THE REGULATOR™
INSURANCE REGULATORY EXAMINERS SOCIETY

When Medicare HMOs bail out on their policyholders

by Scott Hoober
Special to *The Regulator*

Pennsylvania. Texas. New Mexico. New York. Louisiana.

In these and numerous other locales across the U.S., managed care organizations have been dropping their Medicare customers, forcing seniors to scramble for new coverage — and prompting them to call their insurance departments' consumer hotlines.

The phones start ringing each fall, since HMOs must notify their members by October 2 of their intent to drop coverage, with the change taking effect on January 1. The latest round, in the fall of 2000, affected 941,000 Medicare recipients all across the U.S. — more than twice as many as the year before.

Is the Medicare HMO on the way out?

The answer is "Probably not." In the first place, although anguished senior citizens make good TV interviews, in most of the nation Medicare HMOs continue to provide good care at a good price. As of May 1, despite nearly a million involuntary dropouts, the so-called Medicare+Choice plans still covered 5.6 million retirees.

As Darin Wipperman, managed care specialist with the Health Care Financing Administration (HCFA), points out, the 52,000 Medicare recipients forced to find new care in California certainly faced a major inconvenience and expense — but with some million and a half Medicare HMO enrollees in the state, it's hard to see a systemic crisis.

Indeed, in his first public statement as HCFA administrator under the Bush Administration, Thomas A. Scully said he hopes to double

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Assessing our health care privacy

EDITOR'S NOTE: *The Health Insurance Portability and Accountability Act (HIPAA) of 1996 required the U.S. Department of Health and Human Services to issue a health privacy regulation in the event Congress failed to enact medical privacy legislation by August 1999. Since Congress did not enact such legislation within the prescribed time frame, the Director of the U.S. Health and Human Services Department promulgated the required medical privacy regulation on April 14, 2001. The following questions and answers were provided by Georgetown's Institute for Health Care Research and Policy to assist IRES members in understanding the background and details of this important regulatory initiative.*

1. Why is a federal health privacy law needed?

There is more health-related information being collected and shared about people than ever before – and until now, there were almost no legal limits on how this information could be used and disclosed. This means that medical

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From the President

Good-bye

As I write this column, it's hard to believe that our annual CDS in Baltimore is almost upon us. Our various Educational Committee members and David and his staff have already put a lot of time and effort into making this seminar one that will be recognized by IRES members for its quality and diversity of insurance regulatory topics. If you have not registered yet, I encourage you to do so and look forward to seeing you in Baltimore. Don't miss out!

With the passage of the Gramm-Leach-Bliley legislation, we regulators will continue to confront the challenges of globalization, uniformity and financial integration. Technological advances will also test our ability to monitor a rapidly changing insurance marketplace. I urge you to keep an open mind about the changes taking place in the marketplace and to work hard to bring about real benefits to insurance consumers, our most important constituents.

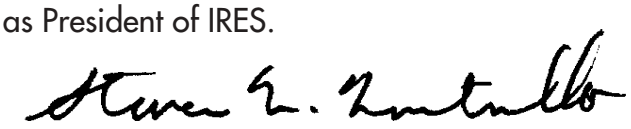
As this is my last column as President of IRES, I would like to recognize those individuals who have made my job easier. First of all, to Wayne Cotter, the Editor of *The Regulator* who helped shape my column to make me look more literate than I am. To my Executive Committee, Jann, Paul, Weldon, Ed, Angela and Pam, a job well done. Your work, effort, guidance and support were much appreciated. To David Chartrand and his staff, Susan, Joy, Paula, Art and Scott, thanks for all the help. IRES is very

fortunate to have such competent and dedicated people.

I also would like to thank New York's former Superintendent of Insurance Neil Levin and the current Superintendent, Gregory Serio, for their support during my term of office.

Best wishes also go to our President-elect Jann Goodpastor for her upcoming term of office. I am confident of Jann's ability and know she will do an excellent job as your President. I urge all of you to participate in our organization and help Jann during her term of office. I know I will.

It has been an honor and privilege to serve as President of IRES.



IRES PRESIDENT

Editor's Note: Thanks, Steve, for your support and assistance during the year. *The Regulator* salutes you for a job well done.

Looking ahead

- **2001 — IRES CDS. Baltimore. July 29 Hyatt Regency Inner Harbor**
- **2002 — IRES Foundation annual Market Conduct School for industry, April 7 San Diego Harbor Island Sheraton**
- **2002 – IRES CDS. San Antonio. July 28-30 Hyatt Regency Riverwalk**
- **2003 — IRES CDS. Scottsdale, Ariz. Hyatt Gainey Ranch**

C.E. News

Attention CDS attendees:

Those of you who are attending the CDS in Baltimore be sure to read the rules for continuing education credit. To get automatic, full (15 hrs) CE credit, you must stay until the end of the CDS. Attendance certificates will not be handed out until 3 p.m. Tuesday, the last day of the CDS. There will be no exceptions made – including travel/flight arrangements. Those who leave early or do not pick-up their certificate will have to submit a N.I.C.E. compliance reporting form and will be granted a maximum of 12 CE credits.

New IRES Web site Feature

As an accredited member of IRES you may now check your CE credits online at **www.go-ires.org**. Check it out! Click onto "Check your CE credit" under the NEW @ IRES listing on the lower left hand side of the IRES home page. The latest summary was posted May 15, 2001. Any credits submitted after that date will appear on the next update.

Also, check out the downloadable NICE manual while you are online and print out the NICE compliance reporting form if you need it. It's that easy.

N·I·C·E

When Medicare HMOs bail on their customers

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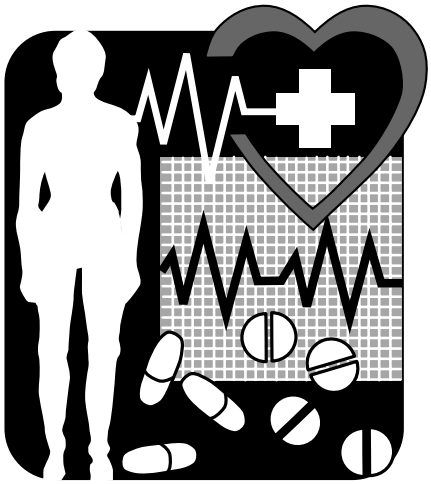
Medicare HMO enrollment, from 14% of all seniors today to 30% by 2005.

Cost cutting

Just about every senior who signs on with a managed-care plan represents a savings to the Medicare program. That's why Congress and the administration have been working to save Medicare+Choice, not kill it. HCFA's Scully says the Bush administration is planning to reduce federal regulation of HMOs, give the elderly more information on their health-care options and publicize doctors' and hospitals' quality of care — though he didn't mention reimbursement rates, which are set by Congress.



The current problems faced by some Medicare HMOs illustrate just how much the nation has come to count on managed care.

Today's HMO isn't the HMO of 20 years ago. Doctors, nurses and technicians are no longer on the plan's payroll, for instance. But whether they're called PPO's, IPA's or POS's, managed care plans dominate the health care landscape. Fully 85% of Americans with insurance are enrolled in managed care.

By contrast, the traditional staff-model HMO (think Kaiser-Permanente, with doctors on the payroll) represents less than 5% of the nation's total health-care market.

"Managed care conceptually is a pretty good thing," said Guenther Ruch, administrator of the Wisconsin insurance department's Division of Regulation and Enforcement — who himself is a member of one of the few remaining staff-model plans.

"This is not a simple issue," he added.

Medicare HMOs hark back to an era when HMOs were scrambling for market share, and when managed care's cost-cutting innovations were so effective that the plans made big bucks on what became known as Medicare risk contracts.

The idea was that HCFA would turn over cash each month to HMOs that agreed to take over seniors' health care. The plans were then at risk if costs came in higher than reimbursements.

The number of Medicare beneficiaries in Medicare+Choice tripled between 1993 and 1998, reaching 6.4 million in 1999.

What HCFA did was figure the average per-capita cost of a Medicare member's care in a given metropolitan area — and then give the HMO 95% of that figure.

That guaranteed the feds a 5% reduction in costs for each senior signed up. And with HMO care costing less than fee-for-service care, the HMOs did fine as long as they could sign up a reasonable cross-section of their service area's Medicare recipients. Many plans offered coverage for the cost of their reimbursement alone, with no additional premium, while others added extra benefits, from drugs to durable medical equipment, often with little or no separate premium.

Since that time, however, everyone else has learned how to shorten hospital stays, do same-day surgery, reduce unnecessary emergency room visits and otherwise control costs, reducing managed care's appeal and sending staff-model plans to the dust heap.

The 5% Solution

But one thing has stayed pretty much the same: the 5% solution.

HCFA still gives managed-care plans 95% of the average per-capita cost. Meaning that for every Medicare patient taken off their hands, their costs drop by 5%.

"Medicare is going broke without something to control costs, and the HMOs are the only game in town," said Michael Wood, former head of the National Center for Managed Care Administration. "Nobody else is controlling costs.

"The administration will have to give some favorable treatment in some modest way to some kind of managed-care plans. Who knows how broke they'd be if there hadn't been some people in HMOs."

HCFA's Wippereman questions Wood's math — but not his conclusion.

"The payment formula isn't solely based on the 95%," he said. "There have been some changes from the Balanced Budget Act. Those changes have led to some concern that supplemental payments and the gradual delinking from fee-for-service cost are actually

making it more likely that the program is spending more than it would if folks were in fee-for-service.

Despite their problems, though, Medicare HMOs continue to be a pretty good deal for beneficiaries, measured by either relatively rich packages of benefits or lower costs.

The question is whether HMOs have been profiteering — though when insurers drop a million customers, the odds are they really and truly aren't making money on that line of business.

"The HMO party line is they're not making enough money, and they're dropping counties to prove it," said Wood. "But the feds' Mathematical Policy Institute comes out with studies all the time that say that HMOs should be saving 8% or 10%."

Whether or not HCFA is still saving 5%, managed care still gives Medicare recipients a better deal than the typical indemnity plan.

An insured tie-in plan can easily cost $200 a month, said Wood, while many managed-care plans offer seniors coverage for perhaps $65-75 a month.

"If you buy it without drug coverage, you can get it for $10 or $20."

Drug coverage is a hot issue since several recent studies, including ones by HCFA and Express Scripts, have found that seniors without prescription coverage often simply do without, leaving conditions untreated.

Drug costs

The trend, in both Medicare HMOs and all other health plans, is toward offering a pharmacy benefit that lets members pay a really great price for generic drugs, a not-so-great price for name-brand drugs on the formulary and a really not-so-great price for drugs that aren't on the formulary at all.

"If you've got to have Claritin, which costs much more than Allegra, go ahead — you pay for it and you get it," as Wood put it.

Wisconsin's Ruch says drug costs have little to do with Medicare+Choice's problems.

"This is not a prescription drug issue at all," he said. "Medicare doesn't cover prescription drugs."

The problem, Ruch says, is inequitable reimbursement rates. "In some parts of the country, their reimbursement rate is based upon a data set that doesn't reflect the marketplace for them."

Wipperman and Wood differ, saying that prescription drugs are the problem — if only because many plans have added drug coverage to their benefits packages and then had trouble paying the bill as usage and prices went through the roof. But perhaps they're also part of the solution.

If Congress actually manages to fund some sort of Medicare drug benefit, that would make all the difference in the profitability, and hence availability, of Medicare HMOs.

"If there was Medicare coverage for a drug benefit," said Wipperman, "then [managed-care] organizations would be directly paid for that.

"Prescription drugs would increase payments all around."

Some of the other trends in health care at large are also having a big impact on Medicare HMOs.

> **"Medicare is going broke without something to control costs, and the HMOs are the only game in town. . .Nobody else is controlling costs."**

For instance, the ever-popular patients' bill of rights, proposed in a number of states as well as at the federal level, doesn't just give patients the right to sue their HMO, it also takes away many of the remaining advantages of managed care.

Managed care manages care, and reduces the cost of that care, by such things as controlling inappropriate use of high-priced medical facilities (such as visiting the emergency room for the sniffles) and paring the use of high-priced subspecialists (by requiring a referral from a primary-care physician). Yet such moves would be outlawed by some of those patients' bills of rights.

Many states report significantly higher complaint levels for indemnity plans than for managed-care plans, so patients' rights could be more p.r. than health care. But no one ever lost an election by appealing to his or her constituents' freedom of choice.

The regulator's role

Unfortunately, much of the debate over Medicare's problems and solutions are occurring in Washington, far removed from the state capitals where most other health plans are regulated.

"We have no regulatory authority whatsoever over the benefit structure [of Medicare+Choice plans], we

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have no regulatory authority with respect to the marketing materials that they use, and we have no regulatory authority with respect to the relationships they have between the plan and the providers.

"So what regulatory authority does that leave us with?"

Consumers tend to feel that if it walks like insurance and talks like insurance, it must be insurance. And many of them know who to call when they have trouble with an insurer.

"People will complain to us," Ruch said, "and what we do here is verify the fact that it is a Medicare+ Choice plan and refer them to HCFA."

There's continued movement at the national level, but the only way it's likely to impact state regulators is if the feds solve Medicare's problems and those phones stop ringing.

The Balanced Budget Refinement Act, passed in late 1999, made a few changes in the program. And then late last year there was the Benefits Improvement and Protections Act (BIPA), popularly known as the Medicare givebacks bill, which put more money into HMOs' coffers as of March 1 of this year.

"BIPA also allowed organizations that nonrenewed to return to the program," said Wipperman, "and four contractors decided to come back in."

From the number of enrollees, all four seemed to retain a sizable portion of their nonrenewals.

The fact that after being kicked out of their health plan, thousands of seniors went back to that same plan as soon as it became available again says one of two things: Either they like HMO care, or there's no one else out there offering the combination of cost and benefits the way Medicare+Choice plans are.

"HMOs are trying to control costs and nobody else is," said Wood. "Has somebody got a better ballgame?" ■

Spreading the pain

If a managed-care plan feels it needs to drop out of Medicare+Choice (M+C) altogether — or drop a county or two, or change its benefits package or its premium structure — the annual process begins in July and takes effect on Jan. 1 of the following year.

"Managed care organizations are required to notify us of their intent to nonrenew in early July, the same date that adjusted community rating proposals are due," says Darin Wipperman, managed care specialist with the Health Care Financing Administration.

HCFA requires 90-day notification to members, which means that seniors who are about to lose their coverage learn about it on Oct. 2.

The 941,000 who lost their coverage as of January 1 of this year were located all over the nation, but Wipperman says the single biggest concentration was in HCFA's Region VI, which covers Texas, Louisiana, New Mexico, Arkansas and Oklahoma — and the state with the largest loss was Texas, where 180,000 Medicare HMO enrollees were dropped.

Another trend, he said, was for an area with numerous plans to have one or more of them pull out.

"If I recall, Suffolk County, N.Y. had five organizations leave," Wipperman said. "There's one left."

That's not necessarily good news for either the remaining plans or the dropped Medicare recipients. That's because in Suffolk County and other such places, the remaining plan or plans usually cap their enrollment at roughly the current level, using what HCFA calls a capacity limit.

"The purpose of a capacity limit is to say, 'We want to make sure our current members are able to access care, so we can only accept a certain number of beneficiaries,'" Wipperman says. "That's been a concept that's existed in the regulations for a long time, but because of the large number of beneficiaries impacted by nonrenewals, we've had them used far more extensively than in the past.

"Essentially, there are parts of the country that have M+C organizations operating, yet they're not necessarily available."

Assessing the nation's health care privacy rules

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records are often afforded *less* legal protection than credit reports and even video rental records.

Medical records are particularly vulnerable now as we move toward networked, electronic health information. The privacy regulation is part of a package of regulations mandated by the Health Insurance Portability and Accountability Act (HIPAA) that includes privacy, security, and electronic transaction standards. Taken together, they are designed to facilitate the development of a uniform computer-based health information system.

The privacy regulation has the force of law and will have a sweeping impact on the health care system.

2. Who is covered by the regulation?

The regulation only directly covers three kinds of entities: health care providers that transmit claims electronically, health plans (**Editor's Note:** "health plans" include health insurers, HMOs and most employer-sponsored health insurance benefit plans), and health care clearinghouses. The regulation includes an important requirement: if these entities share information they must establish contracts that protect the information as it changes hands.

3. What are some key changes from the draft regulation?

The Administration released a draft of this regulation in November 1999 and received more than 52,000 comments on it. The final regulation reflects many of the comments submitted – both by consumer advocates and health care industry representatives. Among the changes:

- The final regulation covers *all* "protected health information" held by a covered entity – paper records, electronic records and oral communications. The draft regulation only covered electronic records.
- The final regulation requires health care providers to obtain the patient's consent before disclosing information for treatment, payment, and health care operations. The draft allowed them to disclose information in these areas *without* authorization.
- The final regulation clarifies that while employers may obtain health information for the purposes of paying health care claims, this information may not be shared with employees that make decisions about hiring and firing. The draft regulation did not clearly address this issue.

4. How will the regulation impact the lives of average Americans?

Americans worry that their health information may be disclosed inappropriately and leave them vulnerable to unwanted exposure, stigma and discrimination. The regulation gives patients many new rights and privacy protections. Among them:

- The regulation gives patients a new right to access their own medical records. Today, only 20 states require doctors to allow people to see and copy their own medical records. This is an important new right.
- The regulation greatly restricts employer access to health information.
- The regulation requires health care providers and health plans to give people notice about how their information will be used and disclosed and what options they have to restrict access.
- The regulation ensures that psychotherapy treatment notes are kept confidential. Today, health insurance companies often demand to see highly sensitive treatment notes before they will reimburse for therapy. This regulation will make that practice illegal, and limit the amount of information that insurance companies can demand.

5. Are there any stories about people's health privacy being violated?

There are many stories about people's health information being shared – intentionally and unintentionally. Disclosure can result in embarrassment and even discrimination.

- Terri Seargent, a North Carolina resident, was fired from her job shortly after being diagnosed with a genetic problem that requires extensive treatment. Terri was a valued employee who received a positive review and a raise just before her discharge from the company.
- A hacker downloaded medical records, health information, and Social Security numbers on more than 5,000 patients at the University of Washington Medical Center.
- In 1998, Longs Drugs in California settled a lawsuit filed by an HIV-positive man. After a pharmacist inappropriately disclosed the man's condition to his ex-wife, the woman was able to use that information in a custody dispute.
- In 1999, a Washington, D.C., Superior Court jury ordered a local hospital to pay $250,000 to a patient for failing to keep that patient's medical records confidential. Co-workers learned of the victim's HIV status after an employee at the Washington Hospital Center revealed information in his medical record.

See the Health Privacy Project's Web site – **www.healthprivacy.org** – for a list of other stories that have appeared in newspapers across the country.

6. Doesn't the Americans with Disabilities Act (ADA) already prohibit employers from discriminating against people with disabilities?

The ADA and some state anti-discrimination laws prohibit *discrimination* based on a real or perceived disability. But there is no federal law that stops employers

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from *accessing* health information in the first place. Employees must pursue claims of discrimination at great cost and effort. Ultimately, privacy is the first line of defense against discrimination. The privacy regulation will help to ensure that employers only have limited access to health information for purposes of paying for health insurance. When you couple this regulation with the protections in the ADA you have much more comprehensive protections for people with disabilities.

7. How can the regulation be improved?

There were some constraints placed on the Administration by HIPAA. As stated, the regulation only directly covers three entities. The regulation is restrained by the civil and criminal penalties established in HIPAA. Congress should expand the scope of coverage to include the entire health care industry, and it should give individuals a right to sue for violations of the law.

8. How does the federal regulation interact with state law?

As mandated in HIPAA, the new federal regulation establishes a *baseline* of patient protections. Stronger – more privacy-protective – state laws will remain in effect. States are also free to enact stronger protections in the future.

9. What kinds of state laws exist now?

While many states have laws that address specific areas – such as HIV/AIDS or genetic testing – only a handful of states have anything approaching comprehensive privacy protections for medical records. These states are California, Hawaii, Maine, Maryland, Minnesota and Wisconsin. The lack of comprehensive privacy protections means that more often than not, people are vulnerable to unwanted and unexpected exposure.

- Only 18 states have statutes restricting how insurance companies can use and disclose health information.
- Only 20 states require doctors to allow people to see and copy their own medical record. Of these states, only 9 allow people to appeal the decision if a doctor refuses to provide access.
- Only four states – Hawaii, California, Connecticut and Maryland – have laws that restrict how employers can use medical information.

10. When does the regulation go into effect?

The regulation went into effect on April 14, 2001. The Department of Health and Human Services is considering some modifications, however, the regulation went into effect without any changes. HIPAA gives covered entities two years to come into *compliance*, so covered entities are not required to be compliant with the regulation until April 14, 2003.

11. What are the penalties for violating the regulation?

HIPAA establishes civil and criminal penalties for violations of the regulation. There is a $100 civil penalty up to a maximum of $25,000 per year for each standard violated. Criminal penalties are imposed for certain wrongful disclosures of health information. It is a graduated penalty that may escalate to a maximum of $250,000 for particularly egregious offenses.

12. Can an individual sue if his or her privacy is violated?

The Health Insurance Portability and Accountability Act (HIPAA) does not create a federal right to sue for violations of the Act. However, because the new regulation creates a new "duty of care" with respect to health information, it is possible that violations may be the grounds for state tort actions. ■

The questions and answers were prepared for *The Regulator* by the Health Privacy Project, Institute for Health Care Research and Policy, Georgetown University. Any IRES member with a question, can contact the Institute at 202-687-0880 or by e- mail at **info@healthprivacy.org**. The organization's Web site is www.healthprivacy.org.

Balti' More Than You Know!

Sure it's gonna be hot and probably humid as well, but Baltimore in July is full of things to do. Non-stop activities for kids, great places to eat, concerts, museums, historic sites, terrific shopping, even boat rides.

Right across from your conference hotel is Baltimore's jewel – the Inner Harbor. Harborplace, famous for wonderful eateries and fun shopping, is often a tourist's first destination. A brick promenade stretches in both directions and it's only your choice which way to explore first.

To the right down the walkway you'll pass several boats available for cruises. The Clipper City is a replica of a sailing schooner of the late 1800s. You can enjoy an open deck sail out towards the Chesapeake Bay. Other Harbor cruise ships offer fully narrated tours of the harbor and lunch, dinner and moonlight tours of the Patapsco River.

Continuing along the promenade is the Maryland Science Center. Just outside is a beautiful old carousel that you can ride. Keep walking past the pleasure boats docked and you get to the Rusty Scupper restaurant, a good place to eat and watch all the activity in the Harbor. Across the street from there is the Baltimore Visionary Arts Museum, one of the more unusual museums found in the City.

At Harborplace, taking the promenade to the left you'll see the USS Constellation, newly rebuilt from the original keel up, but actually the last surviving ship from the Civil War and the last all-sail warship ever built. A tour will teach you about life in the 19th century Navy. Just past the Constellation is Baltimore's World Trade Center. Visitors can take an elevator ride to one of the top floors for a spectacular view of the city.

Beyond the Trade Center is the fabulous National Aquarium, the city's most visited attraction. The complex features salt and freshwater habitats, a rain forest, tidal marsh, an icy seacliff, and even an Atlantic coral reef.

Continuing past the Aquarium you'll find an entertainment complex built in an old power plant. Just past the Power Plant, as the complex is called, is the Baltimore Maritime Museum.

Cross Light Street and walk a block to Port Discovery, a terrific hands-on kid's museum.

If you keep following the waterfront you'll find the Pier Six Concert Pavilion, an open-air concert venue offering a wide variety of summer concerts. Across from Pier Six is the Public Works Museum. From there, just across the street, is Little Italy. There you'll find a wonderful old neighborhood of typical Baltimore rowhouses and fabulous restaurants. Pick any place to eat — all are great!

So, we welcome you to Baltimore in July and invite you to stay well into August!

Recommendations by Debbie Rosen McKerrow, Maryland Insurance Administration

Odds and Ends

Recent Health-Related Studies*

Study	Sponsor	Brief Summary	Web Site
McCain-Kennedy: The Trial Lawyers' Pot of Gold	HIAA	This study takes a critical look at the proposed McCain-Kennedy patient care legislation (Patients' Bill of Rights).	www.hiaa.org
How Accessible is Individual Health Insurance for Consumers in Less-Than-Perfect Health	The Kaiser Family Foundation	An examination of the difficulties faced by consumers seeking health insurance coverage in the individual marketplace is the focus of this study.	www.kff.org
How the New Labor Market is Squeezing Workforce Health Benefits	The Commonwealth Fund	The study reveals that there has been a downward trend over the past 20 years in the number of private sector workers that receive employer-sponsored health insurance benefits.	www.commonwealthfund.org
Regional Variations in Prescription Drug Use	Express Scripts (a pharmacy benefits manager)	Using a random sample of Express Scripts members, this study concludes there is wide variation in prescription drug use across geographic regions.	www.express-scripts.com
2000 Drug Trend Report	Express Scripts (a pharmacy benefits manager)	Using a random sample of Express Scripts members, this study finds that the rate of increase in drug spending declined from 1999 to 2000.	www.express-scripts.com

* ***All studies released during June 2001. Prepared by Kathleen McQueen***

Persons Without Health Insurance

United States, 1990-1999

(numbers in thousands)

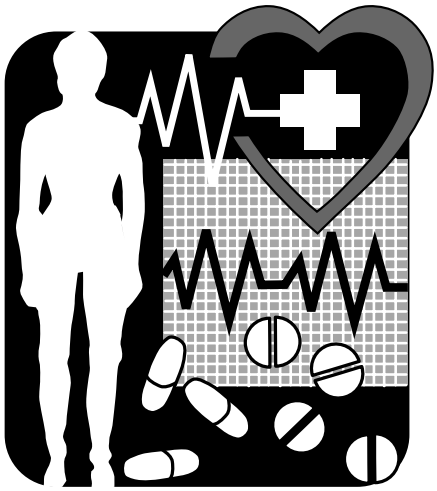
	All People	Uninsured	
		Number	Percent
1999	274,087	42,554	15.5%
1998	271,743	44,281	16.3
1997	269,094	43,448	16.1
1996	266,792	41,715	15.6
1995	264,314	40,581	15.4
1994	262,105	39,718	15.2
1993	259,753	39,713	15.3
1992	256,830	38,641	15.0
1991	251,447	35,444	14.1
1990	248,886	34,719	13.9

SOURCE: ESTIMATES ARE FROM CURRENT POPULATION SURVEY, (CPS) 1990-1999, U.S. Bureau of the Census

The CPS counts as insured those individuals with:
(1) employment-based health insurance coverage; (2) individual health insurance; (3) government health insurance such as Medicaid or Medicare; (4) military health coverage such as CHAMPUS; and (5) health insurance purchased through associations or organizations. An uninsured person would be one without any of these coverages.

Mental health and managed care: evaluating the results

by James Wrich
J. Wrich & Associates, Inc.



Regulators and Health Care: A Special Issue

Editor's Note: Over the past decade, health insurers have increasingly relied on managed behavioral healthcare organizations (MBHOs) to provide the mental health component of their health insurance policies. For millions of Americans, these MBHOs are now responsible for meeting virtually all of their mental health coverage needs.

But who are these firms and are they living up to their contractual obligations? Insurance regulators have a special interest in MBHOs because it is they who must ensure that MBHOs are providing appropriate and cost-effective mental health services to insureds.

Since 1992, J. Wrich & Associates, Inc. (JWA) has been conducting comprehensive performance audits of managed behavioral healthcare contracts. The findings, summarized below by J. Wrich's founder and president, were surprising to both the JWA auditors and their customers. They may also open the eyes of a few regulators.

Scope of Audits

J. Wrich & Associates audits typically focus on four major areas:

(1) Quality of Care: This involves an in-depth review of the diagnoses, referral and treatment by watching the type, level and length of care authorized to the patients' needs as indicated by findings in the patients' charts. Actual care delivered is also compared to written clinical policies and protocols.

(2) Administration: Management of the service is reviewed including quality assurance, accuracy of reported utilization and other data, to assess the impact of administrative practice on clinical services. The MBHO's relationship to the health care plan is also assessed.

(3) The Provider Network: The network is reviewed for its appropriateness and completeness including a rationale for assuring that the capabilities of selected providers will match expected high prevalence disorders among enrollees.

(4) Costworthiness: The ratio of premiums paid to cost of direct services delivered is a major focus. If applicable, we also attempt to assess the co-morbid impact of inappropriate behavioral health care practices on the customer's overall medical/surgical costs.

In addition, JWA reviews MBHOs' policies and procedures; interviews MBHO key management and clinical staff; analyzes case managers' patient charts; converses with network treatment providers; reviews claims paid; inspects the managed care contractor's intake and screening process; and observes the contractor's provider selection process by setting up double-blind mock interviews.

General Concerns

A number of our audit findings have caused concern. While they cannot be generalized to the entire managed care industry, there is significant similarity in placement criteria, practice guidelines, network development procedures and pricing among many of the firms.

Therefore, we believe caution is warranted when organizations turn the management of their behavioral health care programs over to a managed care organization. The following findings, while not universal, are not uncommon in audits we have performed.

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Mental health and regulation of managed care

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Utilization Overstated

The MBHOs we audited tended to overstate utilization. In some instances multiple patient numbers were assigned. One provider issued a new case number each time it authorized additional care. In other instances, case numbers were assigned on an annual basis, thereby counting enrollees more than once if service was provided in two or more calendar years. Several providers combined re-entries with first time users in their counts leading employers to believe utilization was twice the actual rate.

One major audit typified the problem. The contractor reported that it had served 5,085 individuals, while our audit estimated the actual utilization was 3,495 maximum. Thus, the MBHO had overstated the actual utilization by at least 45%.

Timeliness

We have consistently found timeliness of service to fall far outside of the providers' own performance parameters. Under a contractor's typical written standards routine cases are supposed to be serviced within 5 days, urgent cases within 24 hours and emergency services are expected to be provided within 2 hours. We found the actual performance of MBHOs failed to meet these typical standards, exceeding them *by 97% to 347%*.

Uneven Network Development

When MBHOs serve employee groups in multiple locations, we have found considerable unevenness in provider network development and accessibility.

Percentage of providers actually interviewed — In this crucial area we found a wide variation in performance from one MBHO to another. The smaller local and regional providers with whom we are familiar generally do a better job in this area than the large national firms. Well over half of the MBHOs we audited did not conduct an interview at all or in only a spotty fashion, and of those that did, most interviewed the providers over the telephone. Simply requesting paper confirmation of credentials and liability insurance is not a sufficient basis for assuring that the provider is competent.

Percentage of providers site visited — In audits JWA conducted we found the widest variation in quality of performance in this area. Two firms actually visited the sites of more than 90% of its network providers and had regularly scheduled repeat site visits. However, most MBHOs had never seen the offices or facilities of more than 75% of their providers. One MBHO with several thousand providers had not site-visited any provider except those that had received serious complaints about service.

Coverage — Coverage is frequently spotty,

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IRES Foundation establishes teaching award to honor the late Paul DeAngelo

The IRES Foundation Board of Directors has established the Paul L. DeAngelo Memorial Teaching Award for persons who have made major contributions to the education of insurance regulators, consumers and insurers.

The award will bring with it a $1,000 scholarship for attending insurance educational programs. The program is named in honor of the late Paul DeAngelo, New Jersey insurance regulator who died last year.

Nominees can be a current or former regulator with at least five years of regulatory experience, and must have participated as an instructor at educational programs sponsored by IRES, the IRES Foundation or the NAIC.

Other nomination details can be obtained by requesting a Paul L. DeAngelo Award nomination form from the IRES office in Olathe, Kan., 913-768-4700, ireshq@swbell.net. Or you may log on to the IRES Foundation Web site at **www.ires-foundation.org**

IRES FOUNDATION

Mental health and regulation of managed care

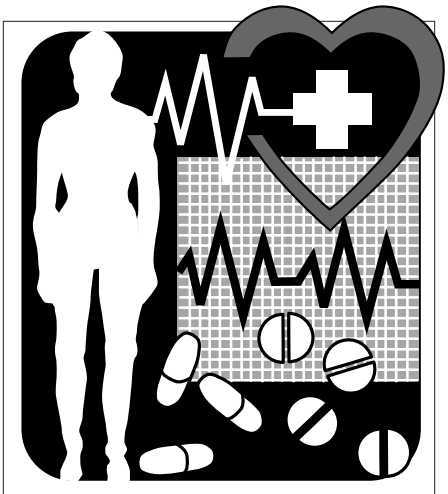
although from a geographic standpoint it has improved over the past seven years. In the case of one MBHO serving a statewide enrollee group, the contractor's proposal and initial agreement called for a minimum of one chemical dependency and one mental health provider in each county. To be lenient in the audit process, adolescent/child therapists or family counselors were counted in lieu of mental health providers. Two years into the contract there were still major gaps in the provider coverage as shown below:

	% Counties Not covered	% Enrollees Not Covered
No providers at all	15%	6%
No substance abuse providers	32%	19%
No mental health providers	16%	7%
No adolescent/child providers	25%	12%
No family counselors	21%	9%

The customer paid the full premium on 100% of the plan's enrollees during that time even though the MBHO's network was never completely in place to serve all of them. Our standards would require a pro-rata discount until the network had been fully developed.

Matching Service to Enrollees' Problems

We have also found that provider networks are rarely developed with adequate consideration of expected incidence of high-risk disorders. Two landmark studies of incidence and prevalence (the Epidemiologic Catchment Area Study and the National Comorbidity Study) indicate that as much as 80% of the adult population with a current behavioral health disorder suffer from one or more of these disorders: (1) substance use disorders; (2) major depressive episode; (3) anxiety disorder and (4) phobia.



Regulators and Health Care: A Special Issue

Only one small regional firm of the managed care organizations we have audited had built their networks on a research-based rationale of expected patient need reflecting these high-incidence disorders. None of the large MBHOs we audited used such a rationale.

Patient Chart Reviews

Patient chart audits have revealed a surprisingly high percentage of problems with the manner in which cases were handled clinically across a full spectrum of service components normally offered by any organization claiming expertise in behavioral health care. Our audits of patient charts have uncovered significant clinical problems in 30% to 58% of the cases reviewed. Deficiencies include failure to properly evaluate and treat substance abuse where the need was evident (54.8% to 78.3%), failure to properly follow-up (up to 78%), failure to provide care within three months due to administrative problems (up to 26%), and failure to refer patients to appropriate specialists (up to 13.2%).

Patient Placement Criteria

Some of the problems found in the patient chart review resulted directly from MBHO practice guidelines, the most significant being patient placement criteria and medical necessity definitions. Our audits have shown that the criteria for inpatient, residential or intensive outpatient treatment is often extremely restrictive.

One audit revealed that an MBHO required *all* of the following conditions or treatments in order to be authorized for inpatient care or intensive outpatient care:

• Patient must be suffering from an Axis I diagnosis (from the Diagnostic Statistical Manual of Mental Disorders (DSM)). An Axis I diagnosis covers disorders such as depression, anxiety and substance use. Patients who are suffering Axis II diagnosis (personality disorders, obsessive-compulsive disorders and mental retardation) are excluded under this standard;

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• For several types of disorders (such as substance abuse), patient must have already undergone prerequisite treatment failure at a lower level of care; and

• Patient must have attempted to harm self within the 24 hours preceding the request for care, or attempted significant action or harm to another person within the previous 24 hours, or significant threatening action to damage property with high lethality within that period.

Conduct disorders in adolescents were routinely excluded from any kind of treatment.

Expenses and Profit

In audits we have conducted, administrative loadings and profit totaling 50% or more of the premium paid in "at-risk" carve-outs are not uncommon**.** To date, we have not reviewed a service in which the combination of administrative loadings and profit was less than 45%.

One audit showed that during a two-year period the contractor had a maximum payout of 38.5% (including the direct service cost of its own staff) for clinical service resulting in estimated administrative loadings and profit of approximately 61.5%.

Implications and Potential Consequences

Traditionally, behavioral health care has represented less than 10% of total health care coverage costs, with the other 90% devoted to medical/surgical coverages. More recently, estimates for the behavioral health care component of total health care costs have been in the 3% to 5% range. In conducting studies of medical surgical claims, JWA have consistently found that a group generally consisting of 15% of the enrollees represent approximately 75% to 80% of the claims expenditures, including 5% who consume 40% to 55% of the total expenditures.

For years the literature has pointed to the strong comorbid relationship between substance use disorders and medical/surgical costs. (A comorbid relationship exists when two or more primary disorders exist simultaneously in the same person and each affects the other(s), *e.g.*, alcoholism and cirrhosis of the liver.)

With over 160 million enrollees in managed behavioral health care programs, one can only imagine the magnitude of the savings if plans were adhering to minimum mental health treatment guidelines.

"Failure of primary physicians to diagnose, appropriately refer and facilitate effective treatment of psychiatric and substance use disorders is probably the single most costly problem in the delivery of health care in the United States."

Failure of primary physicians to diagnose, appropriately refer and facilitate effective treatment of psychiatric and substance use disorders is probably the single most costly problem in the delivery of health care in the United States.

While one may not expect general practice MDs or MD specialists with virtually no training in substance use and psychiatric disorders to effectively handle such problems, tools are available to enable them to either rule out certain disorders or refer patients appropriately. However, in conducting audits of MBHO programs, we do not believe the same allowances should be afforded the psychiatrists, psychologists and social workers who are supposed to be the experts in these areas.

Conclusion

Appropriately delivered, managed behavioral health care can be a major factor in reducing health care expense. However, this requires that patients be provided the right care, the first time at a reasonable cost. In turn, this necessitates accurate diagnoses, appropriate referral, effective care and adequate follow-up.

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Mental health and managed care benefits

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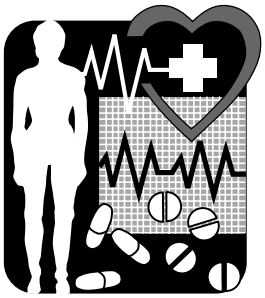
Unfortunately, having audited MBHOs representing roughly 40% of all those covered by such services, we have not seen such care on a consistent basis. Moreover, we do not believe this situation will improve anytime soon. Mergers and acquisitions have left nearly all the large MBHOs with large amounts of debt. When combined with increased market pressure to contain costs in light of double-digit cost increases on the medical side, we believe service is likely to worsen under the current system.



This situation can put increased pressure on overall health care costs. Further, inappropriately delivered managed behavioral health care will drive overall health care costs even higher than if nothing had been done. It will continue to add expense with negative value, especially in the administrative area. In the meantime, denial of care will continue to destroy the treatment system that could provide a solution.

This is an extremely critical period of time. With more than 160 million citizens now covered by some form of managed behavioral health program, the methods used to control costs need to be carefully monitored and objectively evaluated.

Moreover, meaningful standards geared to appropriate care must be established by regulators or other entities not financially dependent on the managed behavioral health industry itself. Not only is this necessary to assure the right care to those who need it, but to prevent serious additional financial and human damage that could be irreversible. ■

J. Wrich & Associates, Inc. (JWA) is a health systems performance company with 29 years of experience in the systems development and evaluation areas of substance abuse, mental health, EAP and managed care. Since 1978, the firm has performed benefit-to-cost analyses, performance audits and outcome evaluations of Employee Assistance Programs (EAPs) and managed care services on behalf of employers and unions.

UPDATE: UPS Wins!

On June 21, 2001, a federal appeals court in Atlanta reversed a 1999 ruling that United Parcel Service (UPS) engaged in sham transactions to avoid hundreds of millions of dollars in corporate income taxes each year since 1984.

The United States Court of Appeals for the 11th Circuit, in a 2-to-1 decision, rejected the United States Tax Court's finding that UPS used a sham insurance policy to move profits to an untaxed insurance affiliate in Bermuda. The appellate judge held that a patina of business purpose, combined with just a tiny prospect of profit or risk of loss, is sufficient to render a corporate tax shelter legitimate.

(IRES members may recall this case from "The UPS tax case: Where were the insurance regulators?" by Mark Gardner in the March 2001 issue of *The Regulator.)*

REGULATORY ROUNDUP

By
Stroock & Stroock
& Lavan LLP

The National Association of Insurance Commissioners ("NAIC") reports on Gramm-Leach-Bliley Act ("GLBA") compliance. The NAIC reported in May that 25 states, which reportedly account for one-third of licensed agents nationwide, have passed legislation designed to meet the producer-licensing deadline mandated by GLBA. Another 17 states have legislation pending.

Title III, Subchapter C, of GLBA mandates that a majority of states must pass laws requiring state insurance regulators to meet federal statutory requirements affecting insurance agent licensing. If the requisite number of states have not passed laws meeting the federal requirements, then, in accordance with GLBA, a new federal producer licensing organization known as the "National Association of Registered Agents and Brokers" (NARAB) will be established that will supercede the regulatory authority of the states over producer licensing.

To avoid creation of NARAB by November 12, 2002, a majority of the states must have laws and regulations in place that guarantee uniformity and reciprocal treatment for non-resident producers doing business in more than one state. Under GLBA, uniformity will be reached if a majority of the states: (i) establish uniform criteria regarding the integrity, personal qualifications, education, training, and experience of licensed insurance producers; (ii) establish continuing education requirements; (iii) establish uniform ethics course requirements; (iv) establish uniform criteria to ensure that an insurance product sold to a consumer is suitable and appropriate for the consumer; and (v) do not impose any requirements upon producers to be licensed or qualified to do business as a nonresident that has the effect of limiting or conditioning the producer's activities based upon the producer's residence or place of operations.

Reciprocity under GLBA will be reached if a majority of states: (i) permit a producer licensed to sell insurance in its home state to do business in other states after satisfying only certain minimum requirements such as submission of a licensing application and payment of all applicable fees; (ii) recognize for continuing education requirement the satisfaction by a producer of the producer's resident state's continuing education requirements; (iii) do not limit or condition producer activities based on the producer's residence or place of operations; and (iv) grant reciprocity to all other states meeting these requirements.

The NAIC has adopted a Producer Licensing Model Act to assist states with meeting the producer licensing uniformity and reciprocity requirements of GLBA. *For more information, please visit www.naic.org.*

NEW YORK — Governor proposes package to overhaul automobile insurance and target no-fault fraud. In May, Governor George Pataki proposed a package of regulatory and legislative changes designed to overhaul automobile insurance and combat fraud in New York. The legislative and regulatory package includes an Executive Order issued by the Governor that appoints the New York Attorney General as Special Prosecutor to coordinate the investigatory and prosecutorial efforts at the state level relating to any indictable offense involving motor vehicle insurance claims. The legislative portion of the package: (i) establishes a new crime of no-fault insurance fraud; (ii) makes acting as a "runner", defined as a person who, for a fee, procures a claimant to unlawfully obtain benefits, a crime punishable as a class E felony; (iii) establishes the crime of insurance fraud against a regulatory official by knowingly making false statements to a regulatory official to influence his or her actions or those actions of an insurance regulatory agency or one of its agents or examiners; (iv) establishes the crime of insurance fraud against an insurance business by knowingly misappropriating money or property from a person engaged in the business of insurance; (v) provides for reduced premiums through participation in preferred provider plans for auto-related medical treatments, alternative deductibles and optional co-payments; and (vi) requires insurers to appropriately reduce insurance premiums for motor vehicle comprehensive and collision insurance to reflect the cost savings that can be attributed to an insured's election to use specified motor vehicle repair shops. The legislation has been introduced in the Senate as Senate bill S.5367.

The regulatory package would reduce notice of no-fault claims to 30 days and implement consumer safeguards. Insurers would be required to establish objective standards of

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The New York-based Stroock & Stroock & Lavan LLP Insurance Regulatory/Corporate Practice Group includes Donald D. Gabay, Martin Minkowitz, William D. Latza, and Vincent Laurenzano, an insurance finance consultant. They gratefully acknowledge the assistance of Robert Schmidlin, an associate with the Group. This column is intended for informational purposes only and does not constitute legal advice.

review when notice is given after 30 days to determine whether the delay was reasonable.

The right to special expedited arbitration dedicated to the resolution of cases would be created where an insurer rejects reasonable justification for failure to give timely notice. *For more information, please visit www.ins.state.ny.us.*

NEW YORK — Court of Appeals Holds That Only Total Loss Is Compensable Under No-Fault Statute. The New York State Court of Appeals (the "Court of Appeals") unanimously held that only a total loss is compensable under the permanent-loss exception of the no-fault automobile insurance provisions of Article 51 of the New York Insurance Law ("Insurance Law") in personal injury auto cases.

Oberly v. Bangs Ambulance, 2001 N.Y. Slip Op. 03711, arises from an appeal by a New York dentist who went to a local hospital complaining of chest pains and was later transferred by an ambulance service to another hospital. While en route, the ambulance struck a curb, causing an intravenous pump to topple and fall onto the dentist's right forearm. Oberly sought to recover as a "serious injury" under the state's no-fault provisions, alleging that the injury affected his ability to practice dentistry.

A trial court held that the dentist could not sustain his claim because of the lack of evidence of a "serious injury" and dismissed the action. The Appellate Division upheld the dismissal in a 3-2 decision.

The Court of Appeals stated that the no-fault law was adopted by the Legislature in 1973 to "assure prompt and full compensation for economic loss and to provide for non-economic loss in the case of serious injury." The 1973 law originally contained two categories of "serious injury", claims for death, dismemberment, significant disfigurement, certain types of fractures and "permanent loss of use of a body organ, member, function or system" and claims for medical charges in excess of $500. The law was amended in 1977, adding two new categories including "permanent consequential limitation of use of a body organ or member" and significant limitation of use of a body function or system." Construing the "permanent loss of use" for the first time, the Court of Appeals concluded "that only a total loss of use is compensable under the 'permanent loss of use' exception to the no-fault remedy." The Court of Appeals reasoned that the statutory text mandated the decision and concluded that by amending the definition of "serious injury," the Legislature intended in 1977 to create a consistent framework.

The decision is expected to significantly narrow the pool of eligible plaintiffs under Article 51 of the Insurance Law. *For more information, please visit www.law.cornell.edu/ny/ctap/*

OHIO — State Senate Passes Bill Designed to Address Situation Arising from Recent Ohio Supreme Court Rulings. In a move to circumvent the results of recent Ohio Supreme Court (the "Ohio Court") rulings such as those in *Scott-Pontzer v. Liberty Mutual Fire Insurance Company,* 85 Ohio St. 3d 669 (1999) and *Linko v. Indemnity Insurance Company of North America,* 90 Ohio St. 3d 445 (2000), the Ohio State Senate passed Senate Bill 97, the "Uninsured and Underinsured Motorists Availability Act of 2001." Its companion, House Bill 257, is now under consideration in the House. Under current Ohio law, uninsured/underinsured motorist coverage is a statutorily mandated offering. Senate Bill 97 would end this state law requirement. Senate Bill 97 also includes an exclusion from coverage under an employer's insurance policy when employees are not acting within the scope of their employment, and reduces the 15-year time period for policyholders to file uninsured/underinsured motorist claims to two years.

In the *Scott-Pontzer* case, the Ohio Court held that a widow could claim uninsured motorist benefits under the commercial automobile policy that was issued to her late husband's employer. The husband was killed by an uninsured motorist while driving his wife's automobile on a personal errand that was not within the scope of his employment. The insurance company had denied the claim because the husband was not the named insured on the policy and was not acting within the scope of his employment when he was killed. The Ohio Court held the husband qualified as a named insured because corporations only act through their employees and because the policy did not specifically state that the employees had to be working to be covered. In the *Linko* case, the Ohio Court held that a parent company's rejection of uninsured/underinsured motorists coverage for all its subsidiaries is not an adequate rejection under Ohio law. The Ohio Court held that to be a valid rejection all related companies must have expressly rejected the coverage. The impact of *Linko* invalidated many rejections of uninsured/underinsured motorist insurance coverage in Ohio. *For more information, please visit www.legislature.state.oh.us.*

RHODE ISLAND — State Senate Passes Flex Rating Legislation. The Rhode Island State Senate passed legislation, Senate Bill 401, that would permit insurance companies to use flex rating for non-business automobile insurance policies. Proponents of the bill believe that allowing insurers to adjust their rates without having to first submit a request to the Rhode Island Insurance Department will reduce administrative costs, generate competitive pricing and allow the Rhode Island Insurance Department to focus on other important tasks such as solvency regulation and market conduct examinations. *For more information, please visit www.rilin.state.ri.us.*

Regulators go to school with IRES and NAIC

Nearly 40 state insurance regulators from around the country went back to school in early May as part of the advanced "Regulating the Marketplace" school conducted annually by IRES and the National Association of Insurance Commissioners.

The school covers all areas of insurance regulation, but focuses on more in-depth, advanced discussions that demonstrate the need for all regulators within an insurance department to communicate with one another and function as a team to police the insurance industry and protect the public.

The sessions include lectures by regulatory experts, technology demonstrations and "case study" sessions. In the case studies, the students are presented with descriptions of possible regulatory problems or controversies. They then break up into teams to discuss how to solve the problems, after which they share their recommendations and ideas with the entire class.

IRES Financial Statement and Annual Audit

Recently IRES had its first audit of its financial records conducted by Harris, Hardy & Johnston, P.C., Independent Certified Public Accountants. Harris, Hardy & Johnston issued its opinion on April 24, 2001, that IRES's statement of cash receipts and disbursements presents fairly, in all material respects, IRES's cash receipts and disbursements for the year ended December 31, 2000, under the cash basis of accounting. Here are some highlights from our Statement of Cash Receipts and Disbursements.

During the year of 2000, IRES's Total Cash Receipts were $262,264 and the Total Cash Disbursements were $325,302. The 2000 Total Cash Disbursements included a 1999 CDS expense of $57,055. IRES's Cash at December 31, 2000 totaled $73,145.

A complete copy of the audited report is posted on the IRES web site (www.go-ires.org) — or you can request a complete copy of the audited report by sending a written request to the IRES administrative office in Olathe, Kan.

R. Weldon Hazlewood, CIE
IRES Treasurer
Chair, Budget and Finance Committee

Insurance Quote of the Month

"They're outrageous. I have yet to see one that's clear. With all the triple and quadruple negatives contained in the language, I think they're purposely being deceitful."

— Edmund Mierzwinski, director of the U.S. Public Interest Research Group, Washington D.C., discussing the privacy notices sent to consumers by financial services firms to comply with S. 900.

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THIS ISSUE:
Regulators and Health Care: A Special Issue

BULLETIN BOARD

√ You can now check on your IRES continuing education credits by using the Society's Web site. We have begun posting a database that will allow AIE and CIE designees to look up their C.E. credit totals on a periodic basis. Just go to the www.go-ires.org home page. You'll see a link called "Check your CE Credits." Click there and you'll be taken to the new self-query database. On your first trip, you'll need to assign yourself a password to access your records. The IRES continuing ed department will update this list several times during the year.

√ Wanna serve on an IRES committee or help plan one of our schools or seminars? If you have a little time to make some phone calls and line up a few speakers, we could use you!! Call David at the IRES office, 913-768-4700.

In the next REGULATOR:

Highlights from the Baltimore Career Development Seminar

Welcome, new IRES members!

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Tressa W. Coward, MS
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Kam Fong, CA
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