is the smallest for OB/GYN physicians; urban areas have just less than three times as many providers per 1000 population as do rural counties. For oncology, a speciality often requiring association with a larger hospital, urban areas have seven times as many per 1000 as rural areas. There are 65 (61 rural) counties in Tennessee that do not have any oncologist.

New Jersey has been cited by Families USA as having defined the most comprehensive access standards for managed care plans.[14] The New Jersey standard requires at least two specialties in a list of 14 (including the five specialties analyzed in this study) within 30 miles or 45 minutes driving time of 90% of the enrolled population. It is clear from the maps that managed care plans in Tennessee could not meet those access standards if the service area were in rural West Tennessee. Other parts of the State would not meet those standards for at least some specialists. Access standards for specialists in managed care plans must take into account the geographic location of physicians as well as the needs of the managed care enrollees.

[14]Geri Dallek, Director, Health Policy, Families USA Foundation. "Text of Key State HMO Consumer Protection Provision: The Best of the States". January 1997.

FIGURE 2-3
Urban/Rural Differences in Access and Choice of Provider

Summary Information	Rural	Urban
Number of Counties	74	21
1997 Population	1,626,719	3,461,817

Provider Information			
Primary Care Physicians	Rural	Urban	Urban/Rural
Primary Care Physicians/1000	0.78	1.55	1.99
Cardiologists	Rural	Urban	Urban/Rural
Cardiologists/1000	0.04	0.14	3.50
Counties with No Specialists	47	0	
Obstetrics and Gynecologists	Rural	Urban	Urban/Rural
Obstetrics and Gynecologists/1000	0.08	0.23	2.88
Counties with No Specialists	30	0	
Oncologist	Rural	Urban	Urban/Rural
Oncologist/1000	0.01	0.07	7.00
Counties with No Specialists	61	4	
Ophthalmologists	Rural	Urban	Urban/Rural
Ophthalmologists/1000	0.02	0.10	5.00
Counties with No Specialists	48	2	
Orthopedic Surgeons	Rural	Urban	Urban/Rural
Orthopedic Surgeons/1000	0.03	0.12	4.00
Counties with No Specialists	40	0	

CHAPTER 3.

MANAGED CARE PATIENT PROTECTIONS

(c) Are the regulatory mechanisms for health care insurance companies in the state of Tennessee adequate to protect consumers?

To address the question posed by the Committee, this part of the study undertakes the following tasks:

- Identify and describe the health insurance regulatory mechanisms in Tennessee and the agencies affecting or regulating health insurance plans.
- Determine the procedures for dealing with problems and complaints against health plans.
- Identify and interview relevant consumer advocacy groups and determine where they think the problems are.
- Compare Tennessee laws and regulations to models acts and studies on consumer protections.

Which agencies play a part in regulating health insurance in Tennessee? What type of protections do they enforce and how do they handle problems and complaints?

About 93.7 percent of all Tennesseans had some form of health insurance in 1996. About 44 percent of Tennesseans (47 percent of the insured) are covered by self-funded or insured employer-based ERISA health plans which are exempt from most state regulations, about 20 percent of the insured are covered by the TennCare program, and the remaining insured individuals are covered by either Medicare, commercial HMOs and insurance companies, or government employee health plans.[1] Below are the state agencies and divisions within those agencies that regulate health insurance and health plans in Tennessee, and descriptions of each of their responsibilities.

The Insurance Division of TDCI is responsible for regulating commercial HMOs, licensed insurance companies, medical service plans, hospital service corporations, and hospital and medical service corporations (as defined in Tennessee Code Annotated, Title 56). The regulation of HMOs includes a list of required minimum services, a requirement of an adequate amount of working capital, an initial filing of certain documents with TDCI and subsequent semi-annual filings of financial statements, and rules on contracting and open enrollment periods. The Insurance Commissioner can issue a cease and desist order to any HMO (after a formal hearing) if the HMO is financially unsound or is not complying with state regulations.[2]

The Consumer Insurance Services Section within the Insurance Division handles consumer inquiries, consumer complaints, and investigations for all insurance plans that they regulate. Complaints by TennCare members are forwarded to the Bureau of TennCare in the Department of Health, and complaints about state health plans are directed to the Department of Finance and Administration. During 1996 this section received 3,338 consumer complaints about insurance companies (health, life, property, and casualty) and about 500 complaints about agents; from January 1, 1997, to October 27, 1997, the section received 3,211 consumer complaints.[3] About half of the consumer complaints were about health and life insurance and about half were about property and casualty insurance.

More details about numbers or types of complaints were not available because the Consumer Insurance Services Section is in the process of converting its computer systems to be compatible with NAIC guidelines so information can be shared nationally. The conversion was started in mid-1996 but is still not complete due a programmer leaving and the subsequent lack of programmers with the right skills to finish the conversion. Since the conversion started, the section has been unable to run detailed reports about complaints, and when we requested to come to the department and manually examine the complaint files, we were informed that the public information laws pertain to Tennessee residents only and we could not be shown the files.[4]

When a consumer has a problem with a commercial health plan, he or she can call

a toll-free number or mail a letter or a complaint form (available from the division's offices and web site) to the Consumer Insurance Services Section. The section sends a copy of the complaint to the insurance company or HMO in question and at the same time mails an acknowledgment letter to the consumer explaining the process and containing a phone number to contact the investigator assigned to the case. The health plan has 15 business days to contact the section with a response, which the section reviews and then forwards to the consumer. An expedited review can be arranged in urgent situations. If the consumer does not agree with the outcome, he or she can contact the section again, who will contact the health plan and review the case. The Insurance Division is regulatory, not judicial, and can only make sure that the plan is following its stated policy and state regulations.[5] The division can take action against violations by agents or insurance companies through warnings, fines, suspensions, and license revocation.[6]

TennCare Division

This division was created in January 1995 to oversee certain areas involving managed care organizations (MCOs) and behavioral health organizations (BHOs) participating in the TennCare program. The division's responsibilities revolve around contract compliance, such as ensuring that the MCOs and BHOs meet certain minimum financial requirements. The TennCare Division has an internal agreement with the Insurance Division whereby the TennCare Division fully regulates any licensed HMO that receives or will receive more than 80 percent of its revenue from participating in TennCare. HMOs that receive less than 80 percent of their revenues from TennCare are primarily regulated by the Insurance Division, with the TennCare Division only monitoring certain aspects of their operations.[7] The TennCare HMOs regulated by the Insurance Division are John Deere and Prudential, who have substantial non-TennCare business, while the TennCare Division regulates the rest of the HMOs.[8] The TennCare Division has CPA examiners and coordinates efforts with the Comptroller's regulatory audits of HMOs and BHOs.[9]

The TennCare Division processes complaints from providers doing business with

MCOs and BHOs. Any consumer complaints received are directed to the TennCare Bureau in the Department of Health. From September 1995 to September 1997, the division received and reviewed 310 provider complaints.[10] Most of these complaints were about payment issues; the Division can request an explanation from the MCO but it is not a collection agency. The ultimate resolution for such complaints is between the provider and the MCO, and there is a provision for binding arbitration if needed.[11]

Tennessee Department of Health

Bureau of TennCare

The TennCare Bureau was moved from the Department of Health to the Department of Finance and Administration in early 1995, and was moved back to the Department of Health in January 1997. It is the agency in charge of the daily operations of TennCare, and it works with TDCI to ensure contract compliance. Included in the TennCare Bureau is administration of the TennCare Partners Program, which was moved from the Department of Mental Health and Mental Retardation in October 1997. The rest of the Department of MHMR is in the process of merging with the Department of Health.

The TennCare Partners Program was implemented on July 1, 1996, to help consolidate and coordinate funding and services for mental health and substance abuse under TennCare. The Department of Mental Health and Mental Retardation had been overseeing the program under an agreement with the Department of Health. In early 1997 it was announced that the TennCare Partners Program was going to end on January 1, 1998, and that the services that were being performed by behavioral health organizations would return to the TennCare HMOs. However, in May 1997, it was announced that although combining physical and mental health services under the same managed care organization was still the goal, the program would not end in January 1998 in order to give managed care organizations more time to develop appropriate mental health networks and services Tthere is currently no definite termination date.[12] The TennCare Partners employees were transferred to the Bureau of TennCare and participate in quality monitoring and contract compliance of the managed care organizations (MCOs).[13]

One of the Bureau's responsibilities is to receive and review consumer complaints from TennCare enrollees. Every managed care organization (HMOs and BHOs) participating in the TennCare program is required to have an internal complaint/appeal system, which must be approved by the Bureau. MCOs must notify enrollees of any decision made to delay, deny, terminate, suspend, or reduce covered services, and enrollees have the right to appeal this decision. Appeals are made to the TennCare Bureau, which logs them in and forwards them to the appropriate MCO for review. The MCO sends the results of its review back to the Bureau for review, and if the MCO has upheld its original decision, the state's Appeals Unit reviews the case. If the Appeals Unit disagrees with the MCO's decision, the MCO is notified that it must provide the service; if the MCO's denial is upheld by the state and the enrollee is still unsatisfied, he or she may request a fair hearing before an Administrative Law Judge.[14]

From January 1, 1997, to June 30, 1997, the Bureau of TennCare received 514 service appeals. Figure 3-1 shows the number of complaints received during this six-month period for each TennCare HMO and the corresponding rate per 1000 members.[15]

Of the 514 TennCare complaints received in the first half of 1997, 316 were related to pharmaceuticals, 46 were about physician care, 21 were dental-related, 15 were about access to care, 12 were about physical therapy, nine were about home health, nine were about rehabilitation services, and the rest were about various other things.[16] During this period, 412 service appeals were resolved: 29 percent were withdrawn by enrollees, 54 percent were reversed by the MCO upon appeal, 14 percent were reversed by the Appeals Unit, and less than 2 percent (eight cases) resulted in a hearing before an Administrative Law Judge.[17]

FIGURE 3-1
Complaints by Tenncare Mco—january Through June 1997

TennCare MCO	Number Complaints	Rate per 1000 members	Members (as of1/31/98)
OmniCare	5	.24	44,244
Blue Care	168	.75	419,898
Health Net	30	.70	79,546
John Deere	11	.87	21,504
TLC	8	.44	48,132
Phoenix	54	1.68	93,765
PHP	62	1.79	89,126
Prudential	4	.78	11,107
Access...MedPlus	89	.69	290,491
Blue Care- East TN	75	1.34	102,873
VHP/Vanderbilt	8	1.55	11,365
TOTAL	**514**	**.89**	**1,212,052**

The Select Oversight Committee on TennCare, a standing joint committee of the Tennessee General Assembly, is also involved in TennCare oversight and monitoring. This committee, created in 1994, consists of 14 members, seven senators and seven representatives. The Oversight Committee reviews and reports on proposed TennCare expenditures to ensure that the program is achieving its intended purpose of maintaining access to quality health care in an effective and efficient manner. The Committee is also charged with reviewing TennCare programs and activities including eligibility and enrollment standards, services and benefits, educational programs, contracts and MCO performance, amendments and other matters dealing with the federal waiver, and department management and staffing. The committee reviews bills that might affect TennCare and may attach comments to them for review by house and senate committees. In 1997, the committee was renewed for two more years, and may continue to be renewed every two years until it is felt that this function is no longer needed.[18]

Consultant's Report on the Tennessee "Patient Advocacy Act of 1997"
February 19, 1998

State Controller

Division of State Audits

This division handles state audits, including contractual, financial, and performance audits of other state agencies and of insurance companies and HMOs regulated by the Department of Commerce and Insurance.[19] Within this division is a TennCare division that works with the TennCare Bureau (Department of Health) and TennCare Division (Department of Commerce and Insurance) in auditing TennCare MCOs. TennCare requires that year-end reviews be done on the financial aspects of contract compliance of the participating MCOs, and the Comptroller's Office assists in performing these reviews, as well as reviews for the nursing home program also administered by the Bureau of TennCare. The Comptroller's Office does not conduct quality audits, since their personnel do not have clinical training. The Department of Health contracts this function to private companies.[20]

Department of Finance and Administration

Insurance Division

The Insurance Division of the Department of Finance and Administration administers the insurance programs for state employees (more than 225,000 covered lives). This includes insurance for state employees and retirees (including higher education), local education employees and retirees (K-12 school systems can join the state plan or provide alternate coverage), and local government employees and retirees (cities, counties, and local quasi-government agencies).[21] They offer both self-insured plans (administered by Blue Cross/Blue Shield) and fully-insured plans that use HMOs. The division handles complaints and appeals, distributes plans' documents and handbooks, and monitors contracts. The Comptroller's Office conducts financial and performance audits of the program.[22]

The State Insurance Committee (members include the Commissioner of Finance and Administration, State Comptroller, Commissioner of Commerce and Insurance, and several other commissioners, employee representatives, and association representatives)

has responsibility for the state group insurance plans in areas such as establishing policy, determining benefits, and determining premiums.

Tennessee, like many other states, divides regulation of managed care between the departments regulating health and regulating insurance. On the health side, much of the regulation and effort is focused on quality of care and program administration, while the insurance side primarily focuses on financial oversight. TDCI appears to be doing an adequate job of financial monitoring but is not as adequate in monitoring complaints, as they are currently unable to create detailed reports on consumer complaints, while the Bureau of TennCare at the Department of Health has a variety of information about complaints made by TennCare enrollees.

What do consumer groups and other interested groups identify as the strengths and weaknesses in patient protections in Tennessee?

American Association for Retired Persons (AARP)

The Tennessee state office of AARP supports managed care consumer protections and believes the state should take a proactive role in assuring that protections are in place. They believe consumers should have a genuine choice between health plans and should receive adequate information on various health plans in order to make an informed choice. They also believe that managed care plans should meet specific standards to ensure that all covered services are accessible and available to enrollees. AARP states that they support legislation that regulates marketing and enrollment, access and benefits, quality, grievance and complaint procedures, available information, HMO enrollee participation, protections against conflict of interest, insolvency protections, and penalties for HMOs who violate state laws.[23]

A volunteer for AARP said that while Tennessee does have some managed care protections, they are for the most part older laws and lacking in specifics, and they hope this is corrected by adding more detailed standards. They are concerned about several areas such as enrollment guidelines and plans changing once members are enrolled. They believe that TennCare has some good protections and would like to see these extended to all health plan consumers in the state.[24]

Consultant's Report on the Tennessee "Patient Advocacy Act of 1997" February 19, 1998

Tennessee Health Care Campaign

Tennessee Health Care Campaign, incorporated in 1989, is a non-profit organization with the goal of obtaining affordable, accessible, and quality health care for all Tennesseans. It receives contributions from sources such as foundations, individuals, member dues, Community Shares workplace contributions, and Vanderbilt University. It is receiving a grant from the state to operate a Hispanic outreach program, but it does not receive funding from health care providers or the insurance industry. The Campaign is working on expanding insurance coverage for children, monitoring the TennCare Partners program, and designing the grievance process for TennCare that was passed by the General Assembly in 1997.

The main consumer protections the Campaign thinks are needed and would like to see legislation passed to address are: requiring standards to ensure the adequacy of managed care networks, allowing women to self-refer to OB/GYNs, and having access to physician profile information such as malpractice suits and license suspensions. They do not support "any willing provider" legislation because they believe it will increase costs in TennCare and will thus result in having to decrease the amount of covered individuals.[25]

Tennessee Medical Association

The Tennessee Medical Association believes that the state needs to provide more oversight to managed care plans. One of their concerns is about plans dropping doctors who have higher-than-average utilization, and how that affects access to proper treatment and continuity of care for consumers. Another concern is that managed care companies who "practice medicine" by denying or changing services or pharmaceuticals should be held liable and accountable for adverse outcomes (instead of blaming the physician only, who may have recommended a different course of action). They also believe that consumers need access to more information about health plans, including such things as financial status, internal policies, details on providers, and updated provider lists, and that the state should help ensure that this happens. Technology could help in the availability and cost of this access, such as by providing information via the Internet and special

phone lines.[26]

The following groups were also contacted, but they had no information or studies specific to Tennessee, though some have looked at other states or have proposed managed care standards through their national offices. These groups are the AFL-CIO, American Federation of State, County, and Municipal Employees, Consumers Union and Business Group on Health. Messages left with the Tennessee State Employees Association were not returned in time for inclusion in this report.

We were able to reach fewer consumer groups and other interested groups than we had hoped, but the ones we did talk to had a variety of concerns about managed care and all wanted to see the state enact more standards. Areas commonly mentioned were access to care, availability and disclosure of information, adequacy of networks, and strong complaint procedures.

What are other states doing in the area of patient protections?

During the first half of 1996 alone, 33 states passed managed care protections of some sort, and most states are continuing to examine managed care issues and what further legislation may be needed. Families USA's report entitled "Text of Key State HMO Consumer Protection Provisions: The Best from the States" studied 12 key HMO consumer protection issues and how different states were addressing them. The issues are 1) access to emergency services, 2) use of specialists and access to specialty care, 3) adequacy of provider networks including standards for travel and waiting time, 4) continuity of care, 5) access to experimental and investigational treatment, 6) utilization review/referral protections, 7) HMO internal quality assurance plans, 8) data reporting, 9) provider financial risk arrangements, 10) grievance/appeal protections, 11) disclosure of information, and 12) provider protections.[27]

1) Access to emergency services

At least eight states (AR, AZ, CA, FL, GA, MD, NY, WV) forbid health plans from requiring prior authorization for emergency services, and at least seven states (AR, CA,

GA, MD, MN, NY, VA) have adopted a "prudent layperson" definition of an emergency that defines an emergency condition as a situation that the average person would have reason to believe could lead to serious impairment, even if it turns out later that was not the case. At least four states (AZ, FL, MD, TX) require HMOs to pay for emergency room evaluations performed to determine whether an emergency condition exists, and two states (Arizona and Texas) have procedures to ensure follow-up specialty care for emergency patients.

2) Use of specialists and access to specialty care

Twenty states have passed legislation that allows direct access to OB/GYN doctors for women (or allows them to serve as primary care physicians). New York passed legislation that allows standing referrals to a specialist for a period of time for patients needing special treatment and allows enrollees with life-threatening or disabling conditions to have an appropriate specialist as their primary care physician and to obtain referrals to specialty care centers. If an HMO does not have an appropriate specialist in a certain area needed by a patient, New York and Texas laws and regulations require that the patient be able to see an out-of-network provider at no additional cost.

3) Adequacy of provider networks including standards for travel and waiting time

At least four states (CA, DE, PA, SD) require an adequate number of physicians to serve the enrolled consumers by specifying a minimum ratio of physicians to patients. Eleven states (AL, CA, DE, FL, MI, MN, NV, OK, TX, UT, WA) address geographical access concerns by setting maximum travel times or distances to physicians and hospitals, and six states (CA, FL, GA, MD, NV, SD) set standards for waiting times for appointments. Minnesota and Utah address rural access by provisions allowing for different standards in rural areas, such as that rural residents in provider shortage areas can use the closest provider, even if not in a managed care plan's network. New Jersey has the most comprehensive and strongest access regulations, addressing issues such as geographic standards for many different types of providers and facilities, defining physician capacity based on the average number of patient visits per year and requiring that HMOs ensure

their providers can handle new patients, addressing travel standards for consumers dependent on public transportation, and setting maximum waiting times for obtaining different types of appointments.

4) Continuity of care

Seven states (KS, MD, MN, NJ, NY, TX, VA) have addressed continuity of care in special situations such as pregnancy or serious medical conditions. New York is the only state requiring continuity of care after enrollment; if the provider of a new enrollee is not in the new network, the enrollee can continue an ongoing course of treatment with the previous provider for up to 60 days for a life-threatening or disabling disease or condition and up through post-partum care if the new enrollee is in the second trimester of pregnancy. Six states address continuity of care after contract termination; for example, New York requires 90 days of continuing care with a provider who leaves the network for patients who are pregnant or receiving ongoing treatment, and New Jersey requires 120 days of continued care from providers as well as hospitals whose contracts are not renewed by the health plan.

5) Access to experimental and investigational treatment

Four states (California, Illinois, Minnesota, and Washington) have provisions in their HMO laws regarding access to experimental procedures for certain patients, such as those with terminal or disabling conditions. These generally require a timely external independent review when a patient is denied coverage of a drug, device, procedure, or therapy considered experimental or investigational, including expedited review when appropriate. There must be written notice to enrollees and providers of the procedures under review and the decisions made, and the basis for reviews and reviewers' professional qualifications must be publicly available. The patient should not have to pay for the review by the external entity, and decisions by the review entity are final.

6) Utilization review/referral protections

Many states have enacted legislation addressing managed care utilization review or referral systems. Key issues in this area are written criteria developed by appropriate specialists, decisions made by qualified medical personnel, information on the review process given to enrollees and providers, appropriate time frames for making decisions including expedited review, notification of decisions and reasons to enrollees and providers, and establishing an appeals process. New York has legislation that addresses all of these issues, and many other states address some of these areas.

7) HMO internal quality assurance plans

Laws and regulations in 42 states require HMOs to develop and implement a quality assurance plan, and laws in more than 20 states provide details on what must be included in the QA plan. The best state laws require that HMOs have a written QA plan with goals and objectives and that they perform continuous monitoring of their quality of care including such things as a physician peer review, provider qualifications, monitoring complaints related to quality, regularly-scheduled meetings, and a system to correct problems. Laws in Minnesota, Maine, and Florida, as well as proposed New Jersey regulations, provide strong examples of this protection.

8) Data reporting

This area is fairly new and as of January 1997 no state required the reporting of the full range of data that might be useful to consumers. These are items such as utilization data, outcome statistics for specified procedures/conditions, results of patient satisfaction surveys, statistics on complaints and malpractice, percent of prior authorizations denied, data on enrollment and disenrollment, provider risk arrangements, medical loss ratios, and reports of all adverse incidents where patients were injured. Minnesota and Maine require HMOs to report to the state certain medical statistics, complaint reports, and results of satisfaction surveys. After this report was printed, other states have added comprehensive reporting requirements including Texas, which requires audited NCQA measures to be collected and reported and requires an annual "report card" on managed care

organizations to be made available to consumers.

9) Provider financial risk arrangements

Four states (California, Georgia, Maryland, and Rhode Island) have laws that attempt to limit physician financial arrangements. California law states that contracts between health plans and providers cannot contain incentive plans that involve payment to a provider for denying, reducing, limiting, or delaying specific medically necessary services to a specific enrollee or group with similar conditions. Georgia law states that managed care plans cannot use financial incentives that compensate providers for providing less care to patients. Rhode Island prohibits health plans and providers from entering into any compensation agreement that would reward providers for limiting services, reducing length of stay, reducing alternative treatments, or reducing the use of needed medications for particular patients. Maryland law states that health plans cannot withhold part of the reimbursement from providers, and allows bonuses or other incentive-based compensation as long as it does not discourage the delivery of appropriate care.

10) Grievance/appeal protections

All the states require HMOs to have grievance systems, but only 13 states provide detailed requirements on what the system should include (AL, AR, CA, GA, IL, MI, MN, NJ, NY, PA, RI, TX, WI). The best grievance laws require notice of the grievance procedures, rights, and decisions; allow grievances to be accepted orally and otherwise assist enrollees in filing grievances; have strict timeframes for decisions and provide for expedited review when appropriate; have standards for reviews by qualified providers; and provide for review by an independent agency under certain circumstances.

11) Disclosure of information

Most states require HMOs to provide various pieces of information to enrollees and prospective enrollees, such as covered benefits, costs to be paid by the enrollee, emergency room coverage, complaint systems, and lists of approved providers and

facilities. The disclosure laws in New York are the most comprehensive in the nation, requiring HMOs to disclose referral and utilization information, provider compensation arrangements, drug formularies, rules on medical record confidentiality, treatment policies for specific conditions, statistics on complaints, rules on experimental treatment, how needs of non-English speaking enrollees are addressed, and descriptions of quality assurance programs.

12) Provider protections

At least 18 states have adopted anti-gag clause regulations, the best of which require providers to disclose all treatment options and prohibit plans from punishing providers who advocate on behalf of patients (regulations from Colorado and Washington are good examples). At least eight states (CO, ME, MD, NY, OR, RI, TX, VA) provide protections to providers in the application or termination process, such as requiring objective standards for determining physician credentials, written notice of decisions to deny or drop a provider from a network, an appeals procedure for providers who were denied or dropped, regular notice of information used in evaluations, considering the health status of patients when reviewing a physician's performance, and prohibiting holding the HMO harmless from a coverage decision or negligent act of the HMO. Maryland and New York provide good models for application and termination protections, including the use of practice profiles to make decisions about providers.[28]

Families USA has not included "any willing provider" as a consumer protection in its reports for several reasons. One is that they believe states can achieve the same benefits for consumers by passing other legislation related to access and adequate networks such as standing referrals, access standards, having a specialist as primary care physician, and being able to go out-of-network at no additional charge when the network has an insufficient number or type of physician needed. Another reason is that they want to propose legislation that is feasible and likely to be agreed-upon and accepted by all parties, and any willing provider is often controversial and not agreed to by everyone affected.[29]

California Managed Care Task Force

California is currently very active in the area of managed care regulation and patient protections. A task force of 30 members was appointed by Governor Pete Wilson and the legislature to study and recommend improvements needed in managed care in California. The task force first met in April 1997 and finalized their recommendations in December 1997. Some of the major suggestions from their list of 77 recommendations are that the state should assign the regulation of managed care to a new state agency and should create an independent appeals process for consumers to appeal decisions made by their health plans. The task force voted down the recommendation to extended liability for medical decisions to managed care plans and other entities contributing to medical decisions, disappointing many consumer advocates. Some other recommendations are funding pilots to test ombudsman programs, encouraging the development of purchasing groups for small and medium-sized employers, establishing consistent standards for complaint resolution in all plans, standardizing the reporting of complaint data so they can be accurately compared between plans, and requiring that certain data and plan details (such as authorization procedures and drug formularies) be disclosed to consumers. There was no explicit mention of "any willing provider" provisions. The recommendations will be given to the governor and brought forward for consideration in California's 1998 legislative session.[30]

Other states have been very active in addressing managed care protection issues in the past few years. Many new laws have been passed since 1995. See Figure 3-2 (in back of chapter) for a summary of what protections each state has enacted.

What are some of the models and ideal standards for consumer protections produced recently?

Establishing protections for consumers of managed health care plans has become a "hot" topic recently, with many consumer groups, academic groups, HMOs, government agencies, special commissions, and others currently studying the situation and making reports and recommendations. Following are descriptions of some of these groups and the standards they believe are badly needed in the health care system.

Consultant's Report on the Tennessee "Patient Advocacy Act of 1997"
February 19, 1998

Advisory Commission on Consumer Protection and Quality in the Health Care Industry

The President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry has been working since May 1997 to respond to its charter to "advise the president on changes in the health care system and recommend measures as necessary to promote and assure health care quality and value, and protect consumers and workers in the health care system." The commission's final report is due to the president on March 30, 1998. The commission's subcommittee on Consumer Rights, Protections, and Responsibilities produced a report in the fall of 1997 (approved by the full commission and released in November 1997) called the "Consumer Bill of Rights and Responsibilities," which proposes federal standards that all health insurers and health plans would have to follow. The president accepted these recommendations, and though they could be modified by Congress, they serve as a useful model since the commission consisted of representatives from consumer groups, health care workers, and health policy experts.

Following is a summary of the proposed rights and responsibilities:[31]

1. Information Disclosure—the right to accurate information on topics such as health plans, doctors and other health care workers, and facilities

2. Choice of Providers and Plans—the right to choice with such guarantees as an adequate network, access to specialists, transitional care for the disabled and pregnant women, and choice of health plans

3. Access to Emergency Services—the right to access emergency health care services, and for the plan to pay when the situation is such that a "prudent layperson" could reasonably expect serious impairment or death in the absence of medical attention

4. Participation in Treatment Decisions—the right and responsibility for patient or representative to participate in decisions related to personal health care; health providers should discuss all treatment options, including option of no treatment, in an understandable manner; health plans should not have "gag clauses" or penalize health providers for advocating on behalf of their patients

5. Respect and Nondiscrimination—right to respectful and nondiscriminatory health care coverage and delivery

6. Confidentiality of Health Information—the right to confidential communication, to review and copy own medical records, and confidentiality of individual records

7. Complaints and Appeals—right to fair process for resolving differences with plans, providers, and facilities, including internal review and independent external review

8. Consumer Responsibilities—consumer has reasonable responsibilities including active involvement in own health, keeping healthy habits, following prescribed treatments, recognizing the limits of medical care, learning about health plan coverage and options, making a good-faith effort of meeting financial obligations, and showing respect for health workers and other patients.

The commission did not recommend any willing provider legislation as part of ensuring choice of providers and health plans. It stated in its report: "Because of its strong desire to maintain the integrity of health plan networks, the Commission has rejected approaches to mandate the inclusion of providers into networks (i.e., "any willing provider" laws) or to require plans to allow enrollees to go out of plan networks at will (i.e., "freedom of choice" laws)."[32]

Families USA: Protections Needed by Managed Care Consumers

Families USA, who has done much work in the area of managed care policy, gave testimony to the U.S. Senate Committee on Labor and Human Resources on eight protections that they believe are crucial for managed care consumers. Following is a summary of these protections:[33]

1. Emergency Services—rules should not cause delay, plans must pay when "an average person would consider the situation an emergency"

2. Access to Needed Care and Specialists—plans should have flexibility for referrals to specialists and continuing treatments, depending on the individual needs of the patient

3. Specialists for those with Special Needs—patients with disabilities or chronic conditions should be able to choose a specialist in that particular condition to be their "gatekeeper" instead of having to always go through a general practitioner

4. Sufficient and Accessible Providers—plans should have enough primary care and specialty physicians in the network to "meet the needs of their patients without long waits and without requiring patients to travel long distances"

5. Patient Grievances and Appeals—plans should have procedures that notify patients of their rights to appeal coverage decisions, establish timeframes for decisions (including rapid decisions for emergencies), and provide for decisions by doctors with expertise in the area being reviewed

6. Disclosure of Plan Information—patients choosing among plans must be able to get information on items such as how referrals are controlled, what financial incentives physicians have not to make referrals, grievance procedures, and limitations of services covered

7. Consumer Advocate Program—consumers should have available an ombudsperson or other impartial advocate who can help with problems and offer independent advice on managed health care plans

8. Protections for Medicaid and Medicare Patients—these plans should have the same protections as commercial plans to make sure taxpayer money is properly spent and to avoid abuses that harm participants.

AFL-CIO

The AFL-CIO states that they realize the potential for benefit under managed care and that the fee-for-service system has its faults, but they also have concerns with managed care that need to be addressed to ensure that consumers receive consistent high-quality care. The AFL-CIO has developed seven principles for quality managed care that outline what they believe are the critical issues in this area.[34]

1. Universal Health Care—the nation needs to address the reality of millions of uninsured Americans, and the only solution to affordable quality care is to expand health care coverage to everyone

2. Quality of Care Through Public Accountability—includes requiring basic quality assurance standards and accreditation, standard performance measures that allow comparisons between providers, full disclosure of physicians' financial arrangements and of plans' profits, and public information on utilization management, grievance resolutions, satisfaction, and other standardized data

3. Consumer Choice—consumers should have a choice of health plans and appropriate providers, women should be able to self-refer to OB/GYNs, consumers should be able to switch primary doctors and specialists if not satisfied, and consumers should be able to go outside the network if needed, especially for speciality care if qualified specialists are not available in the plan

4. Consumer Protections—consumers should be ensured protections such as anti-gag clauses, whistle-blower protection for doctors and other health care workers, the right to sue managed care entities for injuries caused be treatment decisions, adequate internal procedures for denials and appeals, access to an external fair review process, and an independent ombuds program to assist consumers

5. Accessible Medical Care—eliminate financial and discriminatory barriers to care, adopt "prudent layperson" definition of emergency, provide direct and timely access to specialists for patients with serious conditions, continuity of care for a reasonable period under certain circumstances, sufficient number of culturally and linguistically-appropriate primary and specialty services, and public disclosure of hours, locations, waiting times for getting appointments, and other service quality indicators

6. Confidentiality/Privacy—protections needed to preserve consumers' trust and privacy include consumers' written consent before releasing identifiable medical information, prohibiting employers from using medical records for any non-health care purpose such as employment decisions, easier access for patients to their own medical records and ways to amend them, and strict procedures for health workers and facilities concerning guarding medical records and the circumstances under which information in records is released

7. Quality of the Health Care Workforce—assurances of quality including rigorous credentialing of physicians, adequate staffing levels in facilities, proper training and compensation of health care workers, and consistent full-time staffing that does not overly rely on temporary or part-time workers.

Consortium of HMOs and Consumer Groups

In September 1997, three large not-for-profit HMOs and two national consumer groups agreed upon and released 18 managed-care consumer principles that they would like to see become legally-enforceable federal standards. The HMOs involved are Kaiser Permanente, HIP Health Insurance Plans, and Group Health Cooperative of Puget Sound, and the consumer groups are the American Association of Retired People (AARP) and Families USA. Following is a summary of the 18 preliminary standards (the group is continuing to work on additional issues and standards):[35]

1. Accessibility of Services—includes an adequate network, direct access to specialists, and providing culturally-sensitive health care materials

2. Choice of Health Plans—individuals should have a choice of health plans

3. Confidentiality of Health Plan Information—establishing strong protections against improper disclosure of personal medical information

4. Continuity of Care—includes choosing and changing primary care physicians, continuing care with the same doctor for pregnant women and the seriously ill for a period of time if their doctors are dropped from their health plans (unless for bad quality of care) or they must change health plans

5. Disclosure of Information to Consumers—consumers should be provided information such as a description of coverage, cost-sharing requirements, how to select providers and obtain referrals, lists of providers, methods used to compensate physicians, utilization management procedures, drug formularies, procedures for emergency care and out-of-network care, and how to file grievances

6. Coverage of Emergency Care—includes "prudent layperson" definition of medical emergency, procedures for authorizing post-stabilization care, and education for members on availability and use of emergency services

7. Determinations of Exclusions for Experimental Care—plans should establish objective processes for reviewing new drugs, devices, procedures, and therapies, and have an external review of cases where seriously ill patients are denied coverage of experimental care

8. Development of Drug Formularies—health plans that cover prescription drugs should allow physicians to participate in developing the formulary and should provide for exceptions when drugs not on the formulary are medically necessary

9. Disclosure of Loss Ratio—health plans should adopt uniform methods to calculate how much of premium dollars are spent on health care delivery services versus administration or other uses, and disclose these figures to consumers

10. Prohibitions Against Discrimination—health insurance reform should address discriminatory enrollment practices, plans should have culturally-competent networks, and plans should not discriminate in service provision on the basis of age, gender, race, national origin, language, religion, socioeconomic status, sexual orientation, disability, genetic make-up, health status, or source of payment

11. Ombudsman Programs—an external nonprofit ombudsman program should be established to help consumers understand their health plan and their rights, to help members file grievances and appeals, to investigate complaints, and to provide consumer education and information

12. Out-of-Area Coverage—health plans should cover emergencies that happen while the member is traveling outside the plan's service area

13. Performance Measurement and Data Reporting—plans should measure and report their performance (following national standards and subject to independent audit) in areas such as quality of care, access to care, patient satisfaction, and financial stability

14. Provider Communication with Patients—plans should not restrict what providers can tell patients regarding their condition and treatment options, and plans should not penalize providers who report quality concerns or assist patients with claims appeals

15. Provider Credentialing—health plans should not discriminate against providers who treat a disproportionate number of chronic or expensive patients, and plans and provider groups should establish written standards for hiring and contracting with providers and facilities that are modeled on those of the National Committee for Quality Assurance

16. Provider Reimbursement Incentives—plans should disclose general information about reimbursement methods used, and payment methods should not be used that directly encourage providers to limit necessary care

or to over treat patients; appropriate safeguards should be taken when individual providers or small groups are capitated or otherwise at substantial financial risk

17. Quality Assurance—all health plans should be required to follow national quality assurance standards that are comprehensive yet flexible in the specifics to allow for differences in plans; independent reviews of quality of care should be conducted by qualified health professionals at the appropriate regulatory agency

18. Utilization Management—aspects of utilization management activities such as credentials of the reviewers should be regulated; plans should make timely decisions, including expedited review if necessary, and give their reasons for adverse decisions and the procedures for appeal.

National Health Law Program: Model Managed Care Complaint Process

The National Health Law Program states that they developed their model complaint procedure for Medicaid managed care programs, but it can be adapted to other types of health insurance as well.[36] This model calls for health plans to have an adequately-staffed consumer relations office to informally resolve questions and problems and an efficient grievance process with written procedures. The grievance process will handle disputes involving things such as denial or termination of services and dissatisfaction with providers or services, and should provide for an expedited review process for urgent situations. The grievance process is not a substitute for a fair hearing before an impartial state hearing officer or other external review body. Patients must be told about the grievance process orally and in writing (in appropriate and understandable formats) at specified times, such as initial enrollment and whenever services are denied. Grievances should be addressed to a central state agency, who logs and disburses them to individual health plans, to improve accountability and convenience to the consumer. Timelines are specified for communications from the investigator to the plan member, and the complaint should be resolved within 30 days (90 days when process involves a state hearing with the Medicaid agency). Records should be retained for at least five years. If a plan fails to comply with the complaint process required by state and federal regulations, the result is an automatic ruling in favor of the enrollee. The state is prohibited from renewing a contract with an

entity who does not meet these requirements.

The state Medicaid agency or Department of Insurance should collect and analyze data including data on complaints. This data should be broken out by plan and include number and nature of reported complaints, time frame for resolution and the outcome, list of all complaints not yet resolved to the satisfaction of the enrollee or provider, and information on expedited complaints. The data should be collected quarterly and included in the plan's annual reports. The information should be used as an ongoing quality indicator and to help identify problem areas.

It is important to have a clear definition medical necessity, and this model process suggests the following:

> "The health plan must provide all medically necessary care, including services, equipment, and pharmaceutical supplies. Medically necessary care is the care which, in the opinion of the treating physician, is reasonably needed:
>
> - to prevent the onset or worsening of an illness, condition, or disability;
> - to establish a diagnosis;
> - to provide palliative, curative or restorative treatment for physical and/or mental health conditions; and/or
> - to assist the individual to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the individual and those functional capacities that are appropriate for individuals of the same age.
>
> Each service must be performed in accordance with national standards of medical practice generally accepted at the time the services are rendered. Each service must be sufficient in amount, duration, and scope to reasonably achieve its purpose; and the amount, duration and scope may not arbitrarily be denied or reduced solely because of the diagnosis, type of illness or condition."[37]

National Association of Insurance Commissioners: Model Acts

The NAIC has published numerous model laws for states to follow in establishing regulations for health insurance and other types of insurance. In a recent interview published in *Health Affairs*, the president of NAIC states that there are five model laws that, if enacted, would better protect consumers of managed care.[38] These are the Health Care Professional Credentialing Verification Model Act, the Quality Assessment and Improvement Model Act, the Health Care Carrier Grievance Procedure Model Act, the Utilization Review Model Act, and the Managed Care Plan Network Adequacy Model Act.

The Health Care Professional Credentialing Verification Model Act requires that health plans establish written procedures for verifying the credentials of its providers to ensure they meet specified standards and for periodically recredentialing.[39] Nine states had enacted similar legislation or regulations by July 1997; these are Alabama, Illinois, Maine, Massachusetts, New Hampshire, New York, North Carolina, Oklahoma, and West Virginia.[40] The Quality Assessment and Improvement Model Act establishes quality assessment standards for managed care organizations and quality improvement standards for plans with a closed network. As of July 1997, 22 states had enacted related laws or regulations (AL, AZ, FL, GA, IL, IN, MI, MN, MS, NE, NV, NH, NM, NY, NC, ND, OK, RI, TX, UT, WV, WY).[41]

The Health Care Carrier Grievance Procedure Model Act provides standards for health plans to establish procedures to ensure that enrollees have the opportunity to resolve their grievances regarding the plan.[42] As of July 1997, 32 states had established legislation or regulations related to this model act (AL, AZ, CA, CN, GA, HI, ID, IL, IN, IA, LA, MI, MS, MO, MT, NV, NH, NM, NY, ND, OK, PA, SD, TX, UT, VT, VA, WA, WV, WI, WY).[43] The Utilization Review Model Act requires health plans to have a written utilization review program and establishes procedures for a fair review by qualified personnel.[44] As of July 1997, 36 states had adopted laws or regulations similar to this model act, including Tennessee.[45] The Managed Care Plan Network Adequacy Model Act establishes standards for health plans' provider networks that ensure the adequacy, accessibility, and quality of services provided by the network.[46] As of July 1997, 10 states had established

laws or regulations on network adequacy; these are Alabama, Florida, Illinois, Kansas, Maine, New York, North Caroline, Oklahoma, Rhode Island, and Washington.[47]

National Committee for Quality Assurance

The National Committee for Quality Assurance (NCQA) is a private, nonprofit organization that assesses and reports on the quality of managed care plans. NCQA is led by a 23-member board of directors that includes employers, representatives from consumer groups and labor unions, health plans, physicians, and quality experts. The purpose of NCQA is to provide information that enables purchasers and consumers of managed care to make more informed purchasing decisions by allowing them the tools to differentiate among health plans based on quality measurements, not just price. The two major NCQA activities are accreditation and performance measurement, which they regard as complementary strategies for evaluating health plans. Many large private employers and several public employers require that health plans have NCQA accreditation before they consider offering the plan to their employees.[48]

Accreditation of managed care organizations was begun by NCQA in 1991, and since then, they have expanded the accreditation process to include other related organizations as well. Although the accreditation program is voluntary and stringent, it has been accepted by the managed care industry and others, and the NCQA reports that more than half of the HMOs in the nation are currently involved in the NCQA accreditation process. During the accreditation process, NCQA compares plans to more than 50 different standards that are categorized into six areas: quality improvement (40% of plan's score), physician credentials (20%), members' rights and responsibilities (10%), preventative health services (15%), utilization management (10%), and medical records (5%). Reviews are conducted by teams of physicians and managed care experts, and a national committee reviews the teams' findings and assigns one of four accreditation levels based on the plan's compliance with NCQA standards: full, one-year, provisional, or denial.[49]

The other activity of NCQA concerns performance measurement. While

accreditation looks at a health plan's structure and systems, performance measurement looks at what the plan actually achieves and allows for standardized comparison between health plans. NCQA developed and periodically revises HEDIS, the Health Plan Employer Data and Information Set, which is the collection of the standardized measures used. The latest incarnation, called HEDIS 3.0, contains 71 performance measures. NCQA released audit procedures that help ensure HEDIS data are standardized between plans and are being used correctly.[50] HEDIS is used by managed care plans for reporting and in their quality improvement efforts, and employers and state governments are using the standards as well in assessing health plans. An alternative to a state attempting to enact detailed regulations that may become outdated would be to require HMOs to attain NCQA accreditation within a certain number of years of commencing operations.

Many national groups have proposed standards and model laws, and these usually revolve around several main themes including access to providers, ensuring an adequate network, complaint procedures, coverage of emergency services, disclosure of information, protections related to providers, and quality issues. NCQA is at the forefront of the quality movement with its widely-respected accreditation process and HEDIS performance measurements.

Analysis of Tennessee's Protections Compared with Other States and Models/Standards

Comparison to Other States

Most states have passed at least a few patient protections, including Tennessee, and about half of the states have passed more comprehensive reforms (see Figure 3-3 at the end of this chapter for map). Tennessee is not one of the states considered to have comprehensive patient protections in place, nor is it listed in the top states in any category related to general managed care patient protections (TennCare, however, has been cited for good provisions in several areas). Tennessee is not one of the worst states, since some states have not addressed any of the protections examined here, but to be among the better states in these areas, more consumer protections need to be studied and adopted.

Comparison to National Standards

Below are the laws that Tennessee currently has that are similar to those called for in national standards, and following that are some areas that Tennessee needs to strengthen in order to conform to national recommendations.

The main area of state law that applies to managed care is Tennessee Code Annotated title 56 (Insurance), chapter 32 (Health Maintenance Organizations), part 2, the Health Maintenance Organization Act of 1986. This act covers areas such as obtaining certificates of authority, powers, limitations, fees, investments, taxes, complaint systems, prohibited practices, and confidentiality of information.[51] These last three relate directly to patient protections. The law states that HMOs must establish and maintain a complaint system approved by the commissioner of TDCI and must submit an annual report containing certain data, but it does not provide any details on what the complaint system should include.[52] Another section prohibits false or misleading advertising, prohibits HMOs from operating without a certificate of authority, and prohibits canceling or refusing to renew an enrollee's policy except under circumstances, such as failure to pay.[53] The section on confidentiality states that HMOs must keep patient information confidential, and should not release it except in defined circumstances, such as to carry out business, with permission from the enrollee, or when involved in litigation concerning the patient.[54]

Legislation relating to release of medical records was passed in 1994 and amended in 1996. The law on confidentiality of medical records states that medical records are private and not considered public records, can be obtained by patients, cannot be sold for any reason, and that identifying information in the records will not be released without permission except to meet requirements for reporting to health or government authorities, as needed by third-party payers for purposes such as utilization review and case management, and if subpoenaed by a proper court of law.[55] Another aspect of confidentiality was addressed in the Genetic Information Nondiscrimination in Health Insurance Act of 1997, which states that insurance plans cannot deny or change coverage to enrollees on the grounds that they received genetic services, cannot request or require results of genetic tests, and cannot disclose genetic information about a patient without his

or her prior written authorization.[56]

As far as complaint or grievance procedures, all health plans are required to have grievance systems, and both the Bureau of TennCare within the Department of Health and the Insurance Division within TDCI comply with the recommendation for central log-in of complaints as recommended by some consumer groups to increase accountability. Contract provisions for TennCare MCOs require sufficient staff to handle grievances, grievances to be resolved within 30 days, and reporting of certain statistics on grievances.

Regarding emergency services, House Bill 1066, passed in 1997, prohibits health plans in Tennessee from denying coverage for emergency services if the enrollee's symptoms indicated that an emergency medical condition existed, even if prior authorization was not obtained and the provider was not in the plan's network. "Emergency medical condition" is defined as "the sudden onset of a health condition that requires immediate medical attention, where failure to provide medical attention for those presenting symptoms could reasonably be expected to result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or could reasonably be expected to place the person's health in serious jeopardy."[57] The original bill contained the words "prudent layperson," the term often mentioned by standards groups, in its definition of emergency, but those words do not appear in the public chapter (the final version of the bill). The use of "could reasonably be expected" appears similar in intent, though it is more vague as it does not specify whose expectations are being used as the standard (is it always the patient?).

Regarding exclusions and insurance renewal, the Tennessee Health Insurance Portability, Availability, and Renewability Act was passed in April 1997 to bring the state into compliance with the federal Health Insurance Portability and Accountability act of 1996. The state act limits exclusions for preexisting conditions and provides guaranteed renewability when switching groups health plans except in certain cases.[58]

Regarding rights related to prescription drugs, the General Assembly passed a law in May 1997 that requires insurance plans that include drug coverage to pay for "off-label" (unapproved) uses of FDA-approved drugs to treat life-threatening illness as described in

---

Consultant's Report on the Tennessee "Patient Advocacy Act of 1997" February 19, 1998

certain compendia and peer-reviewed journals. Plans cannot deny coverage on the grounds that the drug is not approved for the indication it was used for, if the use is described in one of the references.[59]

Regarding anti-gag rules, House Bill 2077, passed in 1996, prohibits health plans from restricting medical personnel from informing patients about alternative medical treatments or pharmaceuticals that may be available to the patient, whether covered by the plan or not.[60] Senate Bill 629, passed in 1997, prohibits health plans from restricting providers from telling patients about the existence of financial arrangements that provide incentives to reduce or limit care.[61] Actual financial arrangements that may encourage providers to limit care are not outlawed.

Tennessee is accredited by the National Association of Insurance Commissioners, as are most states, which means it has adopted standardized financial practices that affect insurance solvency, and thus financially protect consumers. Tennessee has adopted laws similar to one of the five recommended NAIC model acts related to patient protections, the Utilization Review Model Act.[62] Tennessee does not have laws that the NAIC considers very comparable to its recommended regulations on verification of credentials, quality assurance standards, grievance procedures, or adequacy of managed care provider networks.

These are all areas specified in national standards that Tennessee has already addressed in legislation and regulations. Some key areas often mentioned by standards groups that Tennessee has not specifically addressed in legislation or rules are direct access to specialists, standing referrals to specialists for serious conditions, continuity of care in certain cases, protections for providers in network application and termination, network adequacy, data reporting requirements, certain details related to complaint procedures and quality assurance plans, disclosure of complete plan and provider information to members and potential members, and verification of credentials and recredentialing of providers. The next section contains more details about these areas.

Issues, Conclusions, and Recommendations

After reviewing the managed care standards and recommendations put forth by various groups, certain common elements and themes emerge. Many of these recommendations stem from unfortunate incidents and negative publicity about managed care, and as managed care plans spread, concerned groups want to ensure that quality health care is emphasized over profit and that inconvenient, inefficient, or tragic events do not continue to happen to people enrolled in managed care plans. Some of the important themes common to the many groups studying managed care patient protections are the need for continuity of care if plans or doctors change, a good complaint/appeals process, adequate access to the right kinds of doctors or specialists needed by patients, assurances that doctors are not being paid to withhold information or expensive care, emergency services to be covered even if the incident turns out not to be a true emergency, and disclosure of certain information such as health plan coverage and procedures, financial information, and the credentials of providers and medical reviewers. All of these are important areas that need to be considered, and many groups feel that they should be incorporated into state regulations to ensure that they are followed by commercial managed care plans.

Many states have already adopted more stringent managed care protections, and in some ways Tennessee is behind in these efforts. New Jersey, New York, and California are often cited as having some of the best and strongest consumer protection regulations, and many other states are in the process of introducing more legislation in these areas. The degree of managed care regulation often corresponds with the level of managed care penetration in a state. Figure 3-4 shows the percent of individuals by state enrolled in HMOs (as opposed to PPOs, fee-for-service, or other types of insurance plans) for all states with more than 40 percent in 1996 (Tennessee had 28.6 percent in HMOs).[63]

FIGURE 3-4
Percent Managed Care Penetration by State, 1996

State	Percent population	State	Percent Population
Arizona	55.1	Minnesota	45.7
California	67.9	New Hampshire	42.7
Colorado	46.9	New Jersey	40.4
Connecticut	43.7	New Mexico	42.0
Dist. of Columbia	56.6	New York	48.5
Florida	42.7	Oregon	61.5
Maryland	41.7	Pennsylvania	42.1
Massachusetts	62.4	Rhode Island	40.2

ERISA

The Employee Retirement Income Security Act, known as ERISA (29 U.S.C. §1001-1461), was passed in 1974 to regulate pension plans and other employee benefits. ERISA applies to all employer-sponsored health plans that it defines as an "employee welfare benefit plan," not including government and church-sponsored plans. ERISA provides a broad federal preemption of state laws relating to employee benefit plans, but state laws relating to insurance and several other areas are not included. The main classifications of ERISA health plans are self-insured (also called self-funded, where the company pays the claims and incurs the risk, and the plan is not considered to be insurance for regulatory purposes) and non-self-insured (also called insured, where the company contracts with established insurance companies or managed care organizations for employees' health services). The percent of insured people in both of these types of ERISA plans are about 44 of the total U.S. population, and the percentage is estimated to be about the same in Tennessee.[64]

Self-insured health plans are exempt from following state insurance and managed care laws, but non-self-insured plans are affected by state regulation in that they are

Consultant's Report on the Tennessee "Patient Advocacy Act of 1997"
February 19, 1998

considered insurance and have to follow state insurance laws, and companies they contract with have to follow all applicable laws for health care organizations doing business in the state. Under ERISA, both self-insured and non-self-insured plans are protected from liability in that plaintiffs can sue only for the value of denied benefits and not for additional damages. There are several consumer protections within ERISA, such as certain financial requirements, a requirement to distribute a written plan summary, and a requirement to allow continuing insurance coverage through COBRA, but stronger and more comprehensive protections passed by states generally do not apply to these plans. Two of the main weaknesses often cited in ERISA plans are lack of solvency requirements for self-insured plans and lack of adequate and unbiased grievance and appeals processes for both types. The main entity with authority over ERISA plans is the U.S. Department of Labor, but it does not have the resources to assist many individuals in pursuing complaints.[65] It should be kept in mind that the only way that *all* health plans and enrollees in Tennessee will be covered by stronger consumer protections is if federal legislation is also passed. It should also be noted that if state legislation is passed that raises the costs of health plans and thus what they charge per member per month, one effect could be that the state would see employers shift their employees to ERISA plans to lower their costs and avoid state regulations.

Major Recommendations

There are several areas where Tennessee could strengthen its patient protections to be more in line with national models and standards and the laws and regulations passed by other states. These are not necessarily areas where health plan enrollees in Tennessee have been experiencing significant problems, but rather can be thought of as proactive measures to improve the system and ward off problems in the future as managed care continues to grow. Some health plans in the state already include some of these provisions, but there is no uniformity since these are not addressed in state regulations that would affect all plans and enrollees (except self-insured ERISA plans). These provisions can be accomplished in TennCare by MCO contract amendment as well as by

statute.

1. **Allow direct access to specialists in certain circumstances**

Includes allowing standing referrals for patients needing multiple visits with a specialist or specialty center for a course of treatment, allowing individuals with serious conditions needing ongoing care to designate an appropriate specialist as their gatekeeper, and expanding the definition of primary care physician to include other types of providers, such as gynecologists. It can also include allowing visits to commonly-used specialists such as OB/GYNs and chiropractors without having to obtain a referral. NCQA does not have specific standards for access but does require that a plan provide sufficient access to care a monitoring of access issues.

2. **Allow continuity of care in certain circumstances**

Mandates coverage for continuity of care with the same provider for a period of time for patients who are pregnant, have disabling conditions, or are otherwise undergoing a course of treatment, if the patient switches health plans or his or her provider is dropped from the plan (except for-cause). The period of time is often specified as 60, 90, or 120 days, and up through post-partum care if the member was in the second trimester of pregnancy. NCQA does not specify continuity requirements but does check to see that the MCO is identifying and addressing relevant continuity issues.

3. **Ensure network adequacy standards**

Plans must maintain a sufficient number and variety of providers in a plan's network to ensure that all covered benefits are adequately accessible and enrollees' needs are met. This can include standards for how many primary care providers and specialists should be within a certain mileage radius of a majority of the enrollees; maximum average drive times for an appointment with each type of provider; timeframes within which the patient should be seen after making an appointment, such as a specified number of weeks for regular appointments and number of months for annual physicals; and provisions ensuring that out-of-network referrals to specialists will not cost the patient any more than in-network visits if the network does not contract with an appropriate provider. This could also include specified ratios of primary care physicians and different specialists to number of enrollees, but some groups warn that this is not the best way to ensure adequacy due to the fact that a provider could contract with more than one plan and distort the ratio within each plan. Rural/urban differences should be incorporated into any standard. Another aspect of network adequacy is ensuring that providers distribute non-English materials when needed and that they employee personnel who can communicate with non-English speakers. Network adequacy is addressed by an

NAIC model act. NCQA does not specify distances, times, or ratios but does require an MCO to have availability standards.

4. **Institute protections related to providers**

Includes requirements for network application and termination, protections for patient advocacy, and credentialing requirements. Protections for providers in the application and termination process include requiring objective standards for physicians, giving written notice of decisions to deny or drop a provider from a network and allowing appeals, prohibiting plans from dropping providers for certain reasons such as high but reasonable utilization, and taking into account the health status of a physician's patient mix when reviewing performance. Providers should not be penalized for advocating on behalf of their patients for medically-necessary care. Credentialing regulations ensure that providers are qualified and include establishing minimum professional requirements, procedures for verifying licenses and history of any problems, and a process for reevaluating participating physicians every specified number of years. Specific guidelines are included in the NCQA accreditation process for protections in termination and application and for credentialing requirements, and there is an NAIC model act on credentialing.

5. **Ban financial arrangements that directly limit care**

This would specify that contracts between health plans and providers cannot contain incentive plans that would directly compensate providers for denying, limiting, reducing, or delaying appropriate care or pharmaceuticals for patients. NCQA is addressing compensation arrangements for staff performing utilization reviews but does not address arrangements with providers.

6. **Add more standards to requirements for complaint/grievance systems**

More details in laws or rules for complaint/grievance procedures, including requiring written procedures and continuous monitoring. Timelines should be included for resolving urgent complaints (we found timelines for normal complaints but not for expedited review). Complaint procedures should be easily understood and available to enrollees, and patients should be told about the complaint process orally and in writing whenever services are denied, not just at enrollment. Detailed complaint/ grievance procedures are specified by NAIC and NCQA standards.

7. **Require comprehensive data reporting**

Certain data are already required to be reported to the state, but there are more items that could be reported and made public that would be useful to consumers such as outcome statistics for specified procedures and conditions, statistics on malpractice, percent of prior authorizations denied, provider risk arrangements, and

medical loss ratios. The state could require audited NCQA measures to be collected and reported and could require a report card on managed care organizations to be made available to consumers.

Many of the issues mentioned above were addressed in Tennessee House Bill 520, the Managed Care Consumer Protection Act, which was filed in 1997 but did not pass (though a few provisions were passed as separate bills). Several of these protections are also present in the Patient Advocacy Act of 1997. Addressing these issues now will help managed care consumers and bring Tennessee in line with what many other states are doing to protect their citizens.

Analysis of Main Provisions in the Patient Advocacy Act of 1997

Section 3: Information Disclosure

Disclosure to consumers is a high priority for many consumer groups. Section 3 of the Patient Advocacy Act proposes 11 items that would have to be disclosed in plan documents to all prospective and currently enrolled members of a health plan. We compared these items to the existing plan brochures of nine TennCare HMOs and one TennCare BHO (see Figure 3-5 for summary of disclosure items and results). Examining what is already being done helps to determine how much revision and extra expense would be required to bring plans into compliance if the Act were passed into law. In short, all the plans were already disclosing many basic items, but few, if any, disclosed other items such as financial information, details about drug formularies, and details about experimental treatments. The President's Advisory Commission recommended some additional disclosure items not mentioned in the Act, including licensure, certification, and accreditation status of health plans, providers, and facilities as applicable, education and years of practice for providers, provider network composition, and experience performing certain procedures and comparable measures of quality and consumer satisfaction for both providers and health care facilities.

All of the ten plan brochures examined were basically readable and understandable; contained detailed descriptions of coverage, benefits, and exclusions; and contained rules

for prior authorization, though little if any detail was given about subsequent reviews. All of the plans also explained how plan limitations affect members and explained possible out-of-pocket costs, and all provided information on choosing primary care providers, how to switch providers, and how to get referrals to specialists. None of the plan documents reviewed mentioned financial arrangements, incentives, or reimbursements of providers or health facilities.

All of the plans mentioned that there were formularies or approved drug lists for prescriptions, and though a few mentioned that some drugs might need prior authorization or require showing medical necessity, none mentioned what these drugs were. A few plans mentioned that both approved generic and name-brand drugs were covered, but none mentioned if there were cases where generics were required to be substituted for name-brand drugs. Four of the plan documents stated what to do to gain an exception to the formulary if a member's doctor prescribed a drug not on the approved list, while the other six stated that drugs must be approved and did not mention if there could be exceptions.

Nine plan documents mentioned that medical records were confidential; the remaining one stated only that patients had a right to access their medical records in accordance with the law. Three of the plans that stated medical records were confidential did not mention outside entities and when the member's permission was needed to release records. Most of the plans do not mention claims, since TennCare members do not have to file claims for regular services. However, several stated that if members receive a bill, they should forward it to the plan to see if it is covered. Only one mentioned timelines in connection with forwarding bills or being reimbursed if the member paid for services, and none mention if there are exceptions to deadlines. Only one plan mentioned lengths of time for responding to requests for prior authorization. All of the plan documents state that experimental or investigational treatments are not covered, but none give a full list of what is considered experimental (the only example mentioned, in seven of the plans, was organ transplants). One plan gives a description of the basis for determining if a treatment or medication is experimental.

We conclude that there are several items that TennCare plans are currently not

disclosing to consumers, and that mandating additional disclosure items will not significantly increase costs to the TennCare plans, since they frequently reprint plan brochures as it is, and the additional information would not take much extra space. One commercial plan (Heritage National Healthplan) was examined to see if there might be notable differences in non-TennCare plans, but the information and disclosures in the plan brochure were very comparable to the TennCare brochures, leading to the assumption that disclosing several more items in commercial plan brochures should not be a major expense for these health plans. The area most likely to be a problem in requiring this additional information is disclosure of financial arrangements and incentives with providers and facilities—this is often considered proprietary information and plans may argue that making this information public would harm their competitiveness.

The items that are already required to be disclosed to TennCare enrollees are the following:[66]

1. Effective date of enrollment
2. Description of services provided including limitations, exclusions, deductibles, copayments, special fees, and out-of-plan use
3. Procedures for obtaining required services
4. Names of providers and location of services sites (including telephone numbers and office sites)
5. Procedures for obtaining emergency services in and out of the plan's service area
6. Enrollee's right to file grievances related to actions by MCO and to eligibility decisions
7. Member responsibilities
8. Written information concerning advance directives
9. Notice to enrollee that enrollment in current plan invalidates any prior authorization for services by another plan

10. Member's responsibility to notify the plan and TennCare of new address

11. Iinformation about changing plans during open enrollment periods

12. Notice that enrollees can disenroll from TennCare at any time and instructions

13. Toll-free TennCare hotline number

14. Fact sheet approved by TennCare containing information on quality and costs of the plan

There is a draft NAIC model act that addresses basic disclosure items for certain types of insurance. The "Individual Accident and Sickness Insurance Minimum Standards Act" requires that a plan disclose a description of benefits, provisions that exclude or otherwise restrict benefits, and provisions respecting renewability.[67] NCQA standards also require disclosure of a variety of items.

FIGURE 3-5

Analysis of Disclosure of Tenncare Plans

	Selected TennCare Plans									
	Access MedPLUS	Health Net	John Deere	OmniCare	TLC/Memphis	PHP TennCare	Phoenix	Prudential	BlueCare	Premier (BHO)
Readable, understandable format	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
(1) coverage, provisions, benefits, exclusions by category, service, provider	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
(2) list of providers[1]	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
(3) prior authorization/review requirements	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
(4) financial arrangements/incentives or contractual provisions with providers/ facilities	N	N	N	N	N	N	N	N	N	N
(5) explanation of how plan limitations effect beneficiaries, including cost sharing	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
(6) formulary- drugs needing prior authorization/showing med. necessity specified	N	N	N	N	N	N	N	N	N	N
(6) formulary- whether generics required	N	N	N	N	N	N	N	N	N	N
(6) formulary- exceptions allowed and how	Y	Y	N	N	N	N	N	Y	Y	N
(7) limitations on choice of PCP, specialists	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
(7) method of provider reimbursement	N	N	N	N	N	N	N	N	N	N
(8) extent of confidentiality of medical records	Y[2]	Y	Y	Y	Y	Y[2]	Y	Y	N	Y[2]
(9) deadlines for filing claims and exceptions	N	N	Y	N	N	N	N	N	N	N
(10) maximum length of time for insurer to respond to requests for prior authorization	N	N	Y	N	N	N	N	N	N	N
(11) list of treatments considered experimental	N[3]	N[3]	N	N[3]	N[3]	N[3]	N[3]	N[3]	N	N
(11) basis for determining what is experimental	Y	N	N	N	N	N	N	N	N	N

Notes

1. Unable to determine if provider lists were current or how often printed
2. States that medical records are private and confidential, but does not mention if/when shown to outside entities
3. Only specific treatment listed is organ transplants

Section 5: Any Willing Provider

Section 5(a) of the Act states that "Any health care provider within the geographic service area of a health benefits plan may apply to the insurer which administers that health benefits plan to be credentialed to provide covered health care services to the beneficiaries of that health benefits plan." Parts (b) and (c) state that except in cases where the provider has a history of unprofessional conduct or malpractice, an insurer cannot fail to credential a provider who applies to the network and agrees to accept the plan's terms and conditions. In general, states seem to be moving away from enacting any willing provider legislation. There are not many states left with broad AWP laws, though more do have AWP relating to pharmacy services only.

None of the major sources examined considered AWP to be a consumer protection. At least one group, the President's Advisory Commission, believes that AWP is harmful to an HMO's ability to maintain a high-quality network. We believe that this provision alone will not significantly increase access to specialists because most specialists we contacted who did not currently participate in TennCare had no interest in participating in the future. Elsewhere in this report we detail our estimate of the added costs of AWP, which are substantial. All of the claimed benefits for consumers (as opposed to providers) are achievable through consumer protections that would cost plans and employers less such as access standards and network adequacy, covered continuity of care for a period of time when faced with a change in a provider or health plan, choice of primary care physician including specialists for people with serious conditions, direct access to specialists such as OB/GYNs as needed, and ability to go out of the network at no additional cost when needed.

Section 6: Provider Protections

Section 6 of the Act proposes due process rules for health care providers who have been terminated from a plan network or whose contracts the HMO refuses to renew. It provides for communicating decisions in writing and establishing processes for hearings and appeals. Legislation similar to this has been passed in at least eight other states, and

this protection has been recommended by leading consumer groups. It is also an NCQA standard that is checked under the physician credentialing category.

Section 7: Access to Providers

Part (b) of section 7of the Patient Advocacy Act states that an insurer cannot require a member to obtain approval before visiting providers of obstetrical/gynecological care, vision care, or dental services chosen from the plan's list of credentialed providers. Access is a big issue with consumer groups and others calling for managed care reforms, and the provision in this Act related to direct access may not go far enough in that it only in effect adds OB/GYN services to the list of specialists that can be accessed directly (vision care and dental services are already often available without referrals, or referrals are easy to obtain, so these are not mentioned by consumer groups in their discussions of direct access). Besides access to OB/GYNs, many national groups also recommend allowing for specialists to serve as gatekeepers for people with disabilities or serious/complex medical conditions (e.g., cystic fibrosis, multiple sclerosis, cancer, AIDS), since these specialists will be able to manage the overall care of these patients more effectively than a traditional primary care physician. A related provision that should be considered in Tennessee is allowing standing referrals to specialists or specialty centers for a period of time for ongoing treatments such as chemotherapy.

FIGURE 3-2

States with Regulations Related to the 12 Key Areas Addressed by Families USA[68]

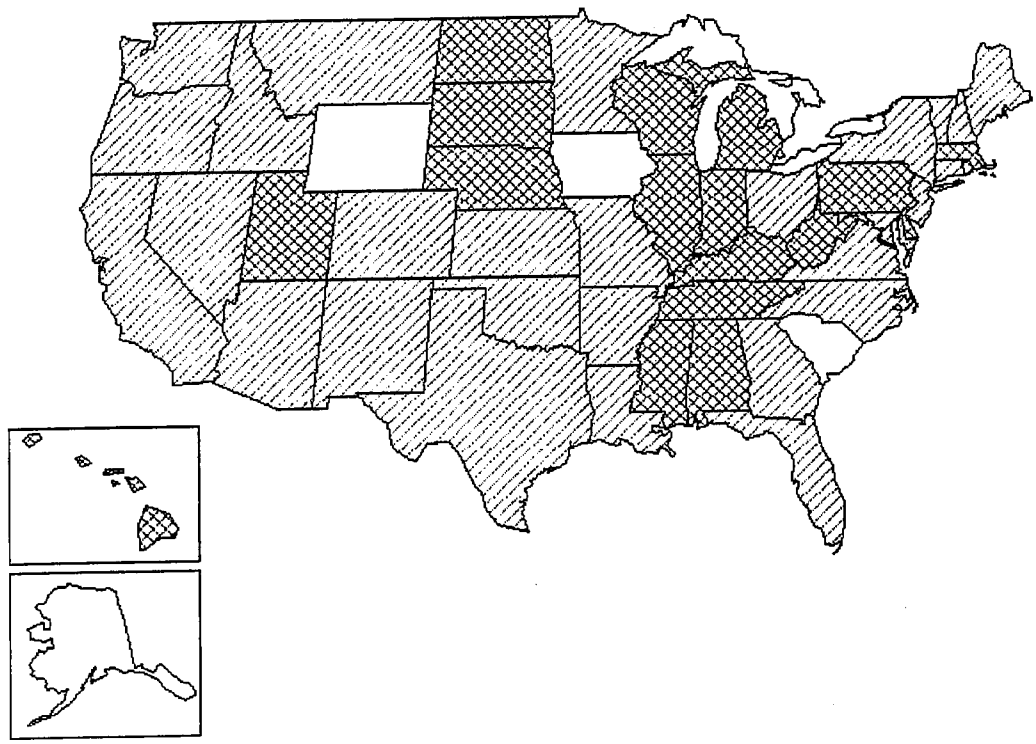
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)
Alabama		X	X							X	X	
Alaska												
Arizona	X										X	
Arkansas	X									X		
California	X	X	X		X	X			X	X		X
Colorado		X										X
Connecticut		X										
Delaware			X									X
Florida	X	X	X									
Georgia	X	X	X				X		X	X	X	X
Hawaii											X	
Idaho												
Illinois		X			X					X		
Indiana		X									X	X
Iowa												
Kansas				X								
Kentucky		X										
Louisiana		X										
Maine		X				X	X	X			X	X
Maryland	X	X	X	X					X			X
Massachusettss											X	X
Michigan			X			X				X	X	X
Minnesota	X		X	X	X		X	X		X		
Mississippi		X										
Missouri												
Montana												
Nebraska		X										
Nevada			X									
New Hampshire												X
New Jersey	X	X	X	X		X	X			X	X	X
New Mexico												
New York	X	X		X		X				X	X	X
North Carolina						X					X	
North Dakota		X										
Ohio												
Oklahoma			X									
Oregon		X				X					X	X
Pennsylvania			X							X		
Rhode Island						X			X	X	X	X
South Carolina												
South Dakota			X									
Tennessee	X					X						X
Texas	X	X	X	X				X		X	X	X
Utah		X	X									
Vermont											X	X
Virginia	X	X		X		X					X	X
Washington		X	X		X						X	X
West Virginia	X	X										
Wisconsin										X		
Wyoming												

Key for Figure 3-2

(1) Access to emergency services
(2) Access to specialists and specialty care
(3) Adequacy of networks and standards for travel/waiting
(4) Continuity of care in special situations
(5) Access to experimental treatments
(6) Utilization review/referral protections
(7) Detailed HMO internal quality assurance plans *(note: 42 states require QA plans, but not many provide complete and adequate details on what should be included)*
(8) Data reporting *(note: fairly new area; a few states require extensive data to be reported, others may require certain items)*
(9) Provider financial risk arrangements
(10) Grievance/appeal protections *(note: all states require MCOs to have system, but only a few provide details of what should be included)*
(11) Disclosure of information *(note: required information varies by state; there may be other states that require specific disclosures)*
(12) Provider protections *(note: many states prohibit gag rules, some states have other protections as well)*

FIGURE 3-3

States with Comprehensive and Partial Managed Care Consumer Protections



Comprehensive Patient Protections

Partial Patient Protections

None seen

Sources: Molly Stauffer, "Managed Care: State Efforts to Reduce the Red Tape to Access," Health Policy Tracking Service, National Conference of State Legislatures, January 1998, p. 2; Families USA publications; Tennessee Code Annotated.

NOTES

1. "Health Insurance in Tennessee and the Role of the Tennessee Department of Commerce and Insurance (TDCI) in Regulating Entities Furnishing Health Insurance to the Citizens of this State," Memorandum to Senator Jo Ann Graves from Buddy Scruggs, Executive Assistant Commissioner, William Young, Deputy Commissioner, TennCare Division, and Neil Nevins, Assistant Commissioner, Insurance Division (October 6, 1997), pp. 2-3.

2. Tennessee Administrative Rules, Rules of the Department of Commerce and Insurance, Health Maintenance Organizations, Chapter 0780-1-28 (1996).

3. "Special Joint Committee- Patient Advocacy Act of 1997 Request for Information," Letter from C. Neil Nevins, Assistant Commissioner, Insurance, to William E. Young, Deputy Commissioner, TennCare (October 30, 1997), p. 1.

4. Jim Winters, Director, Consumer Services, Insurance Division, Tennessee Department of Commerce and Insurance, Nashville, Tenn., telephone interview by Lauren Jahnke, February 12, 1998.

5. Hugh Norman, Investigator, Insurance Division, Tennessee Department of Commerce and Insurance, Nashville, Tenn., telephone interview by Lauren Jahnke, December 22, 1997.

6. Jim Winters, Director, Consumer Services, Insurance Division, Tennessee Department of Commerce and Insurance, Nashville, Tenn., telephone interview by Lauren Jahnke, February 17, 1998.

7. TDCI memo to Senator Graves, p. 4.

8. John Lyle, Assistance Commissioner, TennCare Division, Tennessee Department of Commerce and Insurance, Nashville, Tenn., telephone interview by Lauren Jahnke, February 17, 1998.

9. Department of Commerce and Insurance, TennCare Division, "Duties and Responsibilities of the TennCare Division within the Department of Commerce and Insurance," available at http://www.state.tn.us/commerce/tncardr.html (updated January 27, 1997).

10. TDCI memo to Senator Graves, p. 5.

11. Lyle, telephone interview.

12. Tennessee Department of Health, Bureau of TennCare, "TennCare Partners Program to Continue," Press release dated May 15, 1997, available at http://www.state.tn.us/health/tenncare/pr051597.htm.

13. Joe Culp, Mental Health Specialist, TennCare Policy, Bureau of TennCare, Tennessee Department of Health, Nashville, Tenn., telephone interview by Lauren Jahnke, January 6, 1998.

14. Tennessee Department of Health, Bureau of TennCare, "Service Appeals Summary Report: January 1, 1997 - June 30, 1997," available at http://170.142.16.205/health/appl1697.htm (updated October 29, 1997).

15. Bureau of TennCare, Tennessee Department of Health, "Appeal Types by MCO," available at http://www.state.tn.us/health/tenncare/aplmco.htm; and "Appeals Received per 1000 Members by MCO," available at http://www.state.tn.us/health/tenncare/graphics/graph1.gif.

16. Bureau of TennCare, Tennessee Department of Health, "Appeal Types by MCO," available at http://www.state.tn.us/health/tenncare/aplmcp.htm.

17. Ibid.

18. Tennessee Code Annotated, Title 3, Chapter 15, part 5, TennCare Oversight Committee (§3-15-501 to 509).

19. Faye Weaver, Staff Assistant to the Comptroller, State Comptroller's Office, Nashville, Tenn., telephone interview by Lauren Jahnke, January 6, 1998.

20. Ron Paolini, Director of Division of TennCare, Division of State Audits, State Comptroller's Office, Nashville, Tenn., telephone interview by Lauren Jahnke, January 6, 1998.

21. Department of Finance and Administration, Division of Insurance Administration webpage, available at http://www.state.tn.us/finance/ins/ins.html.

22. John Anderson, Director of Insurance Administration, Insurance Division, Department of Finance and Administration, Nashville, Tenn., telephone interview by Lauren Jahnke, January 7, 1998.

23. American Association of Retired Persons, "Managed Care Position Paper," Nashville, Tenn., 1997.

24. Joe Conly, Volunteer Member, Capital City Task Force (works with AARP), Nashville, Tenn., telephone interview by Lauren Jahnke, January 6, 1998.

25. Tony Garr, Executive Director, Tennessee Health Care Campaign, Nashville, Tenn., telephone interview by Lauren Jahnke, January 12, 1998, and February 17, 1998..

26. Scott Smith and Barry Jackson, Lobbyists, Tennessee Medical Association, Nashville, Tenn., telephone interview by Lauren Jahnke, December 22, 1997.

27. Summarized from Geri Dallek, "Text of Key State HMO Consumer Protection Provisions: The Best from the States" (Washington, D.C.: Families USA Foundation, January 1997), available at http://www.familiesusa.org/ hmotoc.html.

28. Ibid.

29. Voilet Wu, Intern/Consultant, Families USA, Washington, D.C., telephone interview by Lauren Jahnke, February 17, 1998.

30. "California managed care task force kicks off legislative season with long to-do list," *State Health Watch: The Newsletter on State Health Care Reform*, vol. 4, no. 12, December 1997, pp. 1,7; and California Managed Care Task Force webpage, available at http://www.chipp.cahwnet.gov/mctf/front.htm.

31. Summarized from President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry, "Consumer Bill of Rights and Responsibilities," available at http://www.hcqualitycommission.gov/cborr/ consbill.htm (November 1997).

32. Ibid.

33. Summarized from Families USA, "Families USA Outlines Eight Protections Needed by Managed Care Consumers," Press release dated March 6, 1997, available at http://www.familiesusa.org/press3_6.html.

34. AFL-CIO, "Union Guide to Quality Managed Care" (Washington, D.C.: AFL-CIO Public Policy Department, 1997), pp. 4-10.

35. Summarized from Families USA, "New Agreement on Managed Care Consumer Protections," Press release dated September 24, 1997, available at http://www.familiesusa.org/hmoagre.htm.

36. Summarized from Jane Perkins and Kristi Olson, "Model Managed Care Complaint Process," National Health Law Program, available at http://www.healthlaw.org/grievancemodel.html (revised March 1997).

37. Ibid.

38. John K. Iglehart, "State Regulation of Managed Care: NAIC President Josephine Musser," *Health Affairs*, vol. 16, no. 6 (November/December 1997), p. 38.

39. National Association of Insurance Commissioners, Model Regulation Service, "Health Care Professional Credentialing Verification Model Act" (I-70) (Washington, D.C., July 1996).

40. Ibid., pp. 70-8, 70-9.

41. Ibid., pp. 71-9 to 71-11.

42. National Association of Insurance Commissioners, Model Regulation Service, "Health Care Carrier Grievance Procedure Model Act" (I-72) (Washington, D.C., October 1996).

43. Ibid., pp. 72-13 to 72-16.

44. National Association of Insurance Commissioners, Model Regulation Service, "Utilization Review Model Act" (I-73) (Washington, D.C., October 1996).

45. Ibid., pp. 73-13 to 73-16.

46. National Association of Insurance Commissioners, Model Regulation Service, "Managed Care Plan Network Adequacy Model Act" (I-74) (Washington, D.C., October 1996).

47. Ibid., pp. 74-11 to 74-13.

48. "National Committee for Quality Assurance: An Overview," NCQA webpage, available at http://www.ncqa.org/overview3.htm.

49. Ibid.

50. Ibid.

51. Tennessee Code Annotated, Title 56, §56-32, Health Maintenance Act of 1986.

52. Tennessee Code Annotated, Title 56, §56-32-210.

53. Tennessee Code Annotated, Title 56, §56-32-213.

54. Tennessee Code Annotated, Title 56, §56-32-225.

55. Tennessee Code Annotated, Title 63, §63-2-101.

56. Tennessee General Assembly, House Bill 413 (Public Chapter 121), passed April 1997, available at http://www.legislature.state.tn.us/bills/100gahtm/100_chap/pubc0121.

57. Tennessee General Assembly, House Bill 1066 (Public Chapter 524), passed June 1997 (to be codified in T.C.A. §56-7, part 23, and §68-140, part 3), available at http://www.legislature.state.tn.us/bills/100gahtm/100_chap/pubc0524.

58. Tennessee General Assembly, Senate Bill 1699 (Public Chapter 157), passed April 1997 (to be codified in T.C.A. §56-7), available at http://www.legislature.state.tn.us/bills/100gahtm/100_chap/pubc0157.htm.

59. Tennessee General Assembly, Senate Bill 834 (Public Chapter 277), passed May 1997 (to be codified in T.C.A. §56-7, part 23), available at http://www.legislature.state.tn.us/bills/100gahtm/100_chap/pubc0277.htm.

60. Tennessee General Assembly, House Bill 2077 (Public Chapter 574), passed April 1996 (codified in T.C.A. §56-7, part 23).

61. Tennessee General Assembly, Senate Bill 629 (Public Chapter 324), passed May 1997 (to be codified in T.C.A. §56, §68, and §71), available at http://www.legislature.state.tn.us/bills/100gahtm/100_chap/pubc0324.htm.

62. Tennessee Code Annotated, Title 56, Health Care Service Utilization Act, §56-6-701 to 56-6-706.

63. "Percentage of Americans with Commercial Health Insurance Enrolled in Fee-for-Service Plans, Point-of-Service Options, PPOs, and HMOs by State, 1996," American Association of Health Plans webpage, available at http://www.aahp.org/services/library/statistics/state_percent.htm.

64. TDCI memo to Senator Graves, p. 2.

65. See "ERISA: A Call for Reform," White paper by the National Association of Insurance Commissioners, 1994; U.S. General Accounting Office, "ERISA and Health Reform," GAO/HEHS-95-167, July 1995.

66. State of Tennessee, standard contract between TennCare and managed care organizations, September 11, 1995, pp. 33-34.

67. National Association of Insurance Commissioners, Model Regulation Service, "Individual Accident and Sickness Insurance Minimum Standards" (I-170) (Washington, D.C., draft November 20, 1997), section 5.

68. Summarized from Families USA, "Text of Key State HMO Consumer Protection Provisions: The Best from the States;" "HMO Consumers at Risk: States to the Rescue;" and Tennessee Code and Public Chapters.

APPENDIX 1:

A. Letter to Tennessee Health Plan Sponsor from Senator Jo Ann Graves

B. Information request to Tennessee Health Plan Sponsor from Ed Warren, VP, Research & Planning Consultants (Attachment to Senator Graves letter)

C. Tennessee Health Plan Sponsor Mailing List

D. List of Respondents to Information Request

E. Provider Interview for Evaluation of the Patient Advocacy Act

JO ANN GRAVES
SENATOR
18TH SENATORIAL DISTRICT
ROBERTSON AND SUMNER COUNTIES

6 LEGISLATIVE PLAZA
TENNESSEE GENERAL ASSEMBLY
NASHVILLE, TENNESSEE 37243-0218
TELEPHONE (615) 741-1654

197 WOODLAKE DR.
GALLATIN, TN 37066
(615) 451-4480

Senate Chamber
State of Tennessee

NASHVILLE

MEMBER OF COMMITTEES

COMMERCE, LABOR AND AGRICULTURE
EDUCATION
ENVIRONMENT, CONSERVATION AND TOURISM

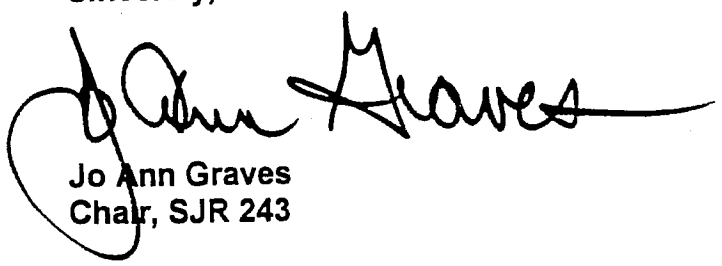
December 3, 1997

Dear Tennessee Health Plan Sponsor:

As you know Tennessee is considering some important legislation, "The Patient Advocacy Act of 1997" (SB 1767/HB 1789) – SJR 243, that will affect the way health plans in Tennessee manage their provider networks. My Committee is charged with developing key information regarding the potential impact of the Act on the cost and quality of health care provided in Tennessee. The Committee has hired a consultant, Research & Planning Consultants of Austin, Texas, to assist us. In order for the consultants to complete their work for the Committee, they need some basic information regarding the health plans you manage.

An information request from the consultants is attached. Please respond as quickly and completely as you can. Your assistance in accomplishing the Committee's tasks is much appreciated.

Sincerely,



Jo Ann Graves
Chair, SJR 243

JAG/rhw

RPC
Research & Planning Consultants

25 ANNIVERSARY

December 3, 1997

Name
Title
Company

Dear :

Research and Planning Consultants (RPC) is assisting the Tennessee Legislature with the evaluation of the Patient Advocacy Act of 1997. Among our tasks is to collect information and data on the health plans that would be affected by the Act. We are asking you for some basic information regarding the health plans in Tennessee for which you have management responsibility. In most instances this information should not require anything beyond copying a document or data file. Please call me at 1-800-580-4567 if you have any questions regarding the request.

Please provide the information request below for each plan that you manage in Tennessee.

1. Basic Information
   - A. Plan Name
   - B. Plan Type (HMO/PPO/Indemnity)
   - C. Plan Sponsor (TennCare, Employer, etc.)
   - D. Tennessee Counties in Service Area
   - E. Number of Covered Lives
   - F. Year Plan Started
   - G. Contact Name and Telephone Number for Follow-up

2. Enrollee Information
   - A. Please provide a copy of the most current enrollee handbook or information packets given to enrollees upon enrollment or reenrollment.
   - B. Please provide a copy of a recent Plan newsletter or example of other correspondence that was mailed to Plan members. Also, please indicate how frequently similar mailings to members are done.

7600 Chevy Chase Drive, Suite 500 Austin, Texas 78752
(512) 371-8100 Fax: (512) 371-0327
Offices Located in Austin and Tallahassee

3. Provider Information
   A. Please provide (in electronic format if possible) a list of all providers under contract with the plan. The list should be sorted by provider type (physician, hospital, pharmacy, dentist, etc.) and include the name, office address(es), and specialty (for physicians).
   B. Please provide sample standard provider contracts for following types of providers:
      1. Primary care physicians
      2. Specialty physicians
      3. Hospitals
      4. Non-physician providers

4. Other Information. Please answer the following questions.
   A. Has the Plan obtained NCQA accreditation? If yes, what is the accreditation level? If no, Is the Plan seeking NCQA accreditation?
   B. Does the plan have written credentialling requirements for providers such as board certification, JCAHCO accreditation, etc.? If yes, please provide the written credentialling requirement.
   C. Please provide any other information or comments that you believe are important to the evaluation of the Patient Advocacy Act of 1997.

Return Information.

Please return your responses to:

Ed Warren, Vice President
Research & Planning Consultants
7600 Chevy Chase Drive Suite 500
Austin, Texas 78752

Phone: 512-371-8141
Fax: 512-371-0327
E-Mail: edwarren@rpconsulting.com

Sincerely,

Edwin L. Warren

Ed Warren
Vice President

Tennessee Health Plan Sponsors Contacted

Aetna Health Plan of TN
David R. Field, President

American Medical Security Health Plan, Inc.
Eric B. Taylor, President

Cigna Healthcare of TN, Inc.
Eric B. Taylor, President

Community Health Plan of Chattanooga Inc.
(Wellport Health Plan).
Brian E. Dalby, President

Erlanger Health Plan Trust
Sylvester L. Reeder, III, President

Health 123, Inc.
Thomas Nagle, President

Health Net, HMO, Inc.
Gary Brutuardt, President

Health Net TNCARE HMO, Inc.
(Phoenix Health Care)
John Davis, Executive Director

Healthsource Tennessee, Inc.
John G. Pearce, President

Healthwise of America
Ken Melkus, President

Heritage National Healthplan, Inc.
Doug Haaland, Executive Director

Memphis Managed Care Corporation
Karl Kovacs, Executive Director

List of Respondents to Information Request

Blue Cross/Blue Shield

PHP of Tennessee

John Deere Health Plans

Premier Behavioral Systems of Tennessee

American Health Care Trust System

Provider Interview for Evaluation of the Patient Advocacy Act.

Contact Chief Financial Officer, VP of Managed Care or other Hospital Official who knows about TennCare contracts at the Hospital.

Date_____ Time_____
Name of Hospital_____
Address _____
_____
_____

Name of Person Interviewed _____
Title _____

Hello, my name is _____. I work for Research & Planning Consultants in Austin Texas. Our firm has been hired by the Tennessee Legislature's Special Committee to study the effects of the Tennessee Patient Advocacy Act of 1997. I would like to ask you some questions regarding (hospital's) participation and experience in the TennCare program. Are you willing to answer some questions. (Yes - go to 1; Refused).

1. Does (hospital) currently have contracts with TennCare Managed Care Organization? Yes No (If yes go to 2. If no go to 5)

2. If yes, which TennCare Managed Care Organizations Do you work with?

1_____ 2_____ 3_____

4_____ 5_____ 6_____

7_____ 8_____ 9_____

10_____ 11_____ 12_____

3. For each of the TennCare MCOs you work with what is the predominate method of reimbursement? (Per Diem, Fee for Service, Capitation, DRG, Other (describe).

1_____ 2_____ 3_____

4_____ 5_____ 6_____

7_____ 8_____ 9_____

10_____ 11_____ 12_____

4. Which contracts with the TennCare MCOs you work with were entered into following negotiation between (hospital) and the TennCare MCO?
Which contracts were signed without negotiation between (hospital) and MCO?

1_____ 2_____ 3_____

4_____ 5_____ 6_____

7_____ 8_____ 9_____

10_____ 11_____ 12_____

5. Which of the following comes closest to expressing your understanding of the negotiation that occurs between MCOs in the TennCare program and hospitals over reimbursement rates?
A. Negotiation Never Occurs
B. Negotiation Rarely Occurs
C. Negotiation Occurs Frequently
D. Negotiation Almost Always Occurs

6. Which of the following comes closest to expressing your understanding of the reimbursement rates hospitals across Tennessee receive from TennCare MCOs?
A. The rates are all the same.
B. The rates are the same with a few exceptions
C. The rates differ most of the time
D. Each hospital's rate is unique

7. Has (hospital) every failed to reach an agreement with a TennCare MCO after initial contact had been made?
If Yes, what is the reason an agreement was not reached?

_____

No.

8. Has hospital ever terminated a relationship with a TennCare MCO at (hospitals) initiation? If yes, Why did hospital terminate relationship?

9, Has any TennCare MCO deselected (hospital) from their network? If yes, what reason was offered by the TennCare MCO?

Bibliography

Publications, Reports, Presentations and Memo's

Academy of Managed Care Pharmacy (AMCP). 1995. "Position Statement on Any Willing Provider Legislation," "AMCP Position Statement on Anticompetitive (Unitary) Pricing," and "AMCP Position Paper on Anticompetitive (Unitary) Pricing." March 1.

AFL-CIO. 1997. "Union Guide to Quality Managed Care" (Washington, D.C.: AFL-CIO Public Policy Dept.)

Alliance for Managed Care. 1995. "Effects of the Texas Patient Protection Act on Employer Health Plan Costs," prepared by Barents Group, LLC. June 9.

Alliance for Managed Competition. 1994. "Market-Based Approaches to Containing Health Care Costs: Effects of Legislative Proposals that Weaken Managed Care," prepared by: KPMG Peat Marwick, Policy Economics Group, August 18.

American Academy of Pediatrics, Tennessee Chapter. 1997. "The Results of 1997 Annual Member Survey.

American Assn. of Health Plans. 1997. "The Effects of Legislation Affecting Managed Care on Health Plan Costs." Report prepared by Health Economics Practice, Barents Group LLC. May 6.

_____. 1997. "Managed Care Savings for Employers and Households: 1990 through 2000," Final Report, May 23.

_____. 1998. "Any-Willing-Provider Requirements, Executive Summary."

American Assn. of Retired Persons. 1997. "Managed Care Position Paper," Nashville, Tenn.

American Medical Assn.. 1995. "PPA-II - The New Patient Protection Act," February.

Arthur Andersen & Co. 1994. "Florida Health Security Program: Actuarial Report," Tampa, Florida, May.

_____. 1997. "Coalition for Affordable HealthCare, Cost Estimates Related to the Impact of an 'Any-Willing-Provider' Requirement in the State of Washington," prepared by Brian S. Blalock, ASA, MAAA and Jay C. Ripps, FSA, MAAA. October 1.

Atkinson & Co. 1994. "The Cost Impact of 'Any Willing Provider' Legislation," June 27.

BlueCross BlueShield of Tennessee. 1998. "Any Willing Provider Contracting Examples." Cover letter to Ed Warren, VP, RPC, from Gary B. Simmons, VP, BCBS. January 26.

Carey, Bill. 1998. "Managed Care for Pharmacies Debated," The Tennessean, Local News. January 16.

Claims Services Resources Group (CSRG). 1997. "Any-Willing-Provider Laws," *The Claims Resource.* Vol. 13, No. 6, p 1. November.

Congressional Budget Office. 1995. CBO Memorandum, "The Effects of Managed Care and Managed Competition." February.

Dept. of Commerce and Insurance. 1997. "Health Insurance in Tennessee and the Role of the Tennessee Dept. of Commerce & Insurance (TDCI) in Regulating Entities Furnishing Health Insurance to the Citizens of this State." Memorandum to Senator Jo Ann Graves from Buddy Scruggs, Executive Asst.. Commissioner, William Young, Deputy Commissioner, TennCare Division, and Neil Nevins, Asst.. Commissioner, Insurance Division. October 6.

Dept. of Pediatrics. 1997. "Presentation to the TennCare Oversight Committee." Dr. Russell W. Chesney, Professor and Chair. October 21.

Families USA. 1996. "HMO Consumers at Risk: States to the Rescue." Washington, D.C., July 1996. (Update published March 1997.)

_____. 1997. "The Text of Key State HMO Consumer Protection Provisions: The Best from the States." Available at *http://www.familiesusa.org/hmotoc.html.* March..

_____. 1997. "Key HMO Consumer Protections," prepared by Geri Dallek, Director of Health Policy.

Federal Trade Commission. 1993. "Federal Trade Commission Opinion Letter," Dallas Regional Office, May 18.

Gold, Sc.D., Marsha R., Robert Hurley, Ph.D., Timothy Lake, M.P.P., Todd Ensor, and Robert Berenson, M.D. 1995. A National Survey of the Arrangements Managed-Care Plans Make with Physicians," *The New England Journal of Medicine*, Vol. 333, No. 25, pp 1678-1683. December 21.

Health Care Financing Administration. 1997. "Special Terms and Conditions," Number: 11-W-00002/.4, Title: Tennessee TennCare Demonstration, Awardee: Tennessee Dept. of Health.

Hellinger, Ph.D., Fred J. 1995. "Any-Willing-Provider and Freedom-Of-Choice Laws: An Economic Assessment," Special Report. *Health Affairs*, Vol. 14, No.4, pp 297-302. Copyright 1995.

_____. 1996. "The Expanding Scope of State Legislation," *JAMA*, Vol. 276, No.13, pp 1065-1070. October 2.

Hulet, FSA, MAAA, Dennis J. 1993. "Point-of-Service Plans: The Standard Health Coverage of the Future?" *Compensation & Benefits Management*, pp 64-72. Spring.

Iglehart, John K. 1997. "State Regulation of Managed Care: NAIC President Josephine Musser." *Health Affairs*, vol. 16, No. 6 (November/December).

KPMG Peat Marwick. 1993. "Trends in Health Insurance: HMOs Experience Lower Rates of Increase than Other Plans," December.

_____. 1994. "Issue Summary: The Cost of Mandatory Out-Of-Network Provisions for HMO's," Policy Economics Group, September 8.

_____. 1996. "The Impact of Managed Care on U.S. Markets," A KPMG Study Executive Summary. Copyright 1996.

Lewin-VHI, Inc. 1995. "The Cost of Legislative Restrictions on Contracting Practices: The Cost to Governments, Employers and Families," Final Report. Prepared for Healthcare Leadership Council, Alliance for Managed Care and Health Insurance Associations of America, by John F. Sheils, David C. Stapleton, Ph.D. and Randall A. Haught. June 21.

Loubeau R.N., B.S., MPH., Patricia R. and Vincent F. Maher, J.D. 1996. "Any-Willing Provider Laws: Point and Counter Point," Medicine and Law. 15:219-226. Copyright 1996.

Marsteller, Jill A., Randall R. Bovbjerg, Diana K. Verrilli and Len M. Nichols. 1995. "Managed Care and the Resurgence of 'Any Willing Provider' and 'Freedom of Chilce' State Legislation". April.

_____. 1997. The Urban Institute. "The Resurgence of Selective Contracting Restrictions." (Forthcoming in the *Journal of Health Politics, Policy and Law*). March 5.

McCarthy, Dianne. 1997. "Narrowing Provider Choice: Any Willing Provider Laws After New York Blue Cross v. Travelers," *American Journal of Law & Medicine*, Vol. 23 No. 1, pp 97-113. Spring.

Mental Health Cooperative. 1997. Presentation to the TennCare Oversight Committee. "Access to Care; Provider Network Adequacy," Pam Womack, Executive Director. October 21.

Milliman & Robertson, Inc. 1993. "Healthcare Resources -- Oversupply or Undersupply?" by David V. Axene, FSA and Richard L. Minifie, ASA. September 27.

_____. 1995. "National Health Expenditure Forecasts 1994-1996," *Research Report.* Addendum to Modeling and Forecasting Health Care Consumption, Published 1994. July.

_____. 1995. "The Infrastructure & Operational Systems Needed by a Primary Care Medical Group to Support capital Managed Care," *Research Report.* November.

_____. 1996. "Provider Incentives in the Optimally Managed Delivery System," *Research Report.* February.

Moses, DO, JD, Richard E. 1997. "Any-Willing-Provider Laws," *Annals of Internal Medicine*, Vol. 126, No. 2, p 174. January 15.

Murphy, Kate. 1994. "'Deselected' Doctors Suffer Legal Setback in Lawsuit Against Aetna," *The Houston Business Journal*, June 24-30.

National Academy for State Health Policy. 1996. "Emerging Challenges in State Regulation of Managed Care," Report on a Survey of Agency Regulation of Prepaid Managed Care Entities. Prepared by Jane Horvath and Kimberly Irvin Snow. August.

_____. 1997. "Medicaid Managed Care: A Guide for States, 3rd Edition." Copyright 1997.

National Assn. of Insurance Commissioners. 1994. "ERISA: A Call for Reform," White paper.

_____. 1997. Model Regulation Service. "Individual Accident and Sickness Insurance Minimum Standards Act" (I-170). Washington, D.C., draft November 20.

_____. 1996. Model Regulation Service. "Health Care Professional Credentialing Verification Model Act" (I-70). Washington, D.C., July.

_____. 1996. Model Regulation Service. "Quality Assessment and Improvement Model Act" (I-71). Washington, D.C., July.

_____. 1996. Model Regulation Service. "Health Care Carrier Grievance Procedure Model Act" (I-72). Washington, D.C., October.

_____. 1996. Model Regulation Service. "Utilization Review Model Act" (I-73). Washington, D.C., October.

_____. 1996. Model Regulation Service. "Managed Care Plan Network Adequacy Model Act" (I-74). Washington, D.C., October.

National Committee for Quality Assurance (NCQA). 1997. "Managed Care Organization Accreditation Status List." December 31.

National Health Lawyers Assn.. 1994. "Managed Care Law Institute Contracting Issues." December 7.

Oshfeldt Ph.D., Robert L., Michael A. Morrisey, Ph.D., Leonard (Jack) Nelson, L.L.M. and Victoria Johnson, Ph.D. 1997. University of Alabama at Birmingham, Lister Hill Center for Health Policy, "The Spread of Any Willing Provider Laws." January.

Pallarito, Karen. 1995. "Ruling Threatens Any-Willing-Provider Laws," *Modern Healthcare*, p 18. January 2.

Physician Payment Review Commission. 1995. "Arrangements Between Managed Care Plans and Physicians," Selected External Research Series, No. 3. February 7.

_____. 1995. "Annual Report to Congress." 1995

_____. 1997. "Annual Report to Congress." 1997

Premier Behavioral Systems of Tennessee. 1997. "Response to Request for Information Concerning the Patient Advocacy Act of 1997," TennCare Partners Program. December 23.

Pretzer, Michael. 1995. "Do Any-Willing-Provider Laws Really Help Doctors?" *Medical Economics*, Vol. 72, No. 5, pp 108-118. March 13.

Principles for Consumer Protection. 19__. "Preliminary Statement of Principles for Consumer Protection."

Purdue University. 1994. "A Review of 'A Cost Analysis of Three State Mandates to

Regulate the Provision of Prescription Drug Benefits'," (The Wyatt Co., June 26, 1992). Prepared by Michael T. Rupp, Ph.D. and Krishnan Ramswamy, M.S., Dept. of Pharmacy Practice. May 26.

Schneidman, Diane. 1994. "Any Willing Provider Legislation: An Overview of State Laws." *ACS Bulletin*, Vol. 79, No. 9, pp 13-18.

Simon Ph.D., Carol J. 1994. "Review of 'The Cost Impact of Any Willing Provider Legislation," American Medical Assn., Center for Health Policy Research. July.

Somerville, Janice. 1995. "Doctors, HMOs Give Peace a Chance," "TennCare Shuns 'Any Willing Provider," *American Medical News,* p 22. April 3.

Special Joint Committee- Patient Advocacy Act of 1997. 1997. "Request for Information," letter from C. Neil Nevins, Asst.. Commissioner, Insurance, to William E. Young, Deputy Commissioner, TennCare. October 30.

State Health Watch. 1997. "TennCare Women who don't get early Prenatal Care say Pregnancy was Mistimed or Unwanted, Study Finds," *The Newsletter on State Health Care Reform*, Vol. 4 No. 10, p 2. October.

_____. 1997. "TennCare Still Plagued by Access Problems, Providers and Consumers Tell Lawmakers," *The Newsletter on State Health Care Reform*, Vol. 4, No. 11, pp 1, 6-7. November.

_____. 1997. "California managed care task force kicks off legislative season with long to-do list." *The Newsletter on State Health Care Reform*, vol. 4, No. 12, December.

_____. 1998. "Tennessee Officials say Encounter Data on Five Measures Show Access to Care Improving Under TennCare," *The Newsletter on State Health Care Reform*, Vol. 5 No. 1, p 5-6. January.

State of Tennessee. 1995. "A Contractor Risk Agreement Between State of Tennessee, d.b.a. TennCare and (Name of Contractor). September 11.

_____. 1996. "A Provider Risk Contract Between the State of Tennessee Dept. of Mental Health and Mental Retardation and (Name of Contractor). February 29.

State of Tennessee, Oversight Committee on TennCare. 1997. Agenda. October 20-21.

Stauffer, Molly. 1998. "Managed Care: State Efforts to Reduce the Red Tape to Access." Health Policy Tracking Service, National Conference of State Legislatures, January.

Taylor, M.D., FAAP., Tedford S. 1997. Medical Direct, First Choice HealthCare. "Patient Access to TennCare Through MCO's."

Tennessee Dental Assn. (TDA). 1997. Presentation to the TennCare Oversight Committee. "The TennCare Dental Program," Dr. George Adams. October 20-21.

Tennessee Department of Health. 1997. "Presentation to the TennCare Oversight Committee," Doris G. Spain, Asst.. Commissioner. October 20-21.

_____. Bureau of TennCare. 1997. HCFA Network Requirements. October 20-21.

Tennessee March of Dimes Birth Defects Foundation. 1997. "Prenatal Care Access Requirements for TennCare Enrollees: Telephone Survey of Managed Care Organizations." June.

Tennessee Pharmacists Assn. 1997. "Presentation to the TennCare Oversight Committee," Baeteena M. Black, D.Ph., Executive Director. October 20-21.

Tennessee Primary Care Assn. 1997. Presentation to the TennCare Oversight Committee. "Remarks on Access to Care and Report on Survey of Access to Primary Health Care for New TennCare Patients in Selected Tennessee Counties," Kathy Wood-Dobbins, Exec. Dir. October 20-21.

United Healthcare. 1998. "Urban vs. Rural Numbers," Contact: Mandy Young. Jan. 28.

United States Dept. of Health & Human Services. 1995. "Managed Health Care: Implications for the Physician Workforce and Medical Education," Council on Graduate Medical Education Sixth Report. September.

United States District Court, Middle District of Louisiana. 1995. "Cigna Healthplan of Louisiana, Inc. Connecticut General Life Insurance v. State of Louisiana, Ex Rel. Richard P. Ieyoub, Attorney General," No. 94-885, Civil Action, April 11.

United States General Accounting Office (GAO). 1995. "ERISA and Health Reform." GAO/HEHS-95-167. Washington, D.C., July.

_____. 1997. "Medicaid Managed Care: Challenge of Holding Plans Accountable Requires Greater State Effort." Report to Ranking Minority Member, Committee on Commerce, House of Representatives. May.

United States Government Printing Office. 1996. "Federal Register." Vol. 61, No. 227. November 22.

West Tennessee Community Development Foundation. 1997. "Presentation to the TennCare Oversight Committee.," Dr. Thomas J. Hamilton. October 20-21.

Wyatt Co. 1991. Report to Health Insurance Assn. of America, "Cost Analysis of State Legislative Mandates on Six Managed Health Care Practices." June 7.

House Bills, Public Chapters, Rules, Laws and Legislation

Joint Commission on Health Care, State of Virginia. 1995. Report of the Joint Commission on Health Care to the Governor and The General Assembly of Virginia. House Document No. 23, "Study of the Impact of Subsection B of Section 38.2-3407 of the Code of Virginia on the Commonwealth's Health Care Market Statute Pursuant to SJR 158 of 1994," December 30.

_____. 1997. Report of the Joint Commission on Health Care to the Governor and The General Assembly of Virginia. House Document No. 79, "Study of the Impact of Legislative Proposals on Managed Care Cost Containment/'Point-of-Service' Mandate Pursuant to HB 1393 and HJR 231 of 1996," February 25.

Joint Interim Committee on Qualified Providers, The State of Texas. 1994. "Report of the Joint Interim Committee on Qualified Providers to the 74th Texas Legislature." December.

State of Tennessee Legislature. 1997. Senate Bill 1767/House Bill 1789-Patient Advocacy Act of 1997.

State of Tennessee Legislature. 1997. Senate Joint Resolution 243 - Senator Jo Ann Graves. Available at *http://www.legislature.stat...Ogahtm/100_bill/SJR0243.htmp.* Filed for intro on May 7.

State of Tennessee, Division of Insurance Administration, . 1997. Fiscal Note Support Form for Senate Bill 1767/House Bill 1789-Patient Advocacy Act of 1997.

State of Utah Legislature. 1996. House Bill 146-Rural Health Care Provider Amendments (Chapter 339), Passed, February 1996.

Tennessee Administrative Rules, Rules of the Dept. of Commerce and Insurance, Health Maintenance Organizations, Chapter 0780-1-28 (1996).

Tennessee Code Annotated, Title 3, §3-15-501 to 509, TennCare Oversight Committee.

_____. Title 56, §56-32, Health Maintenance Act of 1986.

_____. Title 56, §56-6-701 to 706, Health Care Service Utilization Act.

_____. Title 63, §63-2-101, Release of Medical Records.

Tennessee General Assembly, House Bill 413 (Public Chapter 121), passed April 1997, available at http://www.legislature.state.tn.us/bills/100gahtm/100_chap/pubc0121.

_____. House Bill 1066 (Public Chapter 524), passed June 1997, available at http://www.legislature.state.tn.us/bills/100gahtm/100_chap/pubc0524.

_____. House Bill 1789 (Senate Bill 1767), Patient Advocacy Act of 1997 (filed February 1997).

_____. House Bill 2077 (Public Chapter 574), passed April 1996.

_____. Senate Bill 629 (Public Chapter 324), passed May 1997, available at http://www.legislature.state.tn.us/bills/100gahtm/100_chap/pubc0324.htm.

_____. Senate Bill 834 (Public Chapter 277), passed May 1997, available at http://www.legislature.state.tn.us/bills/100gahtm/100_chap/pubc0277.htm.

_____. Senate Bill 1699 (Public Chapter 157), passed April 1997, available at http://www.legislature.state.tn.us/bills/100gahtm/100_chap/pubc0157.htm.

_____. Senate Bill 2645 (Public Chapter 562), passed April 1996.

Internet

American Assn. of Health Plans. 1997. "Point-of-Service Monthly Single Premiums & Percentage Change, 1995-96," Available on *AAHP Website*. August 20.

_____. "Percentage of Americans with Commercial Health Insurance Enrolled in Fee-for-Service Plans, Point-of-Service Options, PPOs, and HMOs by State, 1996." Available at *http://www.aahp.org/services/library/statistics/state_percent.htm*.

California Managed Care Task Force webpage. Available at *http://www.chipp.cahwnet.gov/mctf/front.htm*.

Dallek, Geri. 1997. "Text of Key State HMO Consumer Protection Provisions: The Best from the States." Washington, D.C.: Families USA Foundation, January. Available at *http:// www.familiesusa.org/hmotoc.html*.

Dept. of Commerce and Insurance, TennCare Division webpage. 1997. "Duties and Responsibilities of the TennCare Division within the Dept. of Commerce and Insurance." Available at *http://www.state.tn.us/commerce/tncardr.html* (updated January 27).

Dept. of Finance and Admin.., Division of Insurance Admin.. webpage. Available at *http://www.state.tn.us/finance/ins/ins.html.*

Dept. of Health, State of Tennessee. 1997. "Licensed Health Professionals." Available at *http://170.142.16.205/health/bmf.* October.

Division of Insurance Admin.. (DIA), State of Tennessee. 1997. "Benefits and Programs." Available at *http://www.state.tn.us/finance/ins/programs.html.* Last Update October 8.

_____. 1997. "1997 Annual Enrollment Transfer Period - HMO." Available at *http://www.state.tn.us/finance/ins/aetp/aehmo.html.* Last Update October 8.

_____. 1997. "1997 Annual Enrollment Transfer Period - Health Insurance Options." Available at *http://www.state.tn.us/finance/ins/aetp/aetp.html.* Last Update October 8.

_____. 1997. BlueCross BlueShield of Tenn., Apple Plan. "Benefit Features." Available at *http://www.state.tn.us/finance/ins/aetp/shp.html.* Last Update October 8.

_____. 1997. BlueCross BlueShield of Tenn., Blue Select. "Benefit Features." Available at *http://www.state.tn.us/finance/ins/aetp/bluesel.html.* Last Update October 8.

_____. 1997. BlueCross BlueShield of Tenn., HMO. "Benefit Features." Available at *http://www.state.tn.us/finance/ins/aetp/hbplus.html.* Last Update October 8.

_____. 1997. BlueCross BlueShield of Tenn., PPO. "Benefit Features." Available at *http://www.state.tn.us/finance/ins/aetp/aeppo.html.* Last Update October 8.

_____. 1997. Healthsource. "Benefit Features." Available at *http://www.state.tn.us/finance/ins/aetp/hlthscrc.html.* Last Update October 8.

_____. 1997. Prudential Health Care. "Benefit Features." Available at *http://www.state.tn.us/finance/ins/aetp/prudent.html.* Last Update October 8.

_____. 1997. United Healthcare. "Benefit Features." Available at

http://www.state.tn.us/finance/ins/aetp/united.html. Last Update October 8.

Families USA. 1996. "HMO Consumers at Risk: States to the Rescue." Available at *http://epm.org/families/farisk.html*. July.

_____. 1997. "The Text of Key State HMO Consumer Protection Provisions: The Best from the States." Available at *http://www.familiesusa.org/hmotoc.html*. January.

_____. 1997. "Families USA Outlines Eight Protections Needed by Managed Care Consumers." Available at *http://www.familiesusa.org/press3_6.html*. Press release dated March 6.

_____. 1997. "New Agreement on Managed Care Consumer Protections." Available at *http://www.familiesusa.org/hmoagre.htm*. Press release dated September 24.

Kaiser Family Foundation. 1997. "Fact Sheet." Available at *http://www.kff.org/kff/library.html?document_key+58&data_type_key=58*, December.

_____. 1997. " State Medicaid Info, Tennessee." Available at *http://www.kff.org/state_health/states/tn.html*, December.

National Committee for Quality Assurance (NCQA). 1997. "The State of Managed Care Quality." Available at *http://www.ncqa.org/news/report.html*. November 14.

_____. "National Committee for Quality Assurance: An Overview." Available at *http://www.ncqa.org/overview3.htm*.

Perkins, Jane, and Kristi Olson. 1997. "Model Managed Care Complaint Process." National Health Law Program. Available at *http://www.healthlaw.org/grievancemodel.html* (revised March.)

President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. 1997. "Consumer Bill of Rights and Responsibilities," report to the President of the United States. November. Available at *http://www.hcquality commission.gov/cborr/consbill.htm* (November).

TennCare. 1997. "Service Appeals Summary Report: January 1, 1997 - June 30, 1997." Available at *http://170.142.16.205/health/appl1697.htm* (updated October 29, 1997).

_____. 1997. "Appeals Received per 1000 Members by MCO: January 1, 1997 - June 30,

1997." Available at *http://www.state.tn.us/health/tenncare/graphics/graph1.gif.*

_____. 1997. "Appeal Types by MCO: January 1, 1997 - June 30, 1997." Available at *http://www.state.tn.us/health/tenncare/aplmco.htm.*

_____. 1997. "Service Appeals Summary Report: January 1, 1997 - June 30, 1997." Available at *http://170.142.16.205/health/appl1697.htm.*

_____. 1997. "TennCare Partners Program to Continue." Press release dated May 15. Available at *http://www.state.tn.us/health/tenncare/ pr051597.htm.*

_____. "TennCare Division." Available at *http:/www.state.tn.us/commerce/ tncardiv.html.* October 3.

_____. 1997. "TennCare Fact Sheet." Available at *http:/170.142.16.205/health/ tenncare.* October 30.

_____. 1997. "TennCare Covered Benefits," Bureau of TennCare. Available at *http:/170.142.16.205/health/tenncare/benefits.html.* October 30.

_____. 1997. "Eligibility for TennCare Coverage," Bureau of TennCare. Available at *http:/170.142.16.205/health/tenncare/eligibility.html.* October 30.

_____. 1997. " Duties and Responsibilities of the TennCare Division within the Dept. of Commerce and Insurance," Bureau of TennCare. Available at *http:/www.state.tn.us/ commerce/tncardr.html.* October 30.

_____. 1998. "TennCare Fact Sheet." Available at *http:/www.state.tn.us/health/tenncare.* February 5.

Stauffer, Molly. 1997. "Finance: Any Willing Provider," Health Policy Tracking Service, Issue Briefs, Available at *http://www.hpts.org/HPTS97/other.nsf* October 1.

_____. 1997. "Finance: Direct Access," Health Policy Tracking Service, Issue Briefs, Available at *http://www.hpts.org/HPTS97/other.nsf* October 1.

_____. 1997. "Finance: Freedom of Choice," Health Policy Tracking Service, Issue Briefs, Available at *http://www.hpts.org/HPTS97/other.nsf* October 1.

_____. 1997. "Finance: Point of Service," Health Policy Tracking Service, Issue Briefs, Available at *http://www.hpts.org/HPTS97/other.nsf.* October 1.

Interviews

Lauren Jahnke

Anderson, John. 1998. Director of Insurance Admin.., Insurance Division, Dept. of Finance and Admin.., Nashville, TN. Telephone interview by Lauren Jahnke, January 7.

Conly, Joe. 1998. Volunteer Member, Capital City Task Force (works with AARP), Nashville, Tenn. Telephone interview by Lauren Jahnke, January 6.

Culp, Joe. 1998. Mental Health Specialist, TennCare Policy, Bureau of TennCare, Tennessee Dept. of Health, Nashville, Tenn. Telephone interview by Lauren Jahnke, January 6.

Garr, Tony. 1998. Executive Director, Tennessee Health Care Campaign, Nashville, Tenn. Telephone interview by Lauren Jahnke, January 12 and 17.

Jackson, Barry. 1997. Lobbyist, Tennessee Medical Assn., Nashville, Tenn. Telephone interview by Lauren Jahnke, December 22.

Lyle, John. 1998. Assistance Commissioner, TennCare Division, Tennessee Department of Commerce and Insurance, Nashville, Tenn. Telephone interview by Lauren Jahnke, February 17.

Norman, Hugh. 1997. Investigator, Insurance Division, Tennessee Dept. of Commerce and Insurance, Nashville, Tenn. Telephone interview by Lauren Jahnke, December 22,

Paolini, Ron. 1998. Director of Division of TennCare, Division of State Audits, State Comptroller's Office, Nashville, Tenn. Telephone interview by Lauren Jahnke, January 6.

Smith, Scott. 1997. Lobbyist, Tennessee Medical Assn., Nashville, Tenn. Telephone interview by Lauren Jahnke, December 22.

Weaver, Faye. 1998. Staff Asst. to the Comptroller, State Comptroller's Office, Nashville, Tenn. Telephone interview by Lauren Jahnke, January 6.

Winters, Jim. 1998. Director, Consumer Services, Insurance Division, Tennessee Department of Commerce and Insurance, Nashville, Tenn. Telephone interview by Lauren Jahnke, February 12 and 17.

Wu, Violet. 1998. Intern/Consultant, Families USA Foundation, Washington, D.C.

Telephone interview by Lauren Jahnke, February 17.

Kim Manley

Lyle, John. 1998. TennCare Division, Tennessee Dept. of Commerce and Insurfance, Telephone interview by Kim Manley. January 4.

Young, Bill. 1997. Tennessee Dept. of Insurance, Nashville, Telephone interview by Kim Manley. November 6.

Ed Warren

Barker, Ken. 1997. BCBS Tennessee Chattanooga, Telephone Interview by Ed Warren. January.

_____. 1997. TennCare Bureau, Nashville, Telephone Interview by Ed Warren. December 11.

Birney, Stuart. 1998. HealthNet Nashville, Telephone Interview by Ed Warren. January 16.

Chapman, Dick. 1997. Division of Insurance Administration, Nashville, Telephone Interview by Ed Warren. December 30.

Comola, John. 1998. Blue Cross Blue Shield of Texas, Meeting with Ed Warren. January.

Franco, William. 1998. American Association of Health Plans, Telephone Interview by Ed Warren. January 22.

Hutchens, John M. 1998. Arthur Andersen & Company, Telephone Interview by Ed Warren. February 12.

Lyle, John. 1997. TennCare Division, Tennessee Department of Commerce and Insurance, Telephone Interview by Kim Manley. November 4.

Matthews, Lonnie. 1998. Tennessee Department of Health, Telephone Interview by Ed Warren. February 4.

Oltemari, Beth. 1997. Texas Senate Economic Development Committee, Interview by Ed Warren. December.

Paolini, Ron. 1998. Division of State Audit, Nashville, Telephone Interview by Ed Warren. February 12.

Propp, Liz. 1998. Healthcare Financial Management Association, Washington, D.C., Telephone Interview by Ed Warren. January 28.

Reyer, Liz. 1998. InterStudy Publications, Telephone Interview by Ed Warren. February 3.

Ripps, Jay. 1998. Arthur Andersen & Company, Telephone Interview by Ed Warren. February 12.

Rodgers, Casey. 1997. Tennessee Fiscal Review, Nashville, Telephone Interview by Ed Warren. December 23.

Simmons, Gary. 1998. Blue Cross Blue Shield Tennessee, Chattanooga, Telephone Interview by Ed Warren. January.

Wholey, Douglas. 1998. Carnegie-Mellon University at Pittsburgh, Telephone Interview by Ed Warren. February 12.

Young, Bill. 1997. Tennessee Department of Insurance, Nashville, Telephone Interview by Kim Manley. November 6.