LEGISLATIVE RESEARCH COMMISSION

MANAGED CARE ISSUES COMMITTEE

REPORT TO THE

2001 SESSION OF THE

2001 GENERAL ASSEMBLY

OF NORTH CAROLINA

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STATE OF NORTH CAROLINA
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1999 - 2000

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PREFACE

The Legislative Research Commission, established by Article 6B of Chapter 120 of the General Statutes, is the general purpose study group in the Legislative Branch of State Government. The Commission is cochaired by the Speaker of the House of Representatives and the President Pro Tempore of the Senate and has five additional members appointed from each house of the General Assembly. Among the Commission's duties is that of making or causing to be made, upon the direction of the General Assembly, "such studies of and investigations into governmental agencies and institutions and matters of public policy as will aid the General Assembly in performing its duties in the most efficient and effective manner" (G.S. 120-30.17(1)).

The Legislative Research Commission, prompted by actions during the 1999 Session and 2000 Sessions, has undertaken studies of numerous subjects. These studies were grouped into broad categories and each member of the Commission was given responsibility for one category of study. The Cochairs of the Legislative Research Commission, under the authority of G.S. 120-30.10(b) and (c), appointed committees consisting of members of the General Assembly and the public to conduct the studies. Cochairs, one from each house of the General Assembly, were designated for each committee.

The Legislative Research Commission authorized this study under authority of G.S. 120-30.17(1) and grouped this study in its Managed Care Issues area under the direction of Representative Verla Insko. The Committee was chaired by Senator Allen Wellons and Representative Edd Nye. The full membership of the Committee is listed in Appendix B of this report. A committee notebook containing the committee minutes and all information presented to the committee will be filed in the Legislative Library by the end of the 1999-2000 biennium.

COMMITTEE PROCEEDINGS

The LRC Managed Care Issues Committee met five times, on September 7, October 5, November 9, December 7, and December 20, 2000. The Chairs were Representative Edd Nye and Senator Allen Wellons.

The first meeting was on Thursday, September 7, 2000 at 10:00 A.M. in Room 544 of the Legislative Office Building. Co-Chairperson Representative Edd Nye presided over the meeting.

The first speaker was Dr. Jack Walker, Executive Administrator of North Carolina State Health Plan, who presented an overview of the status and future of the State Health Plan. Dr. Walker then responded to questions from Representative Martin Nesbitt, Mr. Hank Estep, Dr. Pam Silberman, Representative Zeno Edwards, and Senator Charles Dannelly.

The second speaker was Mr. Bill Hale, Legislative Liaison, Department of Insurance, who reviewed the 2000 Congressional actions, Patient's Bill of Rights. Mr. Hale then responded to questions from Representative Nesbitt, Senator Dannelly, Representative Justus, and Senator Wellons. Comments were made by Representative Nesbitt and Senator Wellons.

The third speaker was Ms. Erika Churchill, Committee Counsel, who presented a review of the actions taken by the General Assembly on the May 2000 LRC recommendations. The Legislative Review Commission adopted all six topics, five of which included recommended legislation. Of the five pieces of legislation introduced, only one bill, Prompt Pay, was enacted.

The Committee discussed the goals and objectives for the 2001 Session of the General Assembly. Items discussed included: a patient's bill of rights bill, external review, ombudsman program, Strep B vaccines, cost of insurance, and several other related topics. Mr. Paul Mahoney, Executive Director of the North Carolina Association of Health Plans, stated his group's support of an external review process. The meeting ended.

The second meeting of the LRC Managed Care Issues Committee met on Thursday, October 5, 2000 at 10:00 A.M. in Room 544 of the Legislative Office Building. Co-Chairperson Senator Allen Wellons presided over the meeting.

The first speaker was Mr. John Peterson, Executive Director, North Carolina Businesses for Affordable Health Care, who commented on his organization's concern about government mandates that do not improve the quality of health care but potentially increase cost. Mr. Peterson then answered questions from Mr. Hank Estep, Senator Wellons, Representative Nye, Representative Nesbitt, and Mr. Thomas West. Comments were made by Representative Nesbitt and Representative Nye.

The second speaker was Reverend Ginny Britt, Executive Director of Advocacy for the Poor, who discussed the critical need for affordable health insurance. Then Ms. Britt answered questions from Representative Nye, Ms. Elizabeth O'Keefe, and Mr. Hank Estep. Comments were made by Ms. Elizabeth O'Keefe, Mr. Hank Estep, Senator Wellons, and Dr. Steven Willen.

The third speaker was Ms. Barbara Morales Burke, Department of Insurance, who discussed options for additional regulation, including a transition period of coverage when a provider is no longer included in a plan's network would provide continuity of care, data reporting requirements by HMO and PPO plans, and benefit information that is given to insurers and prospective insurers. Ms. Burke answered questions from Senator Wellons, and Mr. Estep. Comments were made by Ms. O'Keefe, Senator Wellons, Mr. Estep, Representative Nesbitt, and Mr. Bill Hale with the Department of Insurance. The meeting ended.

The third meeting of the LRC Managed Care Issues Committee met on Thursday, November 9, 2000 at 10:00 A.M. in Room 544 of the Legislative Office Building. Co-Chair Representative Edd Nye presided over the meeting.

The first speaker was Mr. Tom Ricketts, PhD., Deputy Director, NC Division of Medical Assistance who commented on prescription drug cost trends. Mr. Ricketts answered questions from Mr. Thomas West. Co-Chair Nye, Senator Harris and Dr. Pam Silberman. Comments were made by Dr. Pam Silberman, Mr. Thomas West, and Mr. Estep.

The second speaker was Ms. Daphne Lyon, Deputy Director, North Carolina Division of Medical Assistance, who discussed increases in prescription drug expenditures in the North Carolina Medicaid program in recent history for this group. Ms. Lyon answered questions from Co-Chair Nye, Senator Wellons, Senator Harris, Mr. West, Representative Nesbitt, and Dr. Silberman. Comments were made by Co-Chair Nye, Representative Nesbitt, and Mr. West.

The third speaker was Ms. Gina Upchurch, R.P.H., M.P.H., Executive Director, Senior PharmAssist, Inc., who spoke on older adults with limited incomes, and the underuse and overuse of prescription drugs. Ms. Upchurch answered questions from Co-Chair Nye and Representative Nesbitt. Mr. Sam Byrd, legislative staff, also answered questions from Representative Nesbitt.

The fourth speaker was Mr. John McDonnell, Progressive Benefit Solution, LLC, discussed employer concerns and cost concerns for employee benefits. Mr. McDonnell answered questions from Dr. Silberman.

The fifth speaker was Ms. Marjorie Powell, Assistant General Counsel, Pharmaceutical Research and Manufacturers Association, who discussed reasons for drug cost increases. Ms Powell answered questions from Co-Chair Nye and Dr. Silberman.

The last presenter was Meg Molloy, Dr. P.H., Executive Director, NC Prevention Partners, who discussed premature deaths and disabilities in North Carolina.

The fourth meeting of the Committee occurred on December 7, 2000 at 10:00 A.M. The Committee considered and discussed draft legislation and recommendation proposals for the final report, including: HMO Patient Protection, Managed Care Ombudsman, Continuity of Care, Health Plan Disclosure, Payment Obligation Disclosure, Provider Directories, Group B Strep Prevention in Newborns, and Prescription Drug Assistance for Low-Income Elderly and Disabled Persons. All were approved for inclusion in the final report with amendments to be incorporated.

The fifth meeting of the Committee was on December 20, 2000 at 10:00 A.M., at which time the Committee approved the final report for submission to the Legislative Research Commission.

FINDINGS AND RECOMMENDATIONS

Upon discussion and debate, the Joint Legislative Research Commission's Committee on Managed Care Issues makes the following findings and recommendations:

1. Continuity of Care in HMO Plans

A. Findings.

Based upon the presentations and briefings, the Committee finds that current law in North Carolina fails to adequately provide for continuity of care for enrollees of health maintenance organizations (HMOs). In support of this finding, the Committee states the following:

- An HMO's relationship with providers are contractual in nature, and so are subject to termination by either party for various reasons specified in the contract.
- An HMO enrollees' policy period does not necessarily coincide with the term of their providers' network participation contracts. Therefore, enrollees may be forced to change providers in order have their care covered if their provider leaves the HMO network during their plan year.
- In certain circumstance where a person is undergoing treatment when the provider's contract terminates, changing providers during the course of treatment and/or changing providers on short notice is a hardship and may possibly have an adverse impact on the treatment.
- It is in the best interest of the enrollees to have the option to maintain treatment with the current provider in some circumstances.

B. Recommendations.

Therefore, the Committee recommends the attached bill entitled "Continuity of Care." In summary, the bill does as follows:

- Requires traditional HMO plans to continue covering the services of a terminated provider when they render care to enrollees who have an "ongoing special condition," including terminal illness and are receiving care for that condition.
- Such continuing care is provided only if the enrollee so requests and the provider agrees to continue to accept the HMO's payment and adhere to other rules of the HMO.

2. Disclosure of Payment Obligations

A. Findings.

Based upon the presentations and briefings, the Committee finds that current law in North Carolina fails to adequately require insurance companies to disclose to consumers information with respect to the calculation of health care benefits to be paid. In support of this finding, the Committee states the following:

- PPO plans are not required to guarantee that participating providers will not bill insureds for the difference between the payment amount specified in the provider contract and the provider's actual charges.
- In any case where the insurer bases its payment to a provider or benefit to the insured on an amount other than actual provider charges (and has not arranged to prohibit balance billing), a provider can balance bill a patient for any charges that remain unpaid. When this occurs, the member's share of the bill may actually be higher than the nominal share of costs advertised in the policy. This is confusing to insureds, especially when they believe that their benefits will be reduced by only a defined percent when they receive care from a non-network provider.
- Even though PPO policies do state that the insurer will base its benefit on the plan's "allowed amount" or "usual, customary, and reasonable charge", the insured has no information to evaluate the impact of such a provision.

B. Recommendations.

Therefore, the Committee recommends the attached bill entitled "Payment Obligation Disclosure." In summary, the bill does as follows:

- Requires health benefit plans that do not utilize the fixed dollar co-payment method to calculate benefit amounts for covered services to:
  - Clearly indicate to the insured whether they will be subject to balance billing from any providers.
  - Explain how the plan calculates its share and the insured's share of the claim if the insured will be responsible for anything other than a fixed-dollar co-payment.
  - Include information about how the actual calculation was made for each claim.
  - Include in their member materials a notice advising that the insured's actual share of a claim may exceed the stated coinsurance percentage.

3. Managed Care Ombudsman

A. Findings.

Based upon presentations, the Committee finds that such an ombudsman program will be beneficial to the citizens of North Carolina. In support of this finding, the Committee states the following:

- The presentation of information to enrollees regarding their benefits is often confusing, especially with respect to benefit rights.
- It would be in the best interest of the citizens to have an individual designated to provide information and guidance to the enrollees of HMOs.
- Currently, there is no one designated person that an enrollee may call upon for assistance in filing grievances and appeals with HMOs regarding health care decisions.

B. Recommendations.

Therefore, the Committee recommends the attached bill entitled "Managed Care Ombudsman." In summary, the bill does as follows:

- Creates the office of the Managed Care Ombudsman with the following duties and responsibilities:

    (1) Develop and distribute educational and informational materials for consumers explaining their rights and responsibilities as HMO enrollees.
    (2) Assist HMO enrollees in filing appeals and grievances pertaining to insurance matters and to assist HMO enrollees in utilizing internal review procedures remedies on behalf of HMO enrollees.
    (3) Publicize the Office of the Managed Care Ombudsman.
    (4) Answer inquiries posed by HMO enrollees.
    (5) Compile data on the activities of the Office, and evaluate such data to make recommendations as to the needed activities of the Office.
    (6) Assist consumers with complaints not relating to appeals, referring those complaints that appear to be of a regulatory nature to regulatory staff within the Department of Insurance.

4. Health Plan Disclosure

A. Findings.

Based upon the presentations and briefings, the Committee finds that consistent, comparable presentation of health benefit plan information would be in the best interest of the consumer. In support of this finding, the Committee states the following:

- Plan summaries commonly prepared as marketing and reference material for insureds are currently subject to limited standards, especially relative to some of the features specific to managed care plans.
- Companies are free to choose the content format and organization of the summaries.
- Wide variations in summary information from insurer to insurer and from plan to plan make it difficult for consumers to compare companies and plans.

B. Recommendations.

Therefore, the Committee recommends the attached bill entitled "Health Plan Disclosure." In summary, the bill does as follows:

- Standardizes the content, formatting, and organization of plan summaries to facilitate comparison.

5. Provider Directories

A. Findings.

Based upon the presentations and briefings, the Committee finds that consumers of health insurance companies need additional information from health insurance companies in order to make informed decisions regarding providers. In support of this finding, the Committee states the following:

- Provider directory information is important to consumers when they are selecting a health plan.
- Once a consumer is covered by a plan, the consumer needs current information on providers when they are preparing to obtain services under the applicable benefits.
- Currently, there are no standards for HMO and PPO plans' distribution of provider network directories or updating the information, and there are few standards as to the content of the directories. Consumers sometimes have difficulty in obtaining complete and/or updated directory information.

B. Recommendations.

Therefore, the Committee recommends the attached bill entitled "Provider Directories." In summary, the bill does as follows:

- Establishes requirements for when and to whom HMOs and PPOs must provide directories and updated directory information.
- Establishes the minimum information to be included in the directory.

6. HMO Patient Protection

A. Findings.

Based on presentations and briefings, the Committee finds that current law in North Carolina does not provide for a mandated external appeal process whereby members of a managed care health plan, having exhausted the plan's internal appeal and grievance process, can have their disputes heard before an independent panel in an unbiased forum.

Also, based on presentations and briefings, the Committee finds that a wide variety of entities are integrating the functions of paying for health care, determining what health care is paid for, and providing the care. This integration of functions is breaking down traditional distinctions. Increasingly, payor determinations are governing health care and controlling decisions that in the past were the exclusive domain of health care providers and patients. The Committee further finds that this integration of functions makes it imperative that managed care entities be held fully responsible for the consequences of their decisions, as much as health care professionals have been held responsible for the consequences of their decisions.

B. Recommendations.

Therefore the Committee recommends the attached legislation, entitled "HMO Patient Protection." In summary, the bill establishes:

- An external, independent review process managed care enrollees to obtain an unbiased review of disputes and a binding decision regarding complaints and issues relating to their health benefit plan; and
- A statutory standard of care for managed care entities in making health care treatment decisions and provides for remedies for violation of that standard.

7. Prevention of Group B Streptococcus Infections in Newborns

A. Findings.

Based on presentations and briefings, the Committee finds the following concerning Group B Streptococcus (GBS) Infections:

- GBS is a bacterium that can be transmitted to newborns from their mothers during birth. The transmission of GBS during labor and delivery may result in a very serious invasive infection in the newborn during the first week of life.
- Invasive GBS disease in newborns may result septicemia, pneumonia, meningitis and brain damage or death. In 1996, it was reported that approximately 7,600 episodes of GBS septicemia occurred in newborns in the United States (1.8/1,000 births). 310 babies died in 1996.
- Nationally, the incidence of GBS has declined by 65% since 1995. The estimate is that in 1998, 3900 neonatal GBS infections and 200 neonatal deaths were prevented by prenatal GBS testing.
- In 1995, 130 cases of GBS infection were reported in North Carolina. (1.28 per 1,000 births). In 1999, the number of reported cases dropped to 41.

The Committee also finds that the State's current system of surveillance, monitoring and reporting of the incidence of early-onset GBS infections needs improvement. This finding is based on the following:

- The incidence data provided to the Committee may not provide an accurate count of the total number of cases of GBS infections in newborns. Despite the best efforts to obtain accurate and complete data, the data that was provided are based solely on the number of newborns diagnosed with GBS reported to the North Carolina Hospital Discharge Database. These data may include cases that were not confirmed with laboratory tests, resulting in an over-count. In addition, the data did not include infants discharged with a diagnosis of streptococcal septicemia, since the specific type of streptococcal pathogen was not identified, resulting in an under-count.

The Committee finds that Obstetricians and other prenatal health care providers in North Carolina are implementing the GBS prevention guidelines set forth as follows and that insurance carriers cover the prevention procedures.

- The Centers for Disease Control and Prevention issued prevention guidelines in 1996 urging doctors to adopt one of two strategies:
  - The first strategy is to provide routine screenings at 35-37 weeks of gestation. If the GBS infection is found, then the woman receives antibiotics before delivery. This strategy is estimated to prevent 86% of this disease.
  - The second strategy is to provide the antibiotic to women who exhibit risk factors for GSB at the time of delivery. However, this second strategy misses women who are GSB-positive but do not exhibit risk factors. This population is estimated to deliver 25-30% of GSB babies.

B. Recommendations.

Therefore, due to the concern that the BBS incidence data may not reflect the true incidence rate of GBS disease in newborns in this State, and therefore State public health leaders are unable to ascertain the actual burden of disease resulting from GBS infections, the Committee recommends to the Secretary of the Department of Health and Human Services that the Department should establish through the appropriate local health agencies or institutions surveillance systems to monitor and report the incidence of early-onset GBS disease in newborns. For surveillance systems that are currently in place, the Department should assess how to improve the accuracy of reporting.

8. Prescription Drug Assistance for Disabled Persons

A. Findings.

Based on presentations and briefings, the Committee finds that the Department of Health and Human Services is expected to propose legislation to establish a prescription drug assistance program to assist low-income elderly and disabled persons to the 2001 General Assembly. Its proposal is expected follow the working group's recommendations, including defining a disabled person consistent with how Medicare defines a disabled person. Under Medicare, a disabled person is a person who has received Social Security or Railroad Retirement disability benefits for more than two years. Thus, this definition places a two-year waiting period on an otherwise eligible beneficiary. If the drug assistance program defines a disabled person as someone who is disabled and *currently* receiving Social Security disability benefits, then eligibility for drug assistance benefits would begin at the time the person begins receiving Social Security disability benefits.

B. Recommendations.

Therefore, to assure that all low-income disabled persons are given an equal opportunity to benefit from the drug assistance program without regard to the length of time the person has been disabled, the Committee recommends to Governor-Elect Easley, the Secretary of Health and Human Services, the House of Representatives Appropriations Subcommittee on Health and Human Services, and the Senate Appropriations Committee on Human Resources that any legislative proposal submitted to the General Assembly by the Department of Health and Human Services to establish a prescription drug assistance program for low-income elderly and disabled persons should define a disabled person as a person who is disabled and:

1. Who is receiving Social Security disability benefits;
2. Who is not eligible for full Medicaid benefits;
3. Whose income is not more than one hundred and fifty percent (150%) of the federal poverty level; and
4. Whose assets do not exceed $4,000 for a single person or $6,000 for a couple.

APPENDIX A

SESSION LAWS 1999 - 395

AN ACT TO AUTHORIZE STUDIES BY THE LEGISLATIVE RESEARCH COMMISSION, TO CREATE VARIOUS STUDY COMMISSIONS, TO DIRECT STATE AGENCIES AND LEGISLATIVE OVERSIGHT COMMITTEES AND COMMISSIONS TO STUDY SPECIFIED ISSUES, AND TO AMEND OTHER LAWS.

The General Assembly of North Carolina enacts:

PART I.-----TITLE

Section 1. This act shall be known as "The Studies Act of 1999".

PART II.-----LEGISLATIVE RESEARCH COMMISSION

Section 2.1. The Legislative Research Commission may study the topics listed below. When applicable, the bill or resolution that originally proposed the issue or study and the name of the sponsor is listed. Unless otherwise specified, the listed bill or resolution refers to the measure introduced in the 1999 Regular Session of the 1999 General Assembly. The Commission may consider the original bill or resolution in determining the nature, scope, and aspects of the study. The following groupings are for reference only:

. . .

(2) Insurance and Managed Care Issues:

a. Managed care issues, including any willing provider, patients' rights, managed care entity liability, office of consumer advocacy for insurance, prompt payment of health claims, and related issues (S.B. 1089 - Harris, H.J.R. 1461 - Mosley).

b. Mental health and chemical dependency parity (H.B. 713 - Alexander; S.B. 836 - Martin of Pitt).

c. Health reform recommendations of the Health Care Planning Commission and its advisory committees (established by Section 1.2 of Chapter 529 of the 1993 Session Laws) that have not been implemented but are still needed and other health reform issues (Insko).

d. Pharmacy choice/competition (H.B. 1277 - Cole; S.B. 137 - Rand).

. . .

Section 21B.4. The Commission may make an interim report to the 1999 General Assembly, Regular Session 2000, upon its convening, and shall make its final report to the 2001 General Assembly upon its convening, and to the Governor. Upon submitting its final report, the Commission shall expire.

Section 21B.5. Upon approval of the Legislative Services Commission, the Legislative Services Officer shall assign appropriate professional staff from the Legislative Services Office of the General Assembly to assist with the study. The House of Representatives' and the Senate's Supervisors of Clerks shall assign clerical staff to the Commission, upon the direction of the Legislative Services Commission. The Commission may meet in the Legislative Building or the Legislative Office Building upon the approval of the Legislative Services Commission.

Section 21B.6. The Speaker of the House of Representatives and the President Pro Tempore of the Senate shall each designate a cochair of the Commission. The Commission shall meet upon the call of the cochairs. A quorum of the Commission is 10 members. While in the discharge of its official duties, the Commission has the powers of a joint committee under G.S. 120-19 and G.S. 120-19.1.

Members of the Commission shall receive per diem, subsistence, and travel allowances in accordance with G.S. 120-3.1, 138-5, or 138-6, as appropriate.

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